Case Nos. 19-35017 and 19-35019

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

ADREE EDMO,
Plaintiff-Appellee,
v.
IDAHO DEPARTMENT OF CORRECTIONS, ET AL.,
Defendants-Appellants.

On Appeal from Orders of the United States District Court
For the District of Idaho
(No. 1:17-cv-00151-BLW)

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Lawrence G. Wasden,
Attorney General State of Idaho
Brady J. Hall,
Special Deputy Attorney General
Marisa S. Crecelius
Moore Elia Kraft & Hall, LLP
P.O. Box 6756
Boise, ID 83707
(208) 336-6900
brady@melawfirm.net
marisa@melawfirm.net
Attorneys for Defendants-Appellants Idaho Department of Corrections, Henry Atencio, Jeff Zmuda, Howard Keith Yordy, Richard Craig, and Rona Siegert

Dylan Eaton
J. Kevin West
Parsons Behle & Latimer
800 West Main Street
Suite 1300
Boise, ID 83702
(208) 562-4900
Deaton@parsonsbehle.com
KWest@parsonsbehle.com
Attorney for Defendants-Appellants Corizon, Inc., Scott Eliason, Murray Young, and Catherine Whinnery

Dated: March 6, 2019

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1 **UNITED STATES DISTRICT COURT**

2 **DISTRICT OF IDAHO**

3

4 ADREE EDMO (a/k/a MASON EDMO),)	CASE NO. 1:17-cv-00151-BLW
5 Plaintiff,)	**EVIDENTIARY HEARING DAY 2**
6 vs.)	
7 IDAHO DEPARTMENT OF CORRECTION; HENRY ATENCIO, in 8 his official capacity; JEFF ZMUDA, in his official 9 capacity; HOWARD KEITH YORDY, in his official and individual 10 capacities; CORIZON, INC.; SCOTT ELIASON; MURRAY YOUNG; 11 RICHARD CRAIG; RONA SIEGERT; CATHERINE WHINNERY; and DOES 12 1-15,)	
13 Defendants.)	

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BEFORE THE HONORABLE B. LYNN WINMILL
17 **THURSDAY, OCTOBER 11, 2018, 8:33 A.M.**
BOISE, IDAHO

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Proceedings recorded by mechanical stenography, transcript
22 produced by computer.

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24 **TAMARA I. HOHENLEITNER, CSR 619, CRR**
FEDERAL OFFICIAL COURT REPORTER
25 550 WEST FORT STREET, BOISE, IDAHO 83724

1 **FOR PLAINTIFF**

2 Lori Rifkin
HADSELL STORMER & RENICK LLP
3 4300 Horton Street, #15
Emeryville, CA 94608
4
Amy Whelan
5 NATIONAL CENTER FOR LESBIAN RIGHTS
870 Market Street, Suite 370
6 San Francisco, CA 94102

7 Shaleen Shanbhag
HADSELL STORMER & RENICK LLP
8 128 N. Fair Oaks Avenue
Pasadena, California 91103
9
Craig Durham
10 Deborah Ferguson
FERGUSON DURHAM, PLLC
11 223 N. 6th Street, Suite 325
Boise, ID 83702
12
FOR DEFENDANTS IDAHO DEPARTMENT OF CORRECTIONS, HENRY ATENCIO,
13 **JEFF ZMUDA, HOWARD KEITH YORDY, RICHARD CRAIG, AND RONA SIEGERT**

14 Brady J. Hall, Special Deputy Attorney General
Marisa S. Crecelius
15 MOORE ELIA KRAFT & HALL, LLP
Post Office Box 6756
16 Boise, Idaho 83707

17 **FOR DEFENDANTS CORIZON, INC., SCOTT ELIASON, MURRAY YOUNG, AND**
CATHERINE WHINNERY
18
Dylan A. Eaton
19 J. Kevin West
PARSONS, BEHLE & LATIMER
20 800 W. Main Street, Suite 1300
Boise, Idaho 83702

21

22

23

24

25

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1 P R O C E E D I N G S
2 October 11, 2018
3 THE CLERK: The court will now hear Civil Case
4 17-151, Adree Edmo vs. Corizon, Incorporated, et al., regarding
5 a motion for preliminary injunction.
6 THE COURT: Good morning. I believe we were ready for
7 the plaintiffs to call their next witness.
8 With that, Ms. Rifkin.
9 MS. RIFKIN: Yes, Your Honor. We would like to call
10 plaintiff, Adree Edmo, Your Honor.
11 THE COURT: Ms. Edmo, would you please step before the
12 clerk and be sworn.
13 ADREE EDMO, PLAINTIFF, SWORN
14 THE COURT: We got started off on the wrong --
15 typically you walk in front of the clerk's space. But that's
16 all right. We started that yesterday with Dr. Ettner.
17 THE CLERK: Please state your complete name and spell
18 your name for the record.
19 THE WITNESS: My name is Adree Edmo. My first name is
20 Adree, A-D-R-E-E. My last name is Edmo, E-D-M-O.
21 THE COURT: You may inquire.
22 MS. RIFKIN: Thank you.
23 DIRECT EXAMINATION
24 BY MS. RIFKIN:
25 Q. Good morning, Ms. Edmo.

1 A. Good morning.
2 Q. Is Adree Edmo your legal name?
3 A. Yes, it is.
4 Q. And has it always been your legal name?
5 A. No, it has not.
6 Q. When did you start using the name "Adree"?
7 A. Approximately in 2013.
8 Q. And when did you legally change your name?
9 A. In September of 2013.
10 Q. How did you pick the name "Adree"?
11 A. My older brother was having a daughter, his first daughter,
12 and he had been asking a name for his daughter. And I proposed
13 the name "Adriana."
14 Shortly after she was born, I found out that he had
15 actually chosen Adriana, and I really enjoyed the name Adriana.
16 So I shortened it to "Adree," which is my legal name now.
17 Q. And how old are you, Ms. Edmo?
18 A. 30 years old.
19 Q. How long have you been incarcerated?
20 A. Since 2012.
21 Q. What is your education?
22 A. I have some college education. I completed a paralegal
23 certificate program through Adams State University of Colorado.
24 It's an extended college program specifically for prisoners.
25 Q. And prior to incarceration, where did you primarily live?

1 A. In Fort Hall, Idaho, on the Fort Hall Indian Reservation.
2 Q. What tribe are you enrolled with?
3 A. I am enrolled into the Shoshone-Bannock tribes.
4 Q. Ms. Edmo, what is your gender identity?
5 A. Female.
6 Q. And how do you know that you are female?
7 A. The best way to explain it is my brain typically operates
8 female, even though my body hasn't corresponded with my brain.
9 My brain operates, I guess, in a way similar to as a female, is
10 the best way I can explain it.
11 Q. When do you first remember feeling that way?
12 A. About the age of around 5 or 6.
13 Q. Did you have a name at that time for what you were feeling?
14 A. No, I did not.
15 Q. And what is your sexual orientation?
16 A. I'm attracted to heterosexual men. So I guess my sexual
17 orientation would be heterosexual.
18 Q. Was there a time that you identified as any other sexual
19 orientation?
20 A. Before learning about gender identity and transgender, a
21 lot of people around me had identified me as being gay, even
22 though, to me, that wasn't necessarily the right word that I
23 would choose, but I accepted it.
24 Q. And what is your understanding of what gender dysphoria
25 means?

1 A. My understanding of gender dysphoria is it means it's an
2 incongruence between a person's -- a feeling of who they are,
3 whether they are male or female. And it's a difference between
4 a person's innate sense of female or male as compared to what
5 they were assigned at birth.
6 Q. When did you learn what gender dysphoria or gender identity
7 disorder is?
8 A. Approximately, I would say for sure in 2012.
9 Q. And was that while you were incarcerated or prior?
10 A. While I was incarcerated.
11 Q. What is the experience of having gender dysphoria like for
12 you?
13 A. The typical feelings that I feel with gender dysphoria are
14 I feel depressed; I feel -- sometimes, when it's extreme, I feel
15 disgusting; I feel tormented; I feel hopeless; and I feel like,
16 with no hope, I have no, like, reason to keep on going. It's
17 pretty extreme.
18 Q. Are there times that it gets better, times that it gets
19 worse?
20 A. I would have to say it's there all the time, but there are
21 times where it is worse, like extremely worse. And there are
22 times where it's not as bad, but it's still there in the
23 foreground.
24 Q. And you said that you identify as female.
25 How do you express yourself as female?

1 A. So, with me, I have always identified as female, I guess,
2 in a sense. I do wear makeup. I have grown my hair out. I
3 have similar gestures as females. I walk, my voice is feminine.
4 I just have, I guess, general mannerisms that you would see in a
5 typical female.
6 Q. And why -- why is wearing makeup something that's important
7 to you?
8 A. It helps create, like, an egosyntonic state of mind. It
9 helps me express on the outside about what I feel on the inside.
10 It helps me give people an idea of who I truly am on the inside.
11 Q. Have you been disciplined for presenting as feminine in
12 prison?
13 A. Yes, I have.
14 Q. Why keep presenting as feminine even though you have been
15 punished for it?
16 A. It's -- it's -- honestly, it's all I ever know. I mean, I
17 don't know what it means to have male or to be a man, as they
18 say. I don't know -- that doesn't -- I can't comprehend that.
19 I just act this way that I am now. It's the only way that I
20 know.
21 Q. Do you think it would be easier to stop presenting
22 outwardly as feminine, to cut your hair and not wear makeup?
23 A. It would not be easy.
24 Q. And why?
25 A. Because it would be -- it would be making me feel like I

1 had to conform to something or somebody that I'm not. And that
2 is not who I am. I mean, it would -- it's embarrassing. It's
3 difficult and it's depressing.
4 Q. Besides gender dysphoria, do you have any other mental
5 health diagnoses that you're aware of?
6 A. The only one that I am sure that I'm aware of is major
7 depressive disorder.
8 Q. Have you received treatment for gender dysphoria?
9 A. I have received hormonal therapy. I received some pretty
10 much process groups of gender dysphoria, and that's about the
11 extent of what I have received.
12 Q. How long have you been receiving hormones for gender
13 dysphoria?
14 A. Since 2012.
15 Q. And how have these hormones affected you?
16 A. Mentally, they have -- I guess a better word is they
17 cleared my mind; whereas before, it was like a -- I guess a
18 cloud over my mental state. It felt like a blurriness. And
19 when I finally started taking hormones, it kind of felt like all
20 that fogginess and kind of -- became clear.
21 Physically, I have grown breasts. I have had body fat
22 redistribution from my waist to more so my hips. It's allowed
23 my skin consistency to change, meaning I have, like, softer
24 skin. I don't produce as much oil in my skin, so my skin is a
25 lot smoother.

1 Q. What kind of treatment are you seeking for gender dysphoria
2 in this lawsuit?
3 A. Sex reassignment surgery or gender confirmation surgery.
4 Q. Why are you seeking surgery?
5 A. Ultimately, I feel the gender confirmation surgery will
6 help me affirm my gender identity as female.
7 Q. Do you continue to experience distress related to gender
8 incongruence?
9 A. Yes.
10 Q. How do you feel about your genitals now?
11 A. They are disgusting. They feel like it's alien to my body.
12 It's embarrassing. Sometimes it's hard to comprehend that I
13 still have male genitalia. And it's even more so embarrassing
14 because I know that other people know that, especially being in
15 prison, and they capitalize on that. And it makes me feel even
16 more depressed, embarrassed, disgusted.
17 I feel -- I don't feel appreciated as who I feel I am, and
18 I feel just like a complete outcast.
19 Q. How often do you think about the kinds of things you just
20 described?
21 A. Every day. It's an everyday reoccurring thought. Every
22 day I wake up, and I have to remind myself that some day, at
23 some point, I will be okay enough, and I will have surgery, and
24 I can continue on in life.
25 Q. Have you taken any steps to try to treat yourself on your

1 own?

2 A. Yes. In 2015, I attempted to castrate my testicles. I

3 used a razor blade that we get at the prison. And I broke open

4 the disposable razor blade, and I attempted to cut the testicle

5 sac open.

6 I did leave a note before I did it, letting the officers

7 know that I in no way -- I was not trying to commit suicide. I

8 was only trying to help myself.

9 And in December of 2016, again, I tried to castrate my

10 testicles; this time I got further. I used a disposable blade

11 again. I broke it out of the razor. And this time, I actually

12 got into the testicle sac and got out the testicle.

13 But I wasn't able to actually sever the testicle because

14 there was too much blood. I didn't know there would be that

15 much blood in that area, and I couldn't see anymore what I was

16 cutting. So I abandoned it and got medical help.

17 Q. Can you describe how you were feeling at the time that you

18 attempted to cut your testicle off?

19 A. I can remember right before it, I had a sense of urgency.

20 I felt like this was -- this was -- like I had to do this. I

21 felt like it was going to benefit me in the long run, and I felt

22 like it was a decision that I had to make. I felt ready. I had

23 adrenaline pumping through my body, and I felt like it

24 was -- like it was going to happen.

25 Q. And you said that after the second -- your second attempt,

1 you sought medical help.
2 What happened?
3 A. The emergency personnel that we have at the prison arrived.
4 They assessed me as best they could right there and took me to
5 the medical building at the prison. And then from there, they
6 called the ambulance, and I went to Saint Alphonsus hospital.
7 Q. And what happened at the hospital?
8 A. They gave me some more pain medication, and they -- I
9 waited for a while for a urologist, I think it is. And once the
10 urologist arrived, she kind of assessed the situation.
11 But due to, like, the adrenaline wearing off, I was in so
12 much pain that she had said I would need anesthesia to go under,
13 and then she repaired my testicle.
14 Q. Were you offered a choice as to whether your testicle would
15 be repaired?
16 A. No.
17 Q. And how did you feel after -- after it was repaired and you
18 came out of the anesthesia?
19 A. After I came to and they brought me back to the prison, I
20 was pretty disappointed in myself. Because I felt like I made
21 it that far, and I was kind of upset because I was, like, I was
22 so close, and I should have finished it. I was just pretty
23 disappointed in myself, ultimately.
24 Q. Do you worry that you will try to castrate yourself again?
25 A. Given the extreme episodes that I go through in gender

1 dysphoria, I -- I don't doubt that I would actually try it
2 again. I don't -- I can't tell you when I will have another
3 extreme episode of gender dysphoria. I don't know when it's
4 going to happen. I just know that it's always there, and
5 sometimes it's worse than others.
6 Q. And what do you do when -- at the times when it's worse
7 than others now?
8 A. Well, I have been self-medicating by using a razor to cut
9 my arm. Because while I'm in a gender dysphoric episode, the
10 mental anguish and torment I go through about who I feel I am
11 versus my physical body, I need to feel actual pain to actually
12 bring me out of that episode, to realize, you know, I need to
13 keep as much tissue down there for surgery to be successful.
14 But at the time, cutting my arm and feeling that physical pain
15 releases that emotional torment that I feel at that time.
16 Q. What do you expect the results of gender confirmation
17 surgery to be for you?
18 A. Ultimately, I expect to have the complete production of
19 testosterone stopped and ultimately my genitals turned into a
20 vagina.
21 Q. What kinds of challenges in your life do you think you
22 might have after gender confirmation surgery?
23 A. I know that gender confirmation surgery is not a fix-all.
24 It's not a magic operation. It's not going to make my life
25 completely fantastic or blissful afterwards.

1 I'm still going to face the same stressors that we all face
2 in everyday life, you know, medical, family, relationship
3 issues. I just know that after having gotten the surgery, it's
4 going to put me at a level a lot better to handle those types of
5 situations than I am now.
6 Q. Do you expect gender confirmation surgery to affect your
7 mental health condition of depression one way or the other?
8 A. Definitely. I feel like I won't have as much depression
9 about myself and about my physical body. I don't think I will
10 be so anxious that people are always knowing that I'm different,
11 and I feel like in -- you know, not only that, I feel like I can
12 actually express who I truly am more visibly and just more
13 adequately.
14 Q. When do you expect to be released from prison?
15 A. In 2021.
16 Q. Do you feel prepared to live in the community as a woman?
17 A. I don't think that there is a major difference to whether
18 or not you step outside the prison and automatically it's like a
19 dramatic change. I mean, I have been living myself since 2012
20 and even before that. So it's not a major difference.
21 I'm about as ready as any person getting out of prison. I
22 will continue to wear makeup. I will continue to wear female
23 clothing.
24 Q. Have you had a job while you have been in prison?
25 A. Yes, I have. I have had two, actually.

1 Q. And at the jobs, have you presented feminine in terms of
2 hair and makeup, as you've described?
3 A. Yes, I have. I've -- actually, as of yesterday, I just
4 barely got my employment back at the Idaho Correctional
5 Industries, which they call "CI." I work out there.
6 Before -- before yesterday, I was working as a production
7 clerk in the production office at Correctional Industries. I
8 went to an interview yesterday, and I was able to get my
9 position back. And I will continue to work as a -- basically an
10 office clerk.
11 Q. If you were in the community right now and had the freedom
12 to dress however you chose and present yourself however you
13 wanted, do you think you would still seek gender confirmation
14 surgery?
15 A. Absolutely.
16 Q. How do correctional officers in the prison address you?
17 A. They address me as "him" or "Mr. Edmo." There are very few
18 and far between that actually address me as just "Edmo." But a
19 lot of them use the pronoun of "he," "him," "his."
20 Q. And what about medical and mental health staff? What
21 pronouns do they use?
22 A. The same. They are mostly -- they use "him," "his."
23 Multiple occasions, they use "Mr. Edmo." Very few medical
24 providers ever call me "Edmo." Very rarely do I ever hear any
25 of them call me "Ms. Edmo."

1 Q. How does that make you feel?
2 A. Since it's been happening since 2012, it irritates me, it
3 embarrasses me. But at the same time, I just kind of have to go
4 with it besides trying to argue with them. I mean, it's really
5 frustrating.
6 Q. And I would like to show you what's been marked as
7 Plaintiff's Exhibit 2.
8 THE COURT: Is that a joint exhibit?
9 MS. RIFKIN: No, Your Honor.
10 THE COURT: Then it's 1002?
11 MS. RIFKIN: I'm sorry. Yes. I'm sorry. Plaintiff's
12 Exhibit 1002.
13 Q. BY MS. RIFKIN: Do you recognize this document, Ms. Edmo?
14 A. Yes. It's my birth certificate.
15 Q. And what sex does it list?
16 A. Female.
17 Q. Has your birth certificate always listed female?
18 A. No, it has not.
19 Q. Did you have it changed?
20 A. Yes.
21 Q. Why did you want it changed?
22 A. Because it helps affirm my identity as a female.
23 MS. RIFKIN: I would like to move Plaintiff's Exhibit
24 1002 into evidence.
25 THE COURT: Any objection?

1 MR. HALL: No objection.
2 MR. EATON: No objection.
3 THE COURT: 1002 will be admitted.
4 (Plaintiff's Exhibit 1002 admitted.)
5 MS. RIFKIN: I have no further questions at this time.
6 THE COURT: Cross.
7 MR. HALL: Yes, Your Honor.
8 THE COURT: Mr. Hall.
9 CROSS-EXAMINATION
10 BY MR. HALL:
11 Q. Good morning, Ms. Edmo.
12 A. Good morning.
13 Q. It's nice to see you again. If you don't remember me, I'm
14 one of the attorneys for the Department of Corrections. We had
15 an opportunity to spend a good seven hours together this summer
16 at a deposition.
17 Do you recall that?
18 A. Yes, I do.
19 Q. And I asked you a number of questions that certainly we're
20 not going to go through today.
21 But were you truthful in the responses you gave at the
22 time?
23 A. Yes, I was.
24 Q. Okay. And you also had a clinical interview with a
25 Dr. Andrade.

1 Do you recall that --
2 A. Yes.
3 Q. -- this summer?
4 And he asked you a number of questions about your history.
5 Were you truthful with that?
6 A. Yes.
7 Q. Is it your habit to be truthful when talking with medical
8 providers?
9 A. Yes. To the best of my ability, yes.
10 Q. And is it your habit to be truthful when talking to mental
11 health providers?
12 A. Yes.
13 Q. Thank you.
14 Ms. Edmo, can you see the record that has been marked as
15 Defendant's Exhibit 2007?
16 A. Yes, I see it.
17 Q. Okay. Did you have an opportunity to receive treatment
18 from the Shoshone-Bannock Tribes Counseling and Family Services
19 in 2011?
20 A. I believe so.
21 Q. And do you recall that this followed a suicide attempt that
22 you had made on yourself in that time?
23 A. I don't remember the -- I don't remember having an intake
24 assessment, but --
25 Q. Do you recall --

1 A. -- I remember a suicide attempt in that year, yes.
2 Q. Do you recall -- and you had treatment with a Dr. Palmer in
3 this time period; correct?
4 A. I don't remember his name.
5 Q. I think you referenced it earlier.
6 MR. HALL: I would like to move to admit Exhibit
7 No. 2007, Your Honor. It's been stipulated.
8 THE COURT: Any objection?
9 MS. RIFKIN: No objection.
10 THE COURT: 2007 will be admitted.
11 (Defendants' Exhibit 2007 admitted.)
12 Q. BY MR. HALL: Ms. Edmo, I have had placed here Exhibit
13 No. 2009.
14 Isn't it true that you received emergency medical treatment
15 in 2011 as well as in 2010 for two separate suicide attempts?
16 A. Yeah, I believe so.
17 MR. HALL: Okay. I would like to move to admit
18 Exhibit No. 2009.
19 THE COURT: Any objection?
20 MS. RIFKIN: No, Your Honor.
21 THE COURT: 2009 will be admitted.
22 (Defendants' Exhibit 2009 admitted.)
23 Q. BY MR. HALL: While we're on this housekeeping, do you
24 recognize the document that's been marked as 2016?
25 A. I -- yes, I can roughly remember it. I don't absolutely

1 remember the absolute context of it.
2 Q. Right. Do you recall having a gender dysphoria group with
3 a Clinician Watson?
4 A. Yes. That would have to be in 2012, 2013.
5 Q. Okay. And this is a document that you produced as part of
6 a homework assignment; correct?
7 A. I believe so. I can't really exactly remember.
8 Q. On the third page of Exhibit No. 2016, there is a signature
9 down there.
10 Is that your signature, Ms. Edmo?
11 A. Yes.
12 MR. HALL: I would like to move to admit Exhibit
13 No. 2016.
14 THE COURT: Any objection?
15 MS. RIFKIN: No.
16 THE COURT: 2016 is admitted.
17 (Defendants' Exhibit 2016 admitted.)
18 Q. BY MR. HALL: And we had talked about your preincarceration
19 history of suicide attempts. There were a couple in the
20 2010-2011 time frame; correct?
21 A. Yes.
22 Q. Okay. And in this document, you discuss living in
23 Washington and dating a man named Casey, sometime prior to
24 moving to Idaho in 2009.
25 Do you recall that?

1 A. Yes, in 20- -- prior, yes.
2 Q. Okay. You had a fight with Casey. And as a result of
3 that, you took it hard, and you attempted suicide; is that
4 correct?
5 A. I believe so.
6 Q. Okay. And then you moved back to Idaho; correct?
7 A. I don't think I ever moved to Washington, but I was in
8 Washington, and I came back to Idaho.
9 Q. Okay. This suicide that's referenced here, that occurred
10 in Washington; correct?
11 A. No, it did not.
12 Q. Okay. So you're saying that suicide that's referenced here
13 occurred in Idaho?
14 A. Yes.
15 Q. Do you recall either way?
16 A. I have never committed -- tried to commit suicide in
17 Washington.
18 Q. Okay. Do you recall trying to commit suicide when you were
19 16 years old?
20 A. No.
21 Q. Before you is Defendant's Exhibit 2007. Let's see if we
22 can zoom in on this a little bit more. And this is the record
23 from Shoshone-Bannock Tribes Counseling & Family Services.
24 Isn't it true that in November of 2003, you were
25 transported to Portneuf via ambulance after an apparent

1 overdose? Do you recall that?

2 A. Yeah. I kind of remember something like that.

3 Q. And do you recall that being related to a suicide attempt?

4 A. No.

5 Q. Now, just for the record, I want to make sure that it's

6 clear.

7 Prior to the incarceration in 2012, there has been multiple

8 suicide attempts that you've taken directly on your own life;

9 correct?

10 A. Two of them, in 2010 and '11, I believe.

11 Q. And is it your testimony that there has been no others?

12 A. No, there hasn't.

13 Q. In your deposition, you recall there were two serious

14 suicide attempts, but there may have been more? Do you recall

15 that?

16 A. I recall letting you know that, yeah, there were two

17 serious ones that I actually had the intent to commit suicide.

18 Q. Okay. There were others that you did not have the intent

19 to commit suicide; is that your testimony?

20 A. Yes.

21 Q. Okay. And during those time period where you were

22 attempting suicide, you were heavily abusing alcohol; correct?

23 A. Yes.

24 Q. And in the three, four years prior to incarceration, you

25 were using alcohol and other drugs at a very high rate; correct?

1 A. Yes.
2 Q. Okay. And I believe that you agreed that your substance
3 abuse was its most extreme in the years -- three or four years
4 prior to your incarceration in 2012; correct?
5 A. Yes.
6 Q. Okay. And isn't it true that your more serious suicide
7 attempts followed relationship problems with one of your
8 partners; correct?
9 A. Yes.
10 Q. And at this time, you were also unemployed; correct?
11 A. Yes.
12 Q. You were -- that was a big stressor for you, was it not?
13 A. It was a stressor.
14 Q. Okay. And you were having self-worth problems, were you
15 not?
16 A. Yes.
17 Q. You didn't feel like your life was worth much at that time;
18 correct?
19 A. I felt worthless, yes.
20 Q. And you had a lot of legal problems at that time with some
21 felony check fraud charges; correct?
22 A. In 2010, yes.
23 Q. And in '11 and '12, you were still dealing with probation
24 and probation violations; correct?
25 A. Yes.

1 Q. Now, in your declaration that you provided, on page 7, you
2 stated that:
3 "I began living full time as a woman around the age of
4 20 or 21. I wore makeup, women's outerwear, underwear
5 and bras, and styled my long hair."
6 Isn't that correct?
7 A. Yes.
8 Q. That's what you stated --
9 A. Yes.
10 Q. -- correct?
11 A. I did.
12 Q. And isn't it true that prior to your incarceration, you
13 never had hair longer than your ears; correct -- about longer
14 than the top of your ears?
15 A. It's been about in the middle.
16 Q. About in the middle?
17 A. Yeah, or about the bottom to the middle of my ears.
18 Q. Okay. So the longest your hair was ever prior to your
19 incarceration was about the middle of your ear; correct?
20 A. Bottom or middle. I don't know the exact, if it was middle
21 or bottom, but I would say to the bottom of my ear.
22 Q. Right. So after your incarceration, you grew your -- in
23 2012, you grew your hair out longer than it's ever been in your
24 life; correct?
25 A. Yes.

1 Q. And you've had, let's say, counseling or verbal warnings
2 from correctional staff about your hair from time to time;
3 correct?
4 A. Yes.
5 Q. And a lot of those have been directed at when you have a
6 ponytail or a bun; correct?
7 A. Yes.
8 Q. And you have a high ponytail; right? Which I imagine is a
9 ponytail up on top, coming off the top of the head; correct?
10 A. No.
11 Q. No? Describe for me a high ponytail, then.
12 A. If I were to wear my hair in a ponytail, it would be about
13 this length (indicating).
14 Q. And you have been counseled by correctional officers since
15 2012 on multiple occasions, about maybe toning down your
16 feminine hairstyle; correct?
17 A. Yes.
18 Q. And the rationale that was given to you on multiple times
19 is along the lines of: "Ms. Edmo, we need to protect you from
20 sexual assault. And we can't have you appearing in a feminine
21 matter that may cause a, quote, 'sexually charged environment.'"
22 Isn't that correct?
23 A. No, that's not correct.
24 Q. No officer has ever told that to you?
25 A. No. Actually, they have told me to take my hair down.

1 Q. You have never been told by a correctional officer that
2 your hair creates a sexually charged environment?
3 A. Only after if I have been given a disciplinary offense
4 report was it explained that it -- the reason why.
5 Q. Right. And isn't it true, Ms. Edmo, that you have never
6 actually been given a disciplinary offense report for wearing
7 makeup or wearing your hair in a feminine style? The
8 disciplinary offense reports have been for disobedience to a
9 direct order; isn't that correct?
10 A. Yes.
11 Q. There is a difference there; right? And you do recognize
12 that?
13 A. I think -- I believe it's covert. The disciplinary process
14 has the officer pick the best offense that describes the
15 behavior. So they would use disobedience to orders.
16 Q. Right. And on all of those disobedience to orders DORs
17 relating to your makeup or your hair, you were warned in
18 advance, like, "Ms. Edmo, you need to take down your hair," or
19 "You need to remove your makeup"; correct?
20 A. Yes.
21 Q. Okay. And your response was no; correct?
22 A. On multiple occasions, yes.
23 Q. Right. You refused that direct order; correct?
24 A. At the time, I didn't think it was a direct order. But
25 they gave me instructions to remove my makeup or take my hair

1 down.

2 Q. Okay. So then after you refused to follow direct order, it

3 was then that you were given a DOR; correct?

4 A. Yes.

5 Q. Okay. And you've understood since your incarceration that,

6 as a transgender female, that you feel that you're at a higher

7 risk of sexual assault in a male facility; isn't that correct?

8 A. No prison is safe.

9 Q. No prison is safe. But you have actually written in your

10 declaration that, because you are a transgender female in a male

11 prison, you feel like you are at a higher risk of sexual assault

12 from the male population; correct?

13 A. Yes.

14 Q. And isn't it true that there are individuals incarcerated

15 with you that are in jail on convictions for sexual assault?

16 A. I don't know what their exact convictions are, but I would

17 believe so.

18 Q. Right. Do you understand that the Department of Correction

19 has an obligation to protect you from sexual assault?

20 A. Yes.

21 Q. And isn't it true that in this lawsuit, which is not a real

22 claim on this motion, that you are making a claim that one of

23 the defendants -- namely, Defendant Keith Yordy -- failed to

24 protect you from sexual assault due to your transgender status

25 and femininity?

1 A. Yes.
2 Q. Do you see there that there is kind of this conflict? You
3 want to feminize in prison, and the IDOC has allowed you to do
4 that in a number of ways. But there are limits to that placed
5 by security, and it's due to the goal of protecting you from
6 sexual assault.
7 Do you understand that?
8 MS. RIFKIN: I'm going to move to strike the testimony
9 of counsel prior to the question.
10 THE COURT: Just a moment.
11 Counsel, I think -- let's rephrase the question.
12 MR. HALL: That's fine.
13 THE COURT: There was a lot of testimony in the
14 question that's probably not necessary.
15 Q. BY MR. HALL: You understand that one of the rationales for
16 limiting your ability to wear your hair pre today in a feminine
17 fashion was to protect you from sexual assault; correct?
18 A. I don't know what their reasons are.
19 Q. But those were the justifications that were provided to
20 you?
21 A. In the DORs, yes.
22 Q. Okay. And, Ms. Edmo, you're aware that there has been some
23 recent policy changes; correct?
24 A. I think so.
25 Q. As of last Friday, the policy has been changed regarding

1 gender dysphoria treatment; correct?
2 A. I received a memo from Ashley Dowell.
3 Q. Okay. That memo said that now all GD offenders, including
4 yourself, will have access to female commissary items that are
5 available to female offenders at other institutions; correct?
6 A. Yes.
7 Q. So makeup?
8 A. Yes.
9 Q. And even female underwear?
10 A. Yes.
11 Q. Now, it's true you've had female underwear from time to
12 time since your incarceration in 2012; correct?
13 A. Yes.
14 Q. And you're also -- it's your understanding of this new
15 policy that IDOC has mandated that its mental health and medical
16 staff are to refer to you and other gender dysphoric inmates by
17 your preferred gender?
18 A. That's what it states.
19 Q. Okay. Are you happy with that? Does that -- does that
20 please you in any way?
21 A. It's a very slight relief.
22 Q. You understand that since 2011, IDOC has had a policy to
23 provide gender dysphoric inmates with treatment for GD?
24 A. I think so.
25 Q. Okay. And that included sex reassignment surgery or gender

1 confirming surgery if it was determined to be medically
2 necessary by a qualified GD evaluator; correct?
3 A. Yes. That's what the policy states.
4 Q. Okay. The policy did not have a prohibition against sex
5 reassignment surgery, per se; correct?
6 A. Per se.
7 Q. Yes, though; correct?
8 A. Yes, per se.
9 Q. Okay. And isn't it true that prior to June 1 of this year,
10 when this motion for preliminary injunction was filed, no
11 medical provider or mental health provider had determined that
12 sexual reassignment was medically necessary for you?
13 A. Yes, that's correct.
14 Q. And those that have determined it purportedly are the
15 experts that have been retained by your counsel; correct?
16 MS. RIFKIN: I would like to move to strike
17 "purportedly."
18 MR. HALL: It's in debate, Your Honor. I think the
19 record will show what Dr. Ettner had testified.
20 THE COURT: Overruled.
21 Q. BY MR. HALL: Would you answer the question, please.
22 A. What was the question again?
23 MR. HALL: Would you read the question back, Madam
24 Court Reporter.
25 (Question read by reporter.)

1 THE WITNESS: Yes.
2 Q. BY MR. HALL: Now, you understand that as part of some
3 procedures for sex reassignment surgery, including a
4 vaginoplasty, that your male anatomy would be used to create a
5 vagina?
6 A. I think that's correct.
7 Q. So you understand that it's important to preserve your male
8 anatomy so that in the future, if it's appropriate for you to
9 have sex reassignment surgery, that tissue is available to
10 create female anatomy; correct?
11 A. As what I have been told, yes.
12 Q. Okay. And you're committed to preserving your male anatomy
13 to be used in the future; correct?
14 A. Yes.
15 Q. Now, you've had -- you've had a number of contacts
16 throughout your incarceration with clinical staff; correct?
17 A. Yes.
18 Q. Including Clinician Watson; correct?
19 A. Yes.
20 Q. And Clinician Stewart; correct?
21 A. Yes.
22 Q. Okay. And throughout those years, both Clinician Watson
23 and Clinician Stewart have repeatedly referred you to and
24 recommended that you undergo a number of different group
25 therapies; correct?

1 A. I wouldn't say "group therapy," but groups.
2 Q. Mood management would be one; correct?
3 A. Yeah. Mood management class, yes.
4 Q. Social skills?
5 A. Social skills class, yes.
6 Q. Healthy relationships; yes?
7 A. Yes.
8 Q. And you've also been recommended and required to complete
9 the sex offender treatment programming; correct?
10 A. Yes.
11 Q. And despite multiple recommendations to undergo those
12 classes, you have repeatedly refused to take those classes;
13 correct?
14 A. Yes.
15 Q. Okay. And however, though, I have noticed throughout the
16 records that there have been periods of time where you expressed
17 to the clinicians, whether it's Watson or Stewart, that you have
18 a moment of clarity that maybe you should take those classes.
19 Do you agree with that?
20 A. I think at some point, yes.
21 Q. Yeah. Where you stated, "You know, I do need to take those
22 classes because it will help me work on my other issues, not
23 just GD."
24 Do you agree with that?
25 A. I would say yes.

1 Q. And as recently as May or April of this year, you told
2 Clinician Watson in a concern form that you were ready to get on
3 top of your mental health issues and take these classes.
4 Do you remember that?
5 A. Because she had recommended them.
6 Q. Right. But you had agreed, which was something rare for
7 you. You had agreed that: Yes, I do need to do that. I need
8 to focus on these other mental health issues. I'm ready to take
9 those classes.
10 Correct?
11 MS. RIFKIN: I'm going to move to object to counsel's
12 characterization as "something rare for you" and move to strike
13 that part of the question. Also lacks foundation.
14 THE COURT: Counsel, I'm going to sustain the
15 objection. It assumes a fact not in evidence. And because of
16 that, it becomes compound and confusing.
17 Q. BY MR. HALL: You agree that you've repeatedly -- and you
18 testified earlier that you repeatedly refused to take these
19 classes; correct?
20 A. Yes.
21 Q. Okay. Yet you have, on only a couple of occasions, had a
22 moment of clarity where you have agreed that, yes, I do need to
23 work on these mental health issues; correct?
24 MS. RIFKIN: I'm objecting as lacks foundation,
25 misstates the evidence as to "only a couple of occasions."

1 Assumes facts not in evidence.
2 THE COURT: Overruled. The witness can respond if she
3 feels she has done it on more than on a couple of occasions, if
4 she wishes.
5 Q. BY MR. HALL: Go ahead. And If I'm mischaracterizing
6 anything, please let me know.
7 THE COURT: Typically -- don't be reluctant to explain
8 a response if you disagree with counsel's characterization.
9 Go ahead.
10 THE WITNESS: Can you repeat the question, please.
11 MR. HALL: Madam Court Reporter, would you read the
12 question back for the witness, please.
13 (Question read by reporter.)
14 THE WITNESS: I'm not sure what you mean by "moment of
15 clarity," but I have agreed to it on a couple of occasions.
16 Q. BY MR. HALL: But as of today, you have not completed mood
17 management, social skills, healthy relationships, or the sex
18 offender treatment program; correct?
19 A. Correct.
20 MR. HALL: I have no further questions. Thank you.
21 THE COURT: Mr. Eaton.
22 CROSS-EXAMINATION
23 BY MR. EATON:
24 Q. Hello, Ms. Edmo.
25 As you probably recall, my name is Dylan Eaton. I

1 represent the Corizon providers.

2 Do you remember me?

3 A. Yes, I do.

4 Q. Okay. Just a couple questions for you.

5 First of all, I believe you indicated that you acknowledge

6 you were diagnosed with gender identity disorder in 2012; is

7 that correct?

8 A. Yes.

9 Q. Okay. And that was by a Dr. Eliason; is that correct?

10 A. I don't know exactly who diagnosed me initially. I know

11 that I had an evaluation by Dr. Lake.

12 Q. Okay. You had an evaluation by Dr. Lake.

13 You recall that?

14 A. Yes.

15 Q. And did the -- and you understand that you actually

16 received that diagnosis in 2012; right?

17 A. Yes, I did.

18 Q. And that made you feel better, didn't it?

19 A. It was exciting.

20 Q. And why is that?

21 A. Because I felt like this was the start of getting my life

22 back together.

23 Q. And you were seeking a GID, gender identity disorder,

24 designation at that time because you wanted to be put on

25 hormones; isn't that right?

1 A. I didn't really know necessarily what the treatment was,
2 but I did ask for an evaluation of a gender identity disorder.
3 Q. And after you received that designation, did you want to be
4 put on hormones?
5 A. They had asked me if that was my -- if I would be willing
6 to go on hormone replacement therapy.
7 Q. And you agreed to that?
8 A. Yes.
9 Q. Okay. And I believe you testified that once you started
10 taking the hormones, that a cloud was lifted, and you started
11 feeling better; is that correct?
12 A. Yes.
13 Q. Okay. So the hormones helped you; right?
14 A. In the beginning, yes.
15 Q. Okay. And you acknowledge that you've been on hormones
16 since 2012; right?
17 A. Yes.
18 Q. And you have been managed by medical providers, including a
19 Dr. Whinnery, on those hormones?
20 A. I have seen Dr. Whinnery for hormones.
21 Q. And you understand that your medications, your hormones
22 have been adjusted periodically, sometimes because of your
23 requests over the years?
24 A. Yes.
25 Q. When we talked at your deposition, I brought up a record by

1 Dr. Stoddart, who had indicated that -- in that record that you
2 had been sad because Dr. Whinnery had left, and she was an
3 advocate for you.
4 Do you remember discussing that with me?
5 A. I remember you referring to that conversation.
6 Q. And I believe you -- we got into a discussion as to you're
7 not sure what "advocate" means, but you indicated that you
8 believed Dr. Whinnery was helping you; correct?
9 A. She was the doctor that initially prescribed me hormones.
10 Q. But she was helping you; right?
11 A. She prescribed the hormones that was helping me, yeah.
12 Q. I'm not just asking about the hormones.
13 But she was helping you with your gender identity disorder
14 and your gender dysphoria treatment; correct?
15 A. Yes.
16 Q. She helped you, for instance, with the prescription to get
17 a bra -- a memo to get a bra; correct?
18 A. Yeah. She wrote the medical memo.
19 Q. Okay. And she tried to work with you to help you get some
20 type of underwear that would work for you; correct?
21 A. On multiple occasions, I asked her, and she attempted to, I
22 believe. I'm not sure if she did actually, but she had told me
23 that she had tried.
24 Q. And she tried to work with you and helped you, for
25 instance, get a jockstrap and pads to help you try to tuck;

1 correct?
2 A. I had asked her for a medical memo for panties, actually.
3 And she said the best she can give me is a jockstrap with some
4 medical pads.
5 Q. So you understand she gave you that and was trying to help
6 you there; correct?
7 A. That's what she prescribed me, yes.
8 Q. And you acknowledge that you have been seeing a
9 psychiatrist, Dr. Eliason, since 2012; correct?
10 A. I have seen him, yes.
11 Q. Okay. And you saw him initially when you were diagnosed
12 for GID; correct?
13 A. I don't know if he was the initial person. I seen him one
14 time prior to seeing Dr. Lake.
15 Q. Okay. So you do recall seeing -- an appointment at least
16 with Dr. Eliason prior to seeing Dr. Lake?
17 A. Yes.
18 Q. And then afterwards, you would acknowledge that you have
19 seen him periodically for mental health conditions --
20 A. Yes.
21 Q. -- since 2012?
22 A. Excuse me. Yes.
23 Q. At some of those appointments, you have received
24 medications, such as Zoloft; correct?
25 A. I believe so.

1 Q. Okay. But you acknowledge that Dr. Eliason and other
2 medical providers have given you medications to help you with
3 your depression, for instance; correct?
4 A. Dr. Eliason has. Yes, Dr. Eliason has.
5 Q. Okay. And you have been in chronic care and seen a medical
6 provider every approximately 90 days; is that correct?
7 A. I don't know if I'm in that program or not. They don't
8 give me that information.
9 Q. So you're not aware of whether you're in chronic care?
10 A. Like I said, I don't know if that's what they designated me
11 into the program. They don't let me know that information.
12 Q. Okay.
13 A. But I assume that I am in chronic care, I think. I can't
14 give you an answer as to if that's absolutely sure or not.
15 Q. And you continue to see a psychiatrist at the ISCI today;
16 correct?
17 A. Yes.
18 Q. And sometimes you will see a mental health nurse
19 practitioner?
20 A. I have seen a mental health nurse practitioner, yes.
21 Q. This year?
22 A. Not this year.
23 Q. Okay. But you do see a psychiatrist? You have seen a
24 psychiatrist this year?
25 A. Yes.

1 Q. On more than one occasion; correct?
2 A. Yes.
3 MR. EATON: I don't believe I have any further
4 questions. Thank you.
5 THE COURT: Before redirect, I'm going to ask just one
6 or two questions.
7 EXAMINATION
8 BY THE COURT:
9 Q. Ms. Edmo, I'm a little confused about the extent of the
10 hormone treatment you've had since you have been incarcerated.
11 Has that been an on-again, off-again? I mean, have you
12 generally had access to hormone treatment while incarcerated or
13 not?
14 A. Yes. As to the dosages, they have been never consistent.
15 Q. Okay. But I assume the doctors have tried to work with you
16 in terms of adjusting that, or they just unilaterally make
17 changes?
18 A. They just unilaterally make changes.
19 Q. I had understood that there was some -- something cropped
20 up in your blood work which suggested that they either
21 substantially reduce or even eliminate the hormone treatment.
22 Did I understand that correctly?
23 A. Yes, you did.
24 So part of my hormone therapy, I receive estrogen and
25 spironolactone, which is a testosterone suppressant. Just as of

1 recently, beginning in December of last year into February of
2 this year, they gave me a blood test, and my liver enzymes had
3 elevated.
4 And they didn't know -- we didn't know exactly what that
5 was attributed to. So they kind of did a, you know, elimination
6 process. And they determined or felt that it was probably due
7 to the spironolactone.
8 So they took me off of it completely. And as a result, I
9 started getting more testosterone in my body. And I can feel
10 that because it's -- prior to hormone therapy, I know what it
11 feels like to be hormonally just testosterone.
12 So I felt that testosterone building up, and I sent in
13 concern forms to the providers asking: Please, is there any
14 other testosterone suppressant that you can find for me or
15 anything, because I can feel it building, and it's not good for
16 me. It feels disgusting. It's gross.
17 So just recently, as of I believe June of this year, they
18 put me back on spironolactone after I continually and repeatedly
19 requested it.
20 Q. All right. I'm going to ask another question. It's a
21 little sensitive, but I think I need to ask.
22 Were you -- I assume, then, that you were on hormone
23 therapy at the time you attempted to self-castrate on both
24 occasions; is that correct?
25 A. Yes, it is.

1 THE COURT: All right. Questions, Ms. Rifkin?
2 REDIRECT EXAMINATION
3 BY MS. RIFKIN:
4 Q. Ms. Edmo, at the time that you stopped sex offender
5 programming, was it your understanding that you were required to
6 attend?
7 A. Before I stopped?
8 Q. At the time that you stopped the programming.
9 A. No. I didn't -- they didn't say it was required that I had
10 to -- I had to finish -- I was required to finish it in order to
11 have a chance at parole.
12 Q. And at what point did you stop attending sex offender
13 programming?
14 A. Right after the Commission had decided that I needed to
15 complete my full sentence. And right after that, they -- my
16 case manager had told me: Since you don't have a date for
17 parole anymore, you're going to full-term release, there is no
18 need for you to be in this program. We need to give that slot
19 to somebody who has parole.
20 MS. RIFKIN: No further questions.
21 THE COURT: Mr. Hall.
22 MR. HALL: No recross, Your Honor.
23 THE COURT: Mr. Eaton.
24 MR. EATON: Nothing further, Your Honor.
25 FURTHER EXAMINATION

1 BY THE COURT:
2 Q. I can find this out in some other form.
3 What is your parole status, then? Based on what you have
4 just said, are you indicating that the parole commission has
5 said that you will not be considered for parole?
6 A. Yes, that's correct.
7 Q. That's your understanding?
8 A. Yes.
9 Q. What is your top-out date?
10 A. 2021.
11 THE COURT: Okay. All right. I assume that was --
12 any follow-up to that?
13 MS. RIFKIN: No, Your Honor.
14 MR. HALL: No follow-up, Your Honor.
15 MR. EATON: No, Your Honor.
16 THE COURT: All right. Ms. Edmo, you may step down.
17 Thank you.
18 Call your next witness.
19 MS. WHELAN: Good morning, Your Honor. I'm Amy
20 Whelan, one of Ms. Edmo's counsel. And we're going to call
21 Dr. Nick Gorton.
22 THE COURT: Dr. Gorton, please step before the clerk
23 and be sworn.
24 RYAN NICHOLAS GORTON, M.D., PLAINTIFF'S WITNESS, SWORN
25 THE CLERK: Please take a seat in the witness stand.

1 Please state your complete name and spell your name for the
2 record.
3 THE WITNESS: Ryan Nicholas Gorton. It's R-Y-A-N,
4 N-I-C-H-O-L-A-S, G-O-R-T-O-N.
5 THE COURT: Is it Ms. "Whalen" or Whelan?
6 MS. WHELAN: "Whalen."
7 THE COURT: There is an Assistant U.S. Attorney in
8 North Idaho that I think pronounces it the same way. So I
9 wanted to make sure I had it right.
10 Ms. Whelan, you may inquire of the witness.
11 MS. WHELAN: Thank you.
12 DIRECT EXAMINATION
13 BY MS. WHELAN:
14 Q. Good morning, Dr. Gorton.
15 A. Good morning.
16 Q. Dr. Gorton, could you just make sure that that microphone
17 is set up for you. I'm having a little bit of trouble hearing
18 you.
19 A. Is this better?
20 Q. That's better.
21 MS. WHELAN: Dr. Gorton's qualifications are set forth
22 in paragraphs 3 through 6 of his first report and his CV. We
23 offer his CV into evidence at this time, which is marked as
24 Plaintiff's Exhibit 1004.
25 THE COURT: Any objection?

1 MR. HALL: No objection, Your Honor.

2 MR. EATON: No objection.

3 THE COURT: 1004 will be admitted.

4 (Plaintiff's Exhibit 1004 admitted.)

5 MS. WHELAN: Could we bring that up for him.

6 Q. BY MS. WHELAN: Dr. Gorton, do you recognize this document?

7 A. I do.

8 Q. And what is it?

9 A. It's my curriculum vitae.

10 Q. You don't have to read your entire CV. But does it look

11 accurate?

12 A. It does.

13 Q. And this CV details your experience, but could you briefly

14 describe your education.

15 A. Yes. I got a bachelor of science in biochemistry at

16 North Carolina State University. And I got my M.D. at the

17 University of North Carolina Chapel Hill. And then I did a

18 residency and chief residency in emergency medicine at Kings

19 County Hospital in Brooklyn.

20 THE COURT: Dr. Gorton, you are a little soft-spoken.

21 If you could bring the microphone just a little closer and don't

22 wander too much from that. Some of us are blessed with a

23 booming voice and some don't, such as myself. So please keep

24 the microphone close so that we can hear you.

25 Go ahead, Ms. Whelan.

1 Q. BY MS. WHELAN: And during your residency and your chief
2 residency, can you explain what you were doing at that time.
3 A. So I had finished medical school. And so, as a physician,
4 I was doing specialty training in emergency medicine.
5 Q. And from 2008 to the present, you have also worked with
6 Project Health.
7 Can you explain what that organization is and what you do
8 for them.
9 A. So Project Health was a collaboration between Lyon-Martin
10 Health Services, which is the clinic where I work, and the
11 Transgender Law Center.
12 And the initial goal of the project was that in California
13 at the time, if you were transgender, there were really only two
14 places you could get care, which is San Francisco and
15 Los Angeles, which is not an ideal situation.
16 So the project was to identify community clinics throughout
17 California and provide them some intensive clinic technical
18 assistance so that they would be able to provide that care in a
19 clinically appropriate way.
20 And the -- we probably trained about eight or nine clinics
21 throughout California.
22 Q. You have also been a consultant with TransLine since
23 January 2011.
24 Can you explain what that organization is and what you do
25 for them.

1 A. So TransLine was actually a project that came out of
2 Project Health in that we would go out to these clinics, and
3 we'd provide them with a bunch of educational training. But
4 then as they started practicing and seeing patients, things came
5 up, and they weren't necessarily sure what to do in all
6 circumstances. So they needed sort of this consultation that
7 was ongoing.
8 And so it was very successful, and the clinics that we
9 worked with said it was absolutely probably one of the most
10 important things we did. So we actually opened it up, and it
11 became a national consultation line.
12 So that if you're healthcare provider and taking care of a
13 transgender patient, and you might not have the experience you
14 need or you might just have a very unusual question, you submit
15 it to TransLine, and one of a number of providers who are
16 experienced in transgender care from Lyon-Martin Clinic but also
17 from some other LGBT clinics throughout the U.S. will answer the
18 question.
19 Q. And are there any restrictions on who can use that hotline?
20 A. Well, it's for healthcare providers. And most of the
21 questions are from physicians or nurse practitioners or P.A.s,
22 but we occasionally get a nurse or mental health provider who
23 has a question.
24 Q. And where are you currently employed?
25 A. I'm employed as an emergency physician at Sutter Davis

1 Hospital in Davis, California. And I also practice pro bono at
2 Lyon-Martin Health Services in San Francisco.
3 Q. Can you explain what Lyon-Martin Health Services is.
4 A. Yes. It was originally a sort of for-us, by-us clinic for
5 lesbian and bisexual women started in the 1980s. And then in
6 the 1990s, the clinic expanded its treatment model to include
7 transgender patients.
8 And it's a -- it's a -- like a safety-net clinic. It's a
9 federally qualified healthcare center.
10 Q. Can you explain what a federally qualified healthcare
11 center is.
12 A. So FQHCs are clinics that enter into an agreement with the
13 government that they will treat anybody who shows up, whether
14 they are insured or not insured. So if you're uninsured, you
15 have a sliding scale payment system. And in return for that,
16 the government reimburses you more for those patients that do
17 have government-sponsored insurance, particularly Medicaid and
18 Medicare.
19 Q. And are the patients you treat at a federally qualified
20 healthcare center different from patients at other primary care
21 clinics?
22 A. Yes. In that, you know, because the majority of our
23 patients are uninsured -- or if they are insured, they have
24 Medicare or Medicaid -- they tend to be a lot more
25 disenfranchised.

1 So, for example, in my clinic, about 20 percent of our
2 patients are homeless or marginally housed. We have higher
3 rates of substance abuse, higher rates of cooccurring mental
4 health conditions. They are people who aren't doing quite as
5 good as you would see in a regular primary care clinic.
6 And we also have a significant portion of our patients who
7 are involved in the criminal justice system. Either they were
8 in prison or they're on parole or some of my patients have gone
9 to prison.
10 Q. You described it as a primary care clinic.
11 Can you describe what your duties and responsibilities are
12 at Lyon-Martin as a primary care doctor.
13 A. So I carry my own panel of patients that I see, and I'm
14 their regular doctor. But I also supervise midlevel providers,
15 like nurse practitioners and physician assistants.
16 I do a lot of training with the clinic. So we have medical
17 students, nurse practitioners, P.A. students, residents, fellows
18 who come and will spend a month or so with us to get training in
19 transgender healthcare.
20 Q. And where do those students come from who you train?
21 A. The majority is, you know, just because of location, they
22 are from the Bay Area and California area, but we have had
23 students from across the country and even a couple of
24 international students.
25 Q. How many students would you estimate that you have trained

1 since 2005, when you began working there?
2 A. That's a hard number, but probably about 10 a year or so.
3 At least 100.
4 Q. How many people with gender dysphoria have you treated in
5 the course of your career?
6 A. That have been my primary patients? About 400 or more than
7 400.
8 Q. And how many people with gender dysphoria are you currently
9 treating?
10 A. Again, that are my primary care patients, about 100.
11 Q. I'm sorry. Did you say 100?
12 A. Yeah, 100.
13 Q. Thank you.
14 Are you familiar with the World Professional Association
15 for Transgender Health, or WPATH?
16 A. I am.
17 Q. And what is that organization?
18 A. It's a professional organization for those who provide care
19 to transgender patients.
20 Q. And what activities does WPATH engage in?
21 A. They release the standards of care and revise it
22 periodically, which is guidance on who should be treated with
23 what particular types of treatments, medical, surgical.
24 They hold a conference every two years that's sort of a
25 research and education conference. So people will present their

1 data from more recent research.
2 They, you know, will periodically make statements or
3 address things that are relating to transgender health.
4 Q. And do you have a role in the association of WPATH?
5 A. I'm a member of WPATH. I'm also on the Medicine Research
6 and the Incarcerated Persons committees.
7 Q. Your CV also lists several publications related to
8 transgender healthcare. We don't need to go over those
9 individually.
10 But does your -- if you could pull up his CV again. Sorry.
11 Does your CV accurately list those publications?
12 A. Can I scroll through it?
13 Q. There is a way. I don't know that you can.
14 A. Like one more page.
15 Yeah, it does.
16 Q. Are there any newer publications that are not listed?
17 A. Could you back up one page?
18 Oh, that are not listed? No. I mean, I have one project
19 I'm working on but not in publication.
20 Q. Your CV also lists numerous presentations related to
21 transgender healthcare. Again, we don't need to go over those
22 individually.
23 But does your CV accurately list those presentations?
24 A. The most important ones. I don't put every presentation
25 that I do on my CV. It would be 30 pages long. So these are

1 the most important ones.
2 Q. Okay. We often hear about peer-reviewed journals.
3 Can you explain what that means.
4 A. Those are medical or, more broadly, scientific journals
5 where you submit a paper, and then peers of yours -- so people
6 who are knowledgeable in that field of study -- will review the
7 paper.
8 And you then have the opportunity to make corrections or
9 they might suggest, you know, you should expand on this or
10 explain this or maybe include this data that you didn't include.
11 And then you make corrections, and you resubmit it.
12 It's published. And then there is a process afterwards and
13 the sometimes vigorous discussion in the editorial pages in
14 subsequent months where people discuss the paper if it's --
15 especially if it's something controversial.
16 Q. And do you have peer-reviewed journal publications listed
17 on your CV?
18 A. I do.
19 Q. Have you ever been retained as an expert in other cases
20 involving transgender healthcare?
21 A. Yes.
22 Q. Can you give some examples of those cases in the past five
23 years.
24 A. Yes. So I was an expert in a case in New York State that
25 was *Cruz v. Zucker*, where the question was whether or not the

1 state Medicaid agency would cover certain treatments for
2 transgender recipients of New York State Medicaid. And that
3 was -- the plaintiffs won, and so New York State now provides
4 that.
5 There was a case in Florida. Reiyn Keohana was the
6 plaintiff. I don't know what the -- it was the prison system
7 was the defendant. And the issue was whether or not she would
8 have female grooming requirements. And ultimately, they agreed
9 to give her those.
10 I was an expert in Michelle Norsworthy's case in
11 California. And at issue was whether or not she needed sex
12 reassignment surgery. And she won, but then they paroled her
13 very soon afterwards, so she didn't get surgery while she was in
14 prison.
15 And I had two similar cases to that in California that were
16 the same issue, a trans woman in prison who was wanting to get
17 sex reassignment surgery. They are not completed yet, but I
18 actually found out one of them yesterday was -- we're not doing
19 it anymore because the state decided to parole that person.
20 Q. You testified earlier about the WPATH standards of care.
21 Do you use those when you treat patients who have gender
22 dysphoria?
23 A. I do.
24 Q. Can we bring up the WPATH standards, which is Joint Exhibit
25 15, please.

1 Dr. Gorton, do these look like the standards of care that
2 we're talking about?
3 A. Yes.
4 Q. During your deposition in this case, defense counsel asked
5 you about your understanding of the standards of care as,
6 quote/unquote, "flexible guidelines."
7 Do you recall that?
8 A. I believe so.
9 Q. Can we go to page 2 of this document -- sorry. Page 2 of
10 the actual document, not the 15-2.
11 Do you see the heading here called "The Standards of Care
12 are Flexible Clinical Guidelines"?
13 A. I do.
14 Q. What is your understanding of what that means?
15 A. What that means is that for most patients in most
16 situations, the guidelines that WPATH sets forth to determine
17 who should be given certain types of treatment are appropriate
18 to follow; but that in some situations, experienced providers
19 can provide treatment even to a patient who hasn't completely
20 met all those criteria, if there is a good reason.
21 And so, like, the examples they give are unique anatomic,
22 social, or psychological situations. So, like, I have a patient
23 who is a transgender woman whose mother has dementia, and her
24 mother was actually accepting her transition but now doesn't
25 remember that her child transitioned.

1 And so when my -- if my patient shows up to provide care
2 for her, she doesn't recognize her. And so when she provides
3 care for her mother, she dresses in men's clothes, and she
4 presents as a man, you know, to make it -- to make her
5 essentially able to care for her mother.
6 And this patient was wanting to be referred for surgery.
7 And typically, you would say: Well, gee, you have to have 12
8 months of living full time in the target gender role.
9 And, you know, if somebody, say, at work, they don't, you
10 know, present as that gender, you would say: Well, gee, maybe I
11 haven't met the 12-month requirement.
12 And in her case, there is a situation where she presents as
13 male, but it has nothing to do with her gender dysphoria, and it
14 wouldn't be appropriate for me to say, well, since you have to
15 provide care for your mother, we are not going to give you this
16 treatment that you otherwise need.
17 Q. And the standards of care give another example of that on
18 page 35.
19 Can we switch to that page, please. The second part.
20 There you go.
21 Do you see the heading on this page that says, quote,
22 "Relationship between the standards of care and informed consent
23 models," end quote?
24 A. I do.
25 Q. Can you explain what informed consent models are.

1 A. So that's something that came out of the United States,
2 historically LGBT community health centers who treated a lot of
3 trans patients in that the criteria for starting hormone therapy
4 was that you had to be diagnosed by a mental health provider
5 before you could start hormone therapy.
6 And in many cases, patients weren't able to access that
7 psychological care because their insurance wouldn't cover it and
8 because they couldn't afford to pay out of pocket.
9 So providers in those clinics said, you know, we have to
10 provide care to this person. You know, not providing care
11 because they don't have the resources to see a psychologist for
12 10 visits is not appropriate.
13 And so they, you know, essentially went -- you know, used
14 the concept that the standards are flexible and made sure that
15 patients understood that we're not -- we're not doing the thing
16 that WPATH says, but there is a good reason we are not doing it
17 and made sure they were okay with that departure from the
18 standard.
19 And you know, that's what the informed consent part of it
20 is about, that the patient understands you are departing from
21 the standard, and they consent to treatment.
22 Q. And those health centers that are listed here -- Callen
23 Lorde Community Health Center, Fenway Community Health
24 Transgender Health Program, and the Tom Waddell Health Center --
25 what are those centers?

1 A. They are all community health centers. Tom Waddell is
2 actually a San Francisco Department of Public Health Clinic, but
3 they are historically clinics that treat and care for the LGBT
4 community.
5 Q. So the first part of that first paragraph references what
6 you just described, the informed consent model. And then the
7 last sentence of that first paragraph says:
8 "The SOC are flexible clinical guidelines; they allow
9 for tailoring of interventions to the needs of the
10 individual receiving services and for tailoring of
11 protocols to the approach and setting in which these
12 services are provided."
13 And then there is a cite to a study there by Ehrbar and
14 Gorton from 2010.
15 Is that right?
16 A. Yes.
17 Q. And that's a cite to a study that you did; correct?
18 A. To a paper that I did, yes.
19 Q. Can you explain how that paper addresses the topic of
20 tailoring the standards of care to particular patients.
21 A. Yes. So, basically, the idea was -- it was a discussion
22 paper for providers of care for transgender patients to sort of
23 examine their own model for providing care; that is, how much
24 and when is appropriate for them to deviate from the standard of
25 care.

1 So, for example, one of the examples we used in that was a
2 patient who also is wanting to get surgery and so needs to meet
3 the requirement of living in the target gender for 12 months.
4 And that's usually expected to be in either school or work or a
5 volunteer context, so something you do in the community. And,
6 say, you had a patient who had such a profound disability that
7 they couldn't participate in schoolwork or volunteer activity.
8 It wouldn't be appropriate to say for this patient that, well,
9 because you can't do those things, we're not going to treat your
10 other condition.
11 So it was just sort of a way for providers to examine their
12 own model and their own comfort level in providing that care.
13 Q. So it sounds like this concept of flexibility is intended
14 to address situations where experienced providers may need to
15 loosen the criteria due to individual patient circumstances; is
16 that fair?
17 MR. EATON: Objection. She is testifying.
18 THE COURT: I'm sorry.
19 MR. EATON: And leading.
20 THE COURT: Well, I -- I think counsel is trying to
21 just paraphrase what the witness has already said. I generally
22 give a fair amount of leeway as long as counsel is not putting
23 words in the witness's mouth, particularly in a court trial.
24 So I'll overrule the objection. But, Counsel, be careful
25 not to testify from the lectern.

1 Go ahead. You may answer.

2 THE WITNESS: Can you ask the question again.

3 MS. WHELAN: Could you read back that question, Court

4 Reporter.

5 (Question read by reporter.)

6 THE WITNESS: Yes, that's correct.

7 Q. BY MS. WHELAN: Yesterday the parties heard testimony about

8 hormone treatments for transgender women.

9 Can you describe the physical effects a transgender woman

10 would experience from hormone medication.

11 A. Sure. So she will develop breasts. Her facial hair is not

12 going to stop growing in, but it -- it will grow slower, and the

13 hairs might be a little thinner.

14 There is some changes in the skin. You know, you produce

15 less sweat. Sometimes people find they smell different.

16 Your distribution of fat and muscle in your body changes,

17 so you have a more feminine figure.

18 Those are some of the physical changes. Also, to your --

19 in some patients -- not in all, but in some patients, the sex

20 drive diminishes, and also there's shrinkage of the testicles.

21 Q. Typically, how long would it take for those physical

22 changes that you described to occur?

23 A. You might notice the first beginnings of those changes

24 within the first month of treatment. But it usually takes two

25 to three years to get the maximum effect that you're going to

1 get.

2 Q. Can you describe what genital surgeries are used to treat

3 transgender women.

4 A. The most typical surgery is the vaginoplasty, which is the

5 construction of a vagina. And there is some different

6 techniques that you can use to do that, but probably the lion's

7 share of it is what's called a penile inversion vaginoplasty.

8 And what you do is you take the head of the penis and its

9 neurovascular pedicle that the nerves and the blood vessels that

10 run to it, and you preserve those, and that actually becomes the

11 clitoris.

12 MR. EATON: Sorry, Your Honor. I'm going to object to

13 the foundation.

14 THE COURT: In what respect?

15 MR. EATON: Well, I don't think he has been qualified

16 or has been established that he is able to testify as to SRS

17 surgeries and how those go.

18 THE COURT: Overruled. The witness clearly was

19 treating as a primary care physician transgender individuals.

20 And I think that's sufficient to -- since he would be making

21 referrals, presumably, for that surgery, I think that's

22 sufficient to establish that he would know what's involved in

23 the process.

24 The objection is overruled. You may answer -- or continue

25 with your answer.

1 THE WITNESS: So I think I was saying you preserve the
2 head of the penis. The head of the penis is the clitoris. And
3 then the shaft of the penis, essentially the tissue inside of
4 it, is removed; and it's inverted, and that's used to create the
5 vagina. A space is created in the perineum, and that's
6 inserted. The testicles are removed, and the scrotum is used to
7 create the labia majora.
8 Q. And what are the goals of genital surgery for transgender
9 women?
10 A. Well, the primary goal is to treat their gender dysphoria.
11 I mean, you know, when you treat gender dysphoria, it also will
12 sometimes diminish other mental health diagnoses.
13 You also get the benefit of removing the testicles, so
14 there is no more testosterone production. And so it simplifies
15 hormone treatments in that you don't usually have to be on any
16 antiandrogen. So if somebody is on --
17 THE REPORTER: Could you slow down.
18 THE WITNESS: Sorry.
19 It simplifies hormone treatment in that if people are on
20 any antiandrogen, that can be stopped usually.
21 And, for example, spironolactone, which is the antiandrogen
22 we use in the vast majority of transgender women, you can
23 discontinue that.
24 Q. BY MS. WHELAN: In your clinical experience, have you had
25 patients who had trouble accessing surgeries to treat their

1 gender dysphoria?
2 A. Yes.
3 Q. And what consequences have you observed in patients who had
4 trouble accessing that surgical care?
5 A. So in -- so I started practicing with trans patients in
6 about 2005. And in 2011 -- around 2011, things changed pretty
7 dramatically in that instead of most of my patients not having
8 access to surgery, most of them did.
9 Private insurers were covering it a lot more, and the state
10 Medicaid agency started covering it.
11 So in comparing those two times, I mean, before we were
12 able to get patient surgery, their dysphoria was inadequately
13 controlled, oftentimes causing severe suffering, sometimes with
14 disastrous consequences.
15 I have had patients -- I haven't had a patient since 2011
16 who committed suicide, but I had some patients who committed
17 suicide. And I think that was a big contributing factor.
18 It's just -- there is a tremendous amount of suffering that
19 people experience if they can't get the surgery that they need.
20 Q. Have you also provided follow-up care to patients who have
21 had genital surgery?
22 A. I provide follow-up care to all my patients who have
23 genital surgery.
24 Q. Approximately how many patients are you currently treating
25 who have had vaginoplasty?

1 A. So I have about 100 trans patients on my panel. So about
2 50 trans women, say. And I would say probably 30 of them have
3 had vaginoplasty.
4 Q. What therapeutic effects have you seen for patients who
5 have had genital surgery?
6 A. The biggest one is that their dysphoria diminishes. You
7 know, like I said, that's -- that's a huge thing, and that's
8 what we are treating with this.
9 But, I mean, there is secondary effects. Like I said,
10 depression, anxiety can get better. I have had patients who no
11 longer needed to take antidepressants.
12 The other thing, too, is when people are able to sort of
13 take care of this huge issue that they have, they can often then
14 focus on other things in life -- going back to school, getting a
15 job, you know, focusing on their relationships.
16 And certainly not in every situation, but, like, I had a
17 patient who was at times homeless, at times marginally housed
18 and had a really bad substance abuse problem who wanted surgery
19 and had to get clean for surgery; so he did and then stayed
20 clean after surgery.
21 And he has been clean and sober for several years, and he
22 actually works as a peer, a substance abuse counselor. And he
23 does that, but then he is also going to school to get therapy
24 credentials to be an MSW.
25 Q. Let's talk about Ms. Edmo in particular.

1 Can you explain what you were retained to do in this case.
2 A. I was retained to evaluate whether or not she was getting
3 appropriate medical treatment for her gender dysphoria and, in
4 specific, whether or not she needed genital sex reassignment
5 surgery.
6 Q. Can you explain what you did prior to writing your first
7 report in this case to form those opinions.
8 A. So I reviewed some of her medical records from prison, and
9 I went to see her and evaluated her.
10 Q. And when you say you reviewed some of her prison medical
11 records, did you later receive a full set?
12 A. I did.
13 Q. And the first set that you reviewed, what percentage would
14 you say is that of her full set that you later received?
15 A. Maybe 80 to 90 percent.
16 Q. Can you say a little bit more about the clinical interview
17 that you did of her at prison. Can you describe that.
18 A. So we were in a visiting room, and I essentially got her
19 history with regards to her gender dysphoria but also with
20 regards to other mental health issues she has, medical issues,
21 how she had been living as a woman in prison, what treatment she
22 had received, what benefits she'd received from those.
23 Q. And after that evaluation and your review of her medical
24 records, did you come to a conclusion as to whether or not
25 Ms. Edmo has gender dysphoria?

1 A. Yes.
2 Q. And what was that conclusion?
3 A. That, yes, she does have gender dysphoria.
4 Q. Did you also determine whether Ms. Edmo needs surgery?
5 A. Yes, she does.
6 Q. When you assessed her need for surgery, did you use the
7 standards of care?
8 A. I did.
9 Q. Can we bring up again Joint Exhibit 15 at page -- I believe
10 it's 15-66.
11 Do you see that on the screen, Dr. Gorton?
12 A. I do.
13 Q. You used these criteria to assess surgery for Ms. -- the
14 need for surgery for Ms. Edmo; is that correct?
15 A. Correct.
16 Q. Can you go through those six factors and describe what you
17 found with respect to Ms. Edmo.
18 A. Sure. So the first one is a persistent well-documented
19 gender dysphoria. And, you know, in my interview with her, this
20 has been a persistent symptom for her, and also her records that
21 I reviewed from prison, document that. So I think she meets
22 that criteria.
23 The capacity to make a fully informed decision and to
24 consent for treatment, she didn't seem at all impaired in her
25 decision-making capacity. So I think that's met.

1 She is obviously over the age of 18, so she meets criteria
2 3.
3 4 is if significant medical or mental health concerns are
4 present, they must be well controlled. So from the medical
5 perspective, there is nothing that is a contraindication for her
6 to have surgery. From the mental health perspective, other than
7 her gender dysphoria, she has depression, anxiety. And those
8 are present, but they are not to a level that would preclude her
9 getting sex reassignment surgery.
10 MR. HALL: Objection. Foundation, move to strike.
11 MR. EATON: Join.
12 MR. HALL: The doctor is not a mental health provider.
13 THE COURT: Well, the question, I think, is not --
14 well, I will overrule the objection.
15 The question is phrased in a way as to characterize the
16 extent or how the mental health problems would impact the
17 decision as to gender confirmation surgery. Even though there
18 is a mental health component, it's primarily driven by the
19 doctor's expertise in this other area.
20 So I'll overrule the objection. Go ahead and answer --
21 well, your answer stands. Let's go ahead and put another
22 question before the witness.
23 MS. WHELAN: Sure.
24 Q. BY MS. WHELAN: Could you just continue with the next two
25 prongs, Dr. Gorton.

1 A. Sure. So No. 5 is 12 continuous months of hormone therapy
2 appropriate to the patient's gender goals. And she has that, as
3 documented in her medical record.
4 And then the final is 12 continuous months of living in a
5 gender role that is congruent with her gender identity. I think
6 she exceeds this; right? Because the idea is that you have to
7 live in the -- your target gender role, and she had been doing
8 that despite an environment that's very hostile to that and some
9 negative consequences that she has experienced because of that.
10 So, I mean, she is doing it despite that. So she more than
11 meets that criteria.
12 Q. Are you also aware that Ms. Edmo has attempted
13 self-surgeries?
14 A. Yes.
15 Q. What is the clinical significance of her self-surgery
16 attempts?
17 A. Primarily that she has severe genital-focused gender
18 dysphoria and that she is not getting the medically necessary
19 treatment to alleviate that.
20 Q. Do you think that Ms. Edmo engaged in self-surgery because
21 her depression or her anxiety are not well controlled?
22 MR. EATON: Objection. Speculation.
23 MR. HALL: Join.
24 THE COURT: Overruled.
25 THE WITNESS: Even if she had no anxiety and no

1 depression, she still might have done this because it's -- the
2 depression and anxiety aren't driving it. I mean, there is a
3 lot of people with depression and anxiety who don't remove their
4 testicles. The dysphoria was driving this.
5 And the -- you know, essentially, it's a function of not
6 having access to medically necessary care. And this isn't
7 unique to her situation or even unique to people with gender
8 dysphoria.
9 I mean, there is a case reported in the literature of a
10 Russian surgeon who was Antarctica and got appendicitis, and
11 there was nobody else to do it, so he took his own appendix out.
12 There was a woman, completely untrained, a Mexican woman
13 who performed a Cesarean section on herself, and she and her
14 child both survived -- in her kitchen.
15 And it's because these people are presented with extreme
16 circumstances where that's the only option. And the only
17 difference between those is the diagnosis. So in the Russian
18 surgeon, it was appendicitis; and in the Mexican woman, it was
19 failure to progress in labor. And in Ms. Edmo's case, it's
20 gender dysphoria.
21 Q. After you wrote your report in this case, you reviewed
22 additional documents; is that correct?
23 A. Yes.
24 Q. Do you recall what those documents were?
25 A. Yes. There were a lot of them.

1 So I got a more complete set of her medical records from
2 prison. I got some -- not very much but some records from
3 before she was in prison, some medical records. I got more
4 information about the DORs that were mentioned in the original
5 set that I got. So I got more complete information about that.
6 There was a slide deck for a lecture that I think providers
7 had received about transgender care. There were multiple
8 depositions. There was Dr. Garvey and Dr. Andrade's reports.
9 I don't know if I'm missing anything, but that's what I can
10 think of now.
11 Q. Have you seen anything in the documents you reviewed after
12 writing your report, that would change your opinion as to
13 whether Ms. Edmo's mental health issues are well controlled?
14 A. No.
15 Q. Have you seen anything in the documents you reviewed that
16 would change your opinion that Ms. Edmo needs genital surgery?
17 A. No.
18 Q. Do you think that a prisoner should be discipline-free for
19 some period of time before receiving surgery?
20 A. Not at all.
21 MR. HALL: Objection. Foundation.
22 MR. EATON: Join.
23 MR. HALL: There has been no testimony that he has any
24 experience in prison or corrections.
25 THE COURT: Rephrase the question as to whether that

1 would be an indicator that she would not be a good candidate.
2 It's roughly the same question, but I think rephrased, it would
3 probably resolve the objection of counsel.
4 Q. BY MS. WHELAN: Dr. Gorton, in your professional opinion,
5 would you ever consider disciplinary actions or even criminal
6 actions of a patient as precluding their medical need for
7 surgery?
8 MR. HALL: Objection. Foundation and it goes
9 towards -- well, Your Honor, it is compound.
10 THE COURT: I'm going to overrule the objection. Go
11 ahead.
12 THE WITNESS: No. And I couldn't do my job as an ER
13 doctor if I thought that, because we get a lot of prisoners that
14 are brought in for care. And there have even been a few cases
15 where I was assaulted by somebody and pressed charges against
16 them, but I still had to treat them because I was the only
17 doctor there.
18 And in those cases, you have to make a bright line between,
19 you know, what the person did -- even if what the person did was
20 punch you in the face -- and the care that you treat. You know,
21 somebody's medical care shouldn't be dependent on whether or not
22 they have committed a crime, and it would be supremely unethical
23 to even consider that.
24 Q. BY MS. WHELAN: Are you familiar with the term
25 "evidence-based medicine"?

1 A. Yes.
2 Q. Can you describe what that term means.
3 A. So, basically, it's taking the sum of all medical
4 literature, all the evidence that we have about treating
5 patients and taking that data and applying it to the individual
6 patient that's in front of you to try and optimize the treatment
7 that you provide to optimize their ultimate outcome.
8 Q. Do you believe that the WPATH standards of care are
9 supported by evidence-based medicine?
10 A. I do.
11 Q. Are you aware that some people have suggested that genital
12 surgery should not be provided because there is insufficient
13 high-quality evidence to support those surgeries?
14 A. Yes.
15 Q. How are you aware of that?
16 A. I have come up with that argument -- or come up against
17 that argument before. That was in the New York State Medicaid
18 case that I worked with. I mean, that was their whole
19 contention, that this isn't supported by the medical literature.
20 And I mean, in this particular case, I think Dr. Garvey's
21 report says that.
22 Q. Can you explain what high-quality evidence is in this
23 context.
24 A. Well, the highest quality evidence is, you know,
25 meta-analysis. So we bring a bunch of studies together, and

1 then each of those studies is a large, well-performed
2 double-blinded randomized controlled clinical trial that runs
3 for a very long period of follow-up.
4 Q. And are those types of studies that you just described --
5 sorry. Strike that.
6 Does that quality of evidence that you just described exist
7 for genital surgeries for transgender people?
8 A. No.
9 Q. Why doesn't that evidence exist?
10 A. There is a lot of reasons. You know, just going through
11 the type of studies, so it's not going to be a large study
12 because it's a rare disease. So, I mean, nobody expects of that
13 a rare disease.
14 You can't do a double-blinded study, because in a
15 double-blinded study, neither the patient nor the provider knows
16 what treatment they received. And this is, obviously, apparent
17 surgery, so patients are going to know what procedure they had.
18 You can't do a placebo-controlled trial because if you have
19 a treatment that you know is effective -- and we do; I mean, we
20 have been doing this for decades, and there is an adequate
21 evidence base to realize that this is effective -- you can't
22 say, well, I'm going to take 100 people, and 50 I'm going to
23 provide them the care that we know that works, and these other
24 50, I'm just going to watch them and see what happens, because
25 that's not ethical, you know. Especially in a disease where

1 suicide is a significant complication, that's not okay.
2 I mean, we even do that -- like, if you're doing a study or
3 if you're in the middle of a study, like, if you're studying a
4 new cancer drug and you give -- half the people get the drug and
5 half get placebo, and then partway through the study, you
6 realize, wow, the patients that are getting the drug have a much
7 greater survival and their cancer is shrinking, you stop the
8 study. You don't say, well, let's keep going with the study so
9 that we get good data and, in doing so, endanger the lives of
10 the people who got the placebo.
11 I mean, that's not medically ethical. I mean, there is no
12 way you could get a placebo-controlled trial of trans surgery
13 study past an IRB. You can't do it.
14 Q. And what is an IRB?
15 A. It's an institutional review board. So if you're doing
16 research, you make a proposal and say, hey, this is the study
17 that I want to do this, and this is how I want to treat the
18 human subjects. And they decide whether or not that's okay.
19 Q. Your report in this case discusses a surgical evaluation
20 for Ms. Edmo that was done by Dr. Eliason.
21 Do you recall that?
22 A. I do.
23 Q. Can we bring up the Eliason assessment, which is Joint
24 Exhibit 1-538.
25 THE COURT: Counsel, so we're clear, we have been

1 referring to this as, I think, 1-538. That's really Exhibit 1,
2 page 538; is that correct?
3 MS. WHELAN: That's correct. I'm sorry.
4 THE COURT: That's fine. I just need to make sure the
5 record is clear for any appellate review.
6 MS. WHELAN: Yes. Thank you, Your Honor.
7 THE COURT: I always have to cover my bets. So go
8 ahead.
9 Q. BY MS. WHELAN: Dr. Gorton, is that up on your screen?
10 A. Yes, it is.
11 Q. Is this the assessment that you reviewed?
12 A. Yes, it is.
13 Q. Did you agree with this assessment?
14 A. No.
15 Q. Can you explain why you didn't agree with this assessment.
16 A. Well, one, I didn't agree with the conclusion that he made
17 that she doesn't need surgery. But, two, his reasoning I also
18 didn't agree with.
19 Q. Can you explain why you didn't agree with his reasoning.
20 A. So if you look at the thing that starts "A" with a colon
21 after it, that stands for "assessment," he talks about
22 situations where sex reassignment surgery might be medically
23 necessary, and he gives three examples.
24 And the first example isn't even germane to transgender
25 people. That talks about people with intersex conditions. I

1 mean, you can have coexisting intersex conditions and gender
2 dysphoria, but that's -- that's actually referring to problems
3 that intersex people have.
4 The third one is -- it says, "Some type of medical problem
5 in which endogenous sexual hormones were causing severe
6 physiologic damage." And so that's the hormones that your body
7 makes itself, not ones that we give you.
8 So, I mean, I can't even -- that's -- it's almost kind of
9 bizarre. I can't even think of a clinical circumstance where
10 that would be the case that your hormones that your body
11 produces are attacking you, so we have to give you sex
12 reassignment surgery. I just don't understand what he is
13 talking about there.
14 And then the second one is it was -- he is talking about
15 how severe the dysphoria is, and that's legitimate. But he
16 says, "Severe and devastating dysphoria that is primarily due to
17 genitals could potentially meet criteria."
18 And the criteria isn't severe and devastating dysphoria;
19 it's clear and significant dysphoria. And that's the criteria
20 that I use and my colleagues use for assessing patients; right?
21 If I required my patients to have severe and devastating
22 dysphoria, over two-thirds of the people I refer for surgery
23 wouldn't get it.
24 You know, and the thing is even if you use his extremely
25 high bar, I think Ms. Edmo meets it. Because, I mean, she tried

1 to cut her testicles off, twice. If that's not something that
2 speaks to severe genital-focused dysphoria, I'm not sure what
3 is.
4 Q. Do you agree with Dr. Eliason's statement that, quote,
5 "Medical necessity for sex reassignment surgery is not very well
6 defined and is constantly shifting"?
7 A. Not at all.
8 Q. Why don't you agree with that statement?
9 A. I mean, this is something that we have been doing this for
10 decades. You know, the first sex reassignment surgery that we
11 know of happened 101 years ago at the University of Oregon. And
12 so we have been doing this for a long time.
13 We know it's effective. And medical necessity is the
14 patient has a disease, and you have a treatment that we know to
15 be effective. And that disease is to a clinically significant
16 level; that's medically necessary. There is no argument about
17 the medical necessity of it.
18 Q. What is your opinion about what might happen to Ms. Edmo if
19 she isn't provided surgery?
20 MR. EATON: Objection. Speculation.
21 MR. HALL: Join.
22 MS. WHELAN: May I, Your Honor?
23 THE COURT: Just a moment. I'm going to overrule the
24 objection. I think this question goes to the very heart of the
25 issue before the court.

1 There, undoubtedly, is some measure of speculation. But on
2 the other hand, the doctor has been involved in treating
3 hundreds of individuals suffering from gender dysphoria. And I
4 think based on that, clearly, there would have to be an
5 understanding of what the consequences are if certain treatment
6 is or is not provided.
7 So I'm going to overrule the objection. Counsel will be
8 allowed to explore the speculative nature, if there is one, of
9 the doctor's testimony during cross.
10 You may go ahead and answer.
11 THE WITNESS: Can I have the question again.
12 THE COURT: I was afraid of that. Go ahead.
13 Q. BY MS. WHELAN: What is your opinion about what might
14 happen to Ms. Edmo if she isn't provided surgery?
15 A. If she is not provided surgery, there is a very substantial
16 chance that she will try to attempt self-surgery again. And
17 that's especially worrisome given her attempts have been
18 progressive. Like her first attempt, she didn't make as much
19 progress as the second attempt. So I think she might be
20 successful if she repeats that.
21 There is also a real chance that she will attempt or commit
22 suicide.
23 Q. Why did you say in your report that surgery should be
24 provided to Ms. Edmo within six months?
25 A. In my -- in the patients that I have treated, there is

1 something that I just kind of noticed that when people who have
2 been needing surgery for a long time finally realize they are
3 going to get it, even before they have surgery, their gender
4 dysphoria improves.
5 They -- you know, it's sort of like there is this -- you
6 know, a relief that comes that's, you know, they know they are
7 going to get the treatment that they want.
8 And so what happens is if there is a delay -- and that
9 could be because the patient gets appendicitis and can't have
10 surgery for a number of months, or, you know, there is a longer
11 wait for the surgeon to be able to get them in -- if it goes
12 more than about six months, that sort of anticipatory benefit
13 that you get with regards to their gender dysphoria starts to
14 fade away.
15 And so if I have patients who, for some reason, there is
16 going to be a delay past that, I actually bring them in and talk
17 with them about it and make sure things aren't getting worse.
18 THE COURT: Counsel, we are past where we would take
19 the break, but I'll let you go for a few more minutes. I don't
20 want to interrupt your line of questioning, either.
21 MS. WHELAN: I'm about done, so I think that will work
22 if it works for you.
23 THE COURT: Just a few more minutes?
24 MS. WHELAN: Just a couple more minutes.
25 THE COURT: All right.

1 Q. BY MS. WHELAN: How likely do you think that it is that
2 Ms. Edmo will regret surgery?
3 A. Very, very low.
4 Q. And on what do you base that opinion?
5 A. One, my evaluation of her. She has -- her gender dysphoria
6 is very genital-focused. And so that makes her less likely to
7 regret it.
8 Also, if you look in the medical literature, regret rates
9 sort of overall generically for transgender patients are on the
10 order of 1 to 2 percent, which sounds like that's a big amount,
11 but it's actually -- like, if you compare it to, say, you know,
12 like prostate surgery or gastric bypass surgery, those have
13 regret rates in the 10 to 20 percent range.
14 And by "regret," I mean you're asking the patient
15 afterwards, "If you could go back in time and make this decision
16 again, would you still choose to do it?" And that's -- you
17 know, so 1 to 2 percent for surgical procedures is actually not
18 bad.
19 And the other thing, too, is there is -- there have been a
20 few studies that have looked at predictors for which patients
21 are more likely to regret. And the one that probably has the
22 strongest effect -- and I could not tell you why this is the
23 case -- but it's the sexual orientation of the transgender woman
24 in that trans women who are straight -- so their sexual
25 preference is for men -- tend to have much lower regret rates

1 than transgender women who are lesbians.
2 Q. Are you also familiar with complications that can result
3 from genital surgeries for transgender women?
4 A. Yes.
5 Q. What are some of those complications?
6 A. I mean, it's a major genitourinary surgery. So you can
7 have infections; you can have complications with urine flow; you
8 can have dehiscence, where the wound doesn't perfectly heal.
9 You -- if patients don't, subsequent to surgery, dilate
10 their vaginas as they are supposed to, you can actually have the
11 vaginal depth decrease and the width decrease. Those are things
12 that you can treat if they come up.
13 I mean, there is the -- in order to have surgery, you have
14 to have anesthesia, and anesthesia carries its own risks, which,
15 you know, you have a one-in-a-million shot that you're going to
16 die under anesthesia. So there is that.
17 Though it's not -- the risks aren't particularly greater
18 than other similar genitourinary surgeries.
19 Q. Based on your clinical experience, what is the likelihood
20 that Ms. Edmo's severe gender dysphoria will significantly
21 improve without surgery?
22 A. Very low to none.
23 MS. WHELAN: Thank you, Dr. Gorton. I have no further
24 questions at this time.
25 THE COURT: Counsel, let's just start cross after we

1 take a 15-minute break. Try to hold it to 15 minutes, Counsel.
2 So, again, try to reconvene at 20 minutes to the hour.
3 Court will be in recess.
4 (Recess at 10:28 a.m. until 10:44 a.m.)
5 THE COURT: I'll remind the witness that you're still
6 under oath.
7 I think we were ready for cross-examination, Mr. Hall -- or
8 Mr. Eaton. Yes, Mr. Eaton.
9 CROSS-EXAMINATION
10 BY MR. EATON:
11 Q. Good morning, Dr. Gorton. How are you today?
12 A. Good.
13 Q. Good. As you know, my name is Dylan Eaton. I represent
14 Corizon as providers in this lawsuit. I talked with you at your
15 deposition.
16 Do you remember that?
17 A. Yes.
18 Q. That deposition was on September 25th?
19 A. That sounds about right.
20 Q. Sounds about right?
21 And so I have the privilege of asking you a few more
22 questions today.
23 First, have you -- you have never worked in a prison;
24 right?
25 A. No, I haven't.

1 Q. Okay. And you have never been a part of a treatment group
2 or committee at a prison; correct?
3 A. No.
4 Q. And you have never provided treatment and care to an inmate
5 who had gender dysphoria or gender identity disorder while they
6 were incarcerated; correct?
7 A. My patients have become incarcerated, but I was their
8 provider before but not during. And I have treated patients
9 after prison if they are on parole, but not while they were in
10 prison.
11 Q. Right. And I understand when we talked at your deposition
12 that you told me you had some pre and post experience with
13 people that have been in prison. But that wasn't my question.
14 My question is: Have you -- you have never provided
15 treatment and care to an inmate who has gender dysphoria or
16 gender identity disorder while they were incarcerated; correct?
17 A. Yeah, I haven't.
18 Q. So that's a correct?
19 A. Yes; correct. Sorry.
20 Q. And you are not a board-certified psychiatrist; correct?
21 A. No, I'm not.
22 Q. Correct?
23 A. Correct. Sorry.
24 Q. Sorry. I just need to watch the double negatives.
25 You are not a licensed psychiatrist; right?

1 A. Correct.
2 Q. And you're not a licensed clinician; right -- mental health
3 clinician?
4 A. Correct.
5 Q. All right. And you are not a licensed therapist; correct?
6 A. Correct.
7 Q. And you are not a psychologist; correct?
8 A. Correct.
9 Q. Do you know what a certified correctional
10 healthcare -- health professional is?
11 A. You mentioned it at the deposition, so that's about it.
12 Q. So you don't know about that term?
13 A. No.
14 Q. Okay. So safe to say that you're not a certified
15 correctional health professional?
16 A. Correct.
17 Q. And you do not perform gender confirmation surgery;
18 correct?
19 A. No, I don't. Correct. Sorry.
20 Q. Correct? That's okay.
21 And just so I understand -- there has been confusion
22 sometimes about terminology -- is "sex reassignment surgery" an
23 okay term as well?
24 A. Yes, that's fine.
25 Q. And I just used the term "gender confirmation surgery."

1 Is that an appropriate term?
2 A. They are used interchangeably.
3 Q. Is that a newer term?
4 A. Yes, it's more new.
5 Q. What about "gender affirming surgery"?
6 A. Those -- "gender affirming surgery" is a newer term as
7 well.
8 Q. Is "gender affirming surgery" even newer than "gender
9 confirmation surgery"?
10 A. They are both relatively new. I don't know which one was
11 first, so...
12 Q. Okay. And you're not licensed to practice medicine in any
13 state other than California; right?
14 A. Correct.
15 Q. If there is a patient with complex mental health problems,
16 say, with several mental health comorbidities, you would refer
17 such a patient to a psychiatrist; correct?
18 A. There is different contexts to answer that question. Are
19 you talking about overall? Are you talking about gender
20 dysphoria patients' referral for surgery?
21 Q. No. I'm talking about if a gender dysphoria patient has
22 complex mental health problems, you would refer them to a
23 psychiatrist, right, to address their mental health issues?
24 A. It depends. I mean, I have patients who come to me, who
25 have complex mental health problems who have previously seen a

1 psychiatrist, and they are very stable on their medicines. And
2 so if they are stable, I just continue those medicines.
3 Certainly, if they became symptomatic or had problems, I
4 refer them back to psychiatry.
5 Q. So you utilize psychiatrists in your practice, correct,
6 even for gender dysphoria patients?
7 A. I do. My clinic actually has psychiatrists there.
8 Q. Okay. You will refer your gender dysphoria patients often
9 to psychiatrists?
10 A. My practice at my clinic is that -- so we have access to
11 psychiatrists; we also have access to therapists. And so the
12 most common thing is I would refer a patient to a therapist.
13 Really, for psychiatry, it's more there is some meds management
14 issue that needs to be addressed.
15 Q. So bottom line, at your Lyon-Martins clinic, you have
16 mental health professionals that you utilize; correct?
17 A. Yes, absolutely.
18 Q. And that includes clinicians? Yes?
19 A. Yes.
20 Q. And that includes therapists?
21 A. I think of those as the same things. But, yes.
22 Q. Okay. And you utilize psychiatrists sometimes?
23 A. Yes.
24 Q. And that situation could be when there is complex mental
25 health issues and comorbidities, that would be an example of

1 when you might refer somebody to a psychiatrist; correct?
2 A. As I answered before, sometimes, yes.
3 Q. Now, you did not charge an expert fee for this case;
4 correct?
5 A. That's correct. They paid my expenses but no expert fee.
6 Q. I think this is the first time I've had an expert not ask
7 for a fee at a deposition. So thank you.
8 So you don't charge at all for fees for being here today or
9 for your testimony at deposition or any of the work you have
10 done on this case; correct?
11 A. Correct.
12 Q. And you don't charge a fee because it's a transgender case;
13 correct?
14 A. No. I actually did have one transgender case that I
15 charged a fee for.
16 Q. Have you had transgender cases where you didn't charge a
17 fee other than this one?
18 A. Correct, yes.
19 Q. Most of them; right?
20 A. Yes.
21 Q. And then I believe you told me that you have charged a fee
22 when you were an expert witness in a Florida licensing case
23 involving a gynecologist; right?
24 A. That's correct.
25 Q. Okay. There was some discussion with Ms. Whelan about some

1 of your involvement with groups when we were looking at your CV.
2 So you do legal -- you're a legal consultant and do
3 specific projects for the Sylvia Rivera Law Project, which is an
4 organization to assist transgender people, especially who are
5 poor or people of color; right?
6 A. That's correct.
7 Q. Right. And you do legal consulting and projects for Lambda
8 Legal Defense and Education Fund, which handles LGBT cases?
9 A. I mean, I think of it as medical consulting because I'm not
10 a lawyer, so -- I mean, to legal organizations, yeah.
11 Q. So you do medical consulting for them?
12 A. Yes.
13 Q. Okay. And Transgender Law Center, which works on
14 transgender precedent-setting cases, I believe is what you told
15 me?
16 A. They do -- they do now. They were a more direct service
17 organization years ago.
18 Q. And you provided consulting and specific projects for them
19 as well; correct?
20 A. Yes.
21 Q. All right. And National Center for Lesbian Rights, which
22 focuses on lesbian rights and, more broadly, LGBT issues, such
23 as transgender issues, you provide consulting and do specific
24 projects for them; right?
25 A. That's correct.

1 Q. And then the National Center for Transgender Equality,
2 you're involved with them as well; correct?
3 A. To a small extent.
4 Q. And you donate to some of these groups; correct?
5 A. Yes.
6 Q. Okay. And I believe you mentioned you also get quite a few
7 calls from attorneys at the National Center for Lesbian Rights,
8 such as Ms. Whelan, who is one of Ms. Edmo's attorneys,
9 regarding various issues and questions on other matters; right?
10 MS. WHELAN: Objection. Misstates the evidence.
11 THE COURT: Well, if you disagree, you can. I'll
12 overrule the objection.
13 THE WITNESS: I mean, I have worked on a handful of
14 projects with them, maybe less than six over 8 to 10 years.
15 But, you know, I'll get questions from people, you know, "Can
16 you work on this project?" And if I have the bandwidth at that
17 time, I do.
18 Q. BY MR. EATON: So I remember discussing this at your
19 deposition. And you indicated that you get calls fairly
20 frequently from Ms. Whelan or other attorneys, right, for other
21 projects?
22 A. Are you speaking --
23 MS. WHELAN: Objection.
24 THE COURT: Just a moment. What is the objection,
25 Ms. Whelan?

1 MS. WHELAN: I'm sorry. It just misstates the
2 deposition testimony, Your Honor.
3 THE COURT: Well, let's put a question --
4 MS. WHELAN: I mean, if he wants to show it to him --
5 THE COURT: I'm going to sustain the objection and ask
6 counsel to put a question before the witness rather than just
7 make an observation.
8 Go ahead and proceed.
9 Q. BY MR. EATON: Do you remember discussing -- do you recall
10 when we were discussing that you would get phone calls from
11 Ms. Whelan on other cases during the deposition?
12 A. I believe what I said is that, overall, I will not
13 infrequently get calls from the organizations you just
14 mentioned; there is a big list of them.
15 And so, overall, yeah. But from Ms. Whelan, I think we
16 worked on two things, this and one other.
17 Q. So she has contacted you occasionally, then, on other
18 matters?
19 A. These two times, yes -- or this time and one other time.
20 Q. All right. Now, you mentioned in your deposition that you
21 realize that getting documentation of a person's prior mental
22 health treatment is important in assessing that person for SRS;
23 correct?
24 A. Ideally, yes.
25 Q. I'm sorry. I didn't hear the first word.

1 A. Ideally, yes.
2 Q. You indicated that that is important; correct?
3 A. You can't always get that information, but you should try,
4 yes.
5 Q. Okay. And after your clinical interview with Ms. Edmo, did
6 you request to receive or obtain any of her prior mental health
7 treatment records?
8 A. I actually got more of her treatment records while she was
9 in prison, from the attorneys. And like I said, I got some more
10 records from -- like, a very little bit -- from her previous
11 treatment before prison.
12 Q. But did you ask for her preincarceration mental health
13 records at the time of your declaration in May of 2018?
14 A. Honestly, I didn't know I could. I mean, usually people
15 just hand you the stuff and say, "This is the data that you
16 have." So, no, I didn't.
17 Q. Did you ask Ms. Edmo if you could obtain any of her
18 preincarceration records?
19 A. The thing is I didn't establish a physician-patient
20 relationship with her, and I made that very clear at the
21 beginning. That's part of my boilerplate I explain to people.
22 So, you know, if I was seeing somebody and they are my
23 patient and I'm providing them care, I -- that's something I
24 typically do; I request their old medical records, if there
25 are -- if they exist and if they are germane. But I didn't

1 think that that was something that I was supposed to do,
2 honestly.
3 Q. So you did not ask Ms. Edmo --
4 A. No.
5 Q. -- for her preincarceration records; is that correct?
6 A. No, I didn't.
7 Q. Correct?
8 A. Correct. Sorry.
9 Q. You did not obtain or review plaintiff's presentence
10 investigation or related documents regarding her convictions
11 prior to your declaration in May of 2018; correct?
12 A. Correct.
13 Q. So I want to be clear. At the time of your May 29, 2018,
14 declaration in this case, you only reviewed medical
15 records -- the prison chart notes that you said you received
16 were about 80 or 90 percent of those records -- and had a
17 clinical interview with Ms. Edmo; correct?
18 A. Correct.
19 Q. And at the time you executed your declaration in May 2018,
20 you hadn't reviewed incident reports regarding Ms. Edmo;
21 correct?
22 A. In her -- are you talking about DORs?
23 Q. No. Incident reports.
24 Do you know what those are?
25 A. Can you give me a description.

1 Q. I'm just wondering: Do you know what they are?
2 A. Well, I'll tell you what I saw in her chart, and you can
3 tell me if this is correct.
4 So there were notes that were written by clinicians in
5 regarding -- or in regards to disciplinary problems that she had
6 that, you know, answer questions like was her mental health a
7 mitigating factor or involved in this.
8 So that's what I had. I don't know if that's what you're
9 talking about.
10 Q. So you saw in the chart some references by clinicians
11 related to DORs that she had received?
12 A. That's correct; yes.
13 Q. But you hadn't actually seen the actual DORs at the time of
14 your May 2018 declaration; correct?
15 A. That's correct.
16 Q. When I say "DORs," you understand I'm talking about
17 disciplinary offense reports?
18 A. Yes.
19 Q. Okay. At the time of your declaration in May of 2018, you
20 hadn't reviewed any of the Management and Treatment Committee
21 meeting minutes regarding Ms. Edmo; correct?
22 A. That's correct.
23 Q. At the time of your May 2018 declaration, you hadn't
24 reviewed sex offender treatment program records regarding
25 Ms. Edmo; correct?

1 A. Correct.
2 Q. At the time of your May 2018 declaration, you hadn't
3 reviewed preincarceration Sho-Ban Tribe medical records
4 regarding Ms. Edmo; correct?
5 A. Correct.
6 Q. At the time of your May 2018 declaration, you hadn't
7 reviewed any preincarceration records from Indian Health
8 Services regarding Ms. Edmo; correct?
9 A. Correct.
10 Q. At the time of your May 2018 declaration, you hadn't
11 reviewed any preincarceration records from Portneuf Hospital
12 regarding Ms. Edmo; correct?
13 A. Correct.
14 Q. At the time of your May 2018 declaration, you hadn't
15 reviewed any presentencing investigation; correct -- documents?
16 A. Correct.
17 Q. And at the time of your May 2018 declaration, you hadn't
18 reviewed any Bannock County Jail records; correct?
19 A. I'm pretty sure not.
20 Q. And at the time of your May 2018 declaration, you hadn't
21 reviewed any Idaho Department of Corrections gender dysphoria
22 policies or procedures; correct?
23 A. Correct.
24 Q. And at the time of your May 2018 declaration, you hadn't
25 reviewed any prior versions of the Idaho Department of

1 Corrections PREA policy; correct?
2 A. Correct.
3 Q. And just so we're clear, then, you executed another shorter
4 declaration again in this case on June 11th of 2018; right?
5 A. I did. And I believe that date is correct.
6 Q. Okay. And for that declaration, the only additional
7 information you reviewed was the complete prison medical chart;
8 correct?
9 A. Partially correct.
10 There was -- what happened was I got a new set of records.
11 And I mean, she has massively long records. So the attorneys
12 that I was working with actually gave me a one-page document
13 that said: These are the pages that you didn't have. So it
14 sort of highlighted the pages that I didn't have.
15 And so I read through those pages. But, as it turned out
16 subsequently, there was -- I mean, they made an error in writing
17 down which pages were -- that hadn't been reviewed yet. So
18 there was actually a small portion of her mental health records
19 that I didn't realize was added to that. And then subsequent to
20 that second declaration, I became aware of that.
21 Sorry. That's complex.
22 Q. So if I understand you correctly, you received the complete
23 medical chart by the time you executed your declaration in June
24 of 2018?
25 A. Yes.

1 Q. Okay. But you're saying that there were a few mental
2 health records that you didn't realize that were in that new
3 packet that were new; correct?
4 A. Correct.
5 Q. But other than that, all of the list of other documents I
6 just went through that you did not review for your May 2018
7 declaration, you also had not reviewed those for your June 2018
8 declaration; correct?
9 A. I'm actually not entirely sure. I mean, I -- what I recall
10 is that I got the subsequent set of records that were her
11 medical records. And then after that, things kind of dribbled
12 in. Like I would get, "Here is a report to read," "Here is a
13 deposition to read."
14 And I can't tell you for certain that none of those came
15 before the second declaration. I just don't know the exact
16 dates.
17 Q. Okay.
18 A. I don't think it was the majority -- I mean, it certainly
19 was not the majority.
20 Q. Well, at your deposition, we went through all of those, and
21 you indicated that all those that we just discussed, had come in
22 within the last few weeks of the deposition, at the end of
23 September; right?
24 A. That certainly may be the case. I mean, it was a little
25 bit fresher in my mind then. So if I said that, that's probably

1 true.

2 Q. And you certainly didn't have her preincarceration medical

3 and mental health records at the time of your June 2018

4 declaration; right?

5 A. No, I don't believe I had those.

6 Q. Now, in your deposition, we discussed paragraph 32 of your

7 May declaration. And I can pull it up if you want me to, but we

8 discussed that the -- that Ms. Edmo reported that she saw a

9 psychiatrist through Indian Health Services who mentioned the

10 possibility of getting a diagnosis related to gender dysphoria;

11 and that if she wanted treatment, they would have to send her to

12 a specialist.

13 Do you recall discussing that with me?

14 A. I recall discussing it, not the exact discussion. But,

15 yeah, we talked about it.

16 Q. Why don't we pull up that declaration, the May declaration,

17 paragraph 32.

18 So are you seeing this on your screen?

19 THE COURT: Counsel, just for the record, is this part

20 of the court record? And if so, can you give us a docket

21 number? Or is it an exhibit?

22 MR. EATON: This is a docket number. It was filed

23 with the court. So I believe the parties indicated they would

24 refer to the docket number for purposes of --

25 THE COURT: Docket No. 62-1, the page is page 59.

1 MR. EATON: Correct, Your Honor.
2 THE COURT: Paragraph 32; is that what you said?
3 MR. EATON: Yes, Your Honor.
4 THE COURT: All right.
5 Q. BY MR. EATON: Are you seeing that, Doctor?
6 A. Yes. Sorry. Yes.
7 Q. And here, this is part of your declaration where you are
8 summarizing what she reported to you; is that correct?
9 A. Correct.
10 Q. And the last sentence says:
11 "She does report that a psychiatrist she had seen
12 through the Indian Health Service mentioned the
13 possibility of getting a diagnosis related to gender
14 dysphoria and said that if she wanted treatment, she
15 would have to send her to a specialist."
16 Do you see that there?
17 A. I do.
18 Q. I read that correctly?
19 A. Yes.
20 Q. And that was per Ms. Edmo's report; correct?
21 A. That's correct.
22 Q. And did you ever confirm this statement with any documents
23 or records?
24 A. Again, all I had were the records from her -- the
25 incomplete prison records.

1 Q. Well, you did not confirm that this statement with any
2 documents in this case; correct?
3 A. No.
4 Q. Correct?
5 A. I'm sorry. Correct.
6 Q. And you mentioned that you interviewed Ms. Edmo for this
7 case; correct?
8 A. Correct.
9 Q. All right. And you did not record that interview, either
10 audio or video; correct?
11 A. Correct.
12 Q. All right. So the only documentation we have regarding
13 your clinical interview with Ms. Edmo is what you put in your
14 declaration; right?
15 A. Correct.
16 Q. And that lasted about two hours?
17 A. Two, two-and-a-half hours, something like that.
18 Q. And you -- the purpose of that was pretty much to get her
19 subjective history; correct?
20 A. It was to get her subjective history, but I also did a
21 limited examination.
22 Q. That was a no-touch medical examination; is that right?
23 A. Correct.
24 Q. So just observation?
25 A. Observation and assessing her -- you know, like, it's part

1 of the physical exam, the psychiatry portion of a physical exam,
2 to assess level of depression.
3 So it would be in the objective section, but it's an
4 objective thing that you ask the patient about and your
5 observations.
6 Q. You didn't ask the patient to disrobe; right?
7 A. No, I did not.
8 Q. And you didn't examine her breasts or her anatomy or
9 anything; correct?
10 A. Not beyond what I could see through her clothes, like her
11 body habitus.
12 Q. Now, your counsel talked to you about the WPATH standards
13 of care.
14 You're a member of WPATH; correct?
15 A. Correct.
16 Q. And I believe you mentioned you served on the
17 Institutionalized Persons Committee for WPATH; is that right?
18 A. Correct.
19 Q. And do you recall telling me in your deposition that you
20 could not recall any person on that committee that worked in a
21 prison; right?
22 A. Correct.
23 Q. All right. So could you pull up Plaintiff's Joint
24 Exhibit 15. That's the WPATH standards. Let's go to the next
25 page. One more. One more. Keep going. I'm trying to get to

1 the first page. Let's go to the second page.
2 You see this is the document you were talking with your
3 counsel about, "The standards of care are flexible clinical
4 guidelines"; right?
5 A. Correct.
6 Q. So you admit that one of the main -- first of all -- sorry.
7 Could we go back one page.
8 If you could look at the second paragraph, this is purposes
9 and use of standards of care just generally; right, Doctor?
10 THE COURT: Can you zoom in on that.
11 MR. EATON: Can we zoom in on the -- there we go.
12 Second paragraph.
13 Q. BY MR. EATON: So you can see the start of this first --
14 second paragraph, it says:
15 "One of the main functions of WPATH is to promote the
16 highest standards of healthcare for individuals
17 through the articulation of standards of care for
18 health of transsexual, transgender, and gender
19 nonconforming people."
20 Do you see that?
21 A. I do.
22 Q. You agree with that; right?
23 A. Yes.
24 Q. Isn't it the purpose of WPATH to set a higher standard of
25 care than the bare minimum?

1 A. I don't know what you're specifically talking about.
2 Q. Well, it's trying to set a high bar for treatment and care
3 of gender dysphoria cases; correct?
4 A. As far as the quality of care, yes.
5 Q. Let's go to the next page, please. Zoom out and go to the
6 next page. We went one too far. Page 2. Go back up one.
7 And again, now we're on the section, "The standards of care
8 are flexible clinical guidelines," that you were talking with
9 your counsel about; correct?
10 A. Yes.
11 Q. And so you admit that WPATH standards of care are intended
12 to be flexible in order to meet the diverse healthcare needs of
13 transsexual, transgender, and gender nonconforming people;
14 right?
15 A. Yes.
16 Q. Indeed, the section says its standards of care are flexible
17 guidelines; correct?
18 A. Correct.
19 Q. Clinical guidelines.
20 And you admit that the WPATH criteria put forth in this
21 document for hormone therapy and surgical treatments for gender
22 dysphoria are clinical guidelines; right?
23 A. Yes.
24 Q. And that's what it says right there on the first
25 paragraph -- or the second paragraph, first sentence; right?

1 Second paragraph, first sentence:

2 "As for all previous versions of the standard of care,
3 the criteria put forth in this document for hormone
4 therapy and surgical treatments for gender dysphoria
5 are clinical guidelines."

6 Right?

7 A. Yes.

8 Q. And then you agree that individual healthcare professionals
9 and programs may modify them, as it says there; correct?

10 A. Yes.

11 Q. And I believe you talked with your counsel about some
12 examples of what it means to be flexible; correct?

13 A. Correct.

14 Q. All right. But those are just examples; right?

15 A. Yeah, they are examples.

16 Q. So there is nothing in WPATH that provides an exhaustive
17 list of when you can be flexible; right?

18 A. They provide a pretty broad list there in the second
19 sentence. You know, anatomic, social, psychological situations;
20 an experienced health professional's evolving method of handling
21 a common situation; research, a little-researched area, or harm
22 reduction. So, I mean, that's --

23 Q. Where are you looking?

24 A. That's the sentence following the one that you said. They
25 give examples. I mean, that's a pretty broad list. I mean, my

1 examples were much more specific, you know. But they are giving
2 the broad sort of groups of departures. They are not giving
3 specific examples like this patient with this clinical
4 situation. They are saying social situations and anatomic
5 situations and an experienced provider's evolving method of
6 treating patients.
7 So these are kind of global groups, not really so much
8 examples.
9 Q. But it says "may come about."
10 So these are examples; right? Examples of categories?
11 A. Yeah, categories.
12 Q. Now, you would agree that treatment and care of gender
13 dysphoria patients has been evolving over the last 10 years;
14 right?
15 A. Yes.
16 Q. We discussed some of those. But terminology has changed,
17 for instance, SRS versus gender confirmation surgery?
18 A. Correct.
19 Q. And the diagnosis of gender identity disorder was changed
20 to gender dysphoria; right?
21 A. That's correct.
22 Q. All right. And over the last 10 years, hormone dose range
23 recommendations have changed over the years, too; right?
24 A. Not a lot but some, yes.
25 Q. Now, I believe in our -- in your deposition, you indicated

1 that you liberally refer your gender dysphoria patients to
2 mental health therapy; right?
3 A. If they need specific issues addressed, yeah.
4 Q. But you do that often with your patients; right?
5 A. Always with patients who are being referred to surgery.
6 And not always -- I would say not in the majority of the
7 patients who it's not specifically related to surgery.
8 Q. Well, it's a helpful tool that you utilize with your
9 patients; right?
10 A. Absolutely, in some patients, yes.
11 Q. All right. And you believe, don't you, that psychotherapy
12 is important for Ms. Edmo; right?
13 A. I do.
14 Q. You believe that it's important that she goes to mental
15 health groups; correct?
16 A. If they are good-quality mental health groups, yes.
17 Q. Now, you acknowledge that Ms. Edmo was properly diagnosed
18 with gender identity disorder in 2012 by Dr. Eliason; correct?
19 A. Correct.
20 Q. And you also acknowledge that Ms. Edmo was properly
21 diagnosed with gender identity disorder in 2012 by Dr. Lake;
22 correct?
23 A. Correct.
24 Q. Now, I wanted to talk to you briefly about elevated liver
25 enzymes.

1 You mentioned that that's a concern in your declaration in
2 this case; correct?
3 A. Correct.
4 Q. All right. So now, another issue you mention in your May
5 2018 declaration relates to management of medications or
6 hormones when plaintiff had elevated liver enzymes in 2018;
7 right?
8 A. It was the end of 2017, like late December into 2018.
9 Q. And into January of 2018?
10 A. Correct.
11 Q. Now, as I understand it, you take issue with plaintiff
12 being taken off spironolactone hormone in late February 2018
13 when she likely still had elevated liver enzymes; right?
14 A. I think she may have been taken off in January. But, yes,
15 I do.
16 Q. Well, let's pull up the June declaration. Let's go to the
17 last paragraph in this declaration. Actually, it's the last
18 page, top there.
19 So on page 3, we're looking at your June declaration;
20 correct, Doctor?
21 A. Correct.
22 Q. All right. At the very bottom of page 3, it starts with
23 the word "it." Do you see that?
24 Like a sentence start with "it" and then carries onto
25 page 4.

1 A. Yes, I see that.
2 Q. All right. That says:
3 "It appears from the records that Ms. Edmo has not
4 been taking any spironolactone or any other adequate
5 antiandrogen since February 19, 2018."
6 Correct?
7 A. It does.
8 Though she was taken off in January, I think they restarted
9 it. That's probably why I remember January.
10 Q. What I'm getting at is that then she was stopped for a
11 while on February 19, 2018; correct?
12 A. Well, I think she was briefly started and then stopped
13 again on the 19th.
14 Q. Right. It was stopped for sure on the 19th?
15 A. Correct.
16 Q. And in your May 2018 declaration, you opine that the
17 spironolactone is likely not causing elevated enzyme -- liver
18 enzymes; right?
19 A. Correct.
20 Q. In fact, you go so far as to say that there was virtually
21 no chance that spironolactone caused Ms. Edmo's elevated liver
22 function tests; correct?
23 A. I don't know if those are the exact words. But, yes.
24 Q. Would you please pull up the June 11th declaration,
25 paragraph 14. I'm sorry. I have been saying "June." I think

1 it's July.

2 You understand that that's the one I'm referring to; right,

3 Doctor?

4 A. Yeah. You have got the dates better than I do, so...

5 Q. So the last sentence in paragraph 14, you say:

6 "As I opined in my May 2018 declaration, there is

7 virtually no chance that spironolactone caused

8 Ms. Edmo's elevated liver function tests."

9 Right?

10 A. Correct.

11 Q. And you also opine that the Effexor, also called

12 venlafaxine, is the most likely cause of her elevated liver

13 enzymes; correct?

14 A. No. What I said is, of the medicines she is on, if one of

15 those medicines caused it, venlafaxine is the most likely

16 culprit.

17 Q. Okay. Let's look at the May declaration, paragraph 59,

18 last line.

19 So in this declaration paragraph, last line at the top of

20 page 24 of your declaration, page 72 of document 62-1, it says:

21 "The medication change is extremely concerning since

22 venlafaxine is the most likely medication prescribed

23 to Ms. Edmo that would cause elevations in LFTs."

24 Correct?

25 A. Yes. Again, I was talking about, of the medications she is

1 taking, that's the most likely culprit. But that's not my
2 opinion that that was the most likely cause of the elevated
3 liver function test; just that if you're going to blame the
4 medicine, the venlafaxine is the more likely culprit.
5 Q. Okay. But you don't disagree with that sentence in your
6 declaration?
7 A. No. Because I was talking about the most likely medicine
8 prescribed to her.
9 THE COURT REPORTER: Would you -- "No, because"?
10 THE WITNESS: No. Because -- I totally lost what I
11 said.
12 Q. BY MR. EATON: I was just asking if you agreed with that
13 sentence. I wasn't really asking for anything more.
14 A. Sorry. Yes.
15 Q. Okay. And you take issue with her being left on a high
16 dose of Effexor during this time frame in February and March
17 2018; right?
18 A. I believe what I was saying in paragraph 59 was that she
19 was on a high dose of Effexor, and then they increased her
20 Effexor, and the mental health provider hadn't looked at her RA
21 result of liver function tests.
22 And we know that in about 1 percent of people who take
23 Effexor -- at the max dose, about 1 percent will have elevated
24 liver function tests.
25 So if you're going to go over that max dose, and she

1 recently had LFTs that were elevated, I would not do that.
2 Q. Right. In fact, you said you would cut the Effexor in half
3 if you were her provider; right?
4 A. I would cut the dose by some. I probably said "half"
5 there. That sounds reasonable.
6 Q. Okay. So her spironolactone was discontinued in February
7 19 of 2018, and she was still on the Effexor going into March;
8 correct?
9 A. Correct.
10 Q. All right. And so could we pull up the lab from March. If
11 you would scroll down a little bit.
12 So this is a lab from March 6 of 2018. And we have been
13 talking about elevated liver enzymes.
14 What in the lab do you look at to make those
15 determinations?
16 A. So there is several tests that look at liver inflammation,
17 liver function. So the two that are highlighted there, AST and
18 ALT, those are proteins that are found in liver cells. And so
19 if the cells get damaged, those get released in the circulation
20 and will go out. So that's a marker for inflammation or damage
21 to liver. But there is also markers of the function of the
22 liver.
23 For example, the two top tests, albumin and bilirubin -- so
24 albumin is a protein made by the liver. So if your liver is not
25 functioning well, that may go down.

1 Bilirubin is actually a waste product of red blood cells
2 being destroyed eventually, and that can go up if your liver's
3 metabolic function is not able to break down all the waste
4 products your body is -- your body is producing.
5 Q. So, in any event, the March 6th, 2018, lab here for
6 Ms. Edmo shows that her liver function was normal; correct?
7 A. Correct.
8 Q. After being taken off spironolactone; correct?
9 A. Yes, but I don't think those are related.
10 Q. And she is still on Effexor at this point?
11 A. I believe so, yes.
12 Q. Let's pull up the May declaration, paragraph 84. I'm not
13 sure if it's paragraph or page 37. I think it's paragraph 37.
14 Let's try page 37 -- oh, I'm sorry. Paragraph 84.
15 So just to help the doctor, why don't you scroll up to the
16 prior page.
17 Just to orient you, Doctor, this is your section where you
18 are talking about surgery, in your opinion, is medically
19 necessary to treat Ms. Edmo's gender dysphoria; right?
20 A. Correct.
21 Q. All right. And then let's scroll down.
22 And you list the criteria in WPATH there; right?
23 A. Correct.
24 Q. And then scroll down to page 48.
25 And you're talking about in part -- you're going through

1 the criteria in this section, correct, for Ms. Edmo?
2 A. My computer screen didn't move. Did you move to a
3 different place?
4 Q. I'm still on page 84.
5 A. I'm on page 37.
6 Q. I'm sorry. It's paragraph 84.
7 A. Oh, sorry. Okay. Yes.
8 Q. Are we on the same page now?
9 A. Yes.
10 Q. Are we on the same paragraph now?
11 A. Yes. Got it.
12 Q. So in this paragraph, you are going through the WPATH
13 criteria as you believe they apply to Ms. Edmo; right?
14 A. Yes.
15 Q. Okay. And where I highlighted there, you are talking about
16 the criteria for whether her mental health issues are well
17 controlled; right?
18 A. Yes.
19 Q. You say her mental health issues are also reasonably well
20 controlled; right?
21 A. Correct.
22 Q. You don't analyze any of her mental health issues in this
23 declaration; right?
24 A. In this particular paragraph, no. I mean, but I think I
25 mentioned them elsewhere.

1 This is my bigger declaration; right? The first one?
2 Q. This is your -- yes, your longer declaration.
3 A. I mentioned her anxiety and depression and assessed those.
4 Q. But you don't address those here when you're talking about
5 the criteria for SRS; correct?
6 A. In this paragraph 84, no. I just am talking about what I
7 have already seen or what I have already stated.
8 Q. Now, WPATH, the final standard for SRS is 12 continuous
9 months living in a gender role that is congruent with their
10 gender identity; right?
11 A. Correct.
12 Q. All right. And you determined that she has fulfilled that?
13 A. I did.
14 Q. The WPATH doesn't further elaborate on how to apply this
15 criteria in a prison setting; right?
16 A. Correct. I mean, they say it's applicable in a prison
17 setting, but they don't give specific guidance.
18 Q. Well, that's in the one-and-a-half-page section that in
19 WPATH that just applies to institutions generally that includes
20 prisons but other institutions as well; correct?
21 A. Correct.
22 Q. Right. And that's not -- the prison setting is not
23 addressed in the specific criteria in WPATH for SRS; right?
24 A. Well, it's like the -- you know, the Institutionalized
25 Persons Committee. Yes, it's applicable to people in nursing

1 homes, but 95 percent of the issues are about prisons. And the
2 same thing with the institutionalized persons comment in WPATH.
3 Yes, it's about all the circumstances, because you shouldn't
4 ignore those. But the vast majority of times this comes up,
5 it's related to prisons.
6 Q. But the section on SRS criteria in the WPATH, that section
7 doesn't address prison settings and how it applies; correct --
8 how the criteria applies?
9 A. Well, those criteria apply broadly across the board to
10 anybody who is transgender.
11 Q. Well, again, it doesn't elaborate on how to apply the 12
12 months living in gender role as a congruent person with their
13 gender identity in a prison setting? It doesn't address that
14 any further, correct, in a prison setting?
15 A. It doesn't do it in any setting. So, no. I mean, they are
16 not specific about where they are applied. They are just
17 applicable to the disease.
18 Q. That might be where the flexibility comes in in the
19 guidelines; right?
20 A. I don't understand what you're asking.
21 Q. It doesn't define where the -- how to apply the section in
22 different settings.
23 So there could be some flexibility there; correct?
24 A. Yes.
25 Q. Now, you did not recommend SRS be performed immediately at

1 the time of your declarations in this case; correct?
2 A. Well, I said within six months, but immediately would have
3 been great, too. I gave a range because I didn't think the day
4 after I evaluated her that they were going to come in and give
5 her surgery, so...
6 Q. Well, if you thought there was a medical need for her to
7 get it immediately and within a month, you would have said that;
8 right?
9 A. I would have specifically -- I mean, I set the range based
10 on my clinical experience with patients. So I think within six
11 months is a reasonable range.
12 MR. EATON: Okay. Could you read my question back to
13 the witness, please.
14 (Question read by reporter.)
15 THE WITNESS: I mean, it's not like your appendix is
16 going to rupture and you have to get surgery tonight. So all
17 patients who are treated for this, they are seen, they are
18 evaluated, there is a process you have to go through. It's not
19 something that happens overnight. So that's not -- I mean,
20 that's not what you do clinically.
21 So, I mean, I would never say this person needs emergency
22 sex reassignment surgery. Let's send them in an ambulance to
23 the hospital. That's kind of absurd.
24 Q. So it's a process for dealing with when SRS is appropriate;
25 right?

1 A. That's correct.

2 Q. And you thought -- it was a guesstimate that within six

3 months, SRS would be appropriate; right?

4 A. Well, it's based on my clinical experience with my

5 patients, what I have observed.

6 Q. So you tell them, your patients, that you should get SRS

7 within six months?

8 A. No. I tell my patients that we're going to refer you for

9 SRS. And in most cases, that actually happens within six

10 months. From the time that I see them, we pretty quickly get

11 them in to see a mental health provider and get them referred.

12 But occasionally there are things that come up that make

13 that process longer. And so I don't tell patients, "Hey, we're

14 going to get this by six months." I'm like, "We are referring

15 you for this. Most of them go in under those windows." And the

16 ones that don't, there ends up being an issue.

17 Q. And I believe in your deposition, you indicated that it's

18 not uncommon for a surgeon to schedule a vaginoplasty out five

19 months or more; right?

20 A. It depends on the surgeon. You know, there are some

21 surgeons that are backed up. And if a patient wants a specific

22 surgeon, like I want Dr. Marci Bowers, she is going to have to

23 wait for it. But if she is willing to go to another surgeon,

24 she can get it sooner.

25 Q. But you don't recall talking to me in your deposition about

1 that's approximately -- it takes a surgeon approximately
2 five -- excuse me -- five months to get the sex reassignment
3 surgery scheduled?
4 A. I may. I mean, you know, it's a range. It depends on the
5 surgeon.
6 But, sure. If you can point me to what I said, I can tell
7 you if it's accurate. But I don't know -- this is a better way
8 of saying it: I don't know if I said specifically five months.
9 But there is a range that providers do; and some of the more
10 popular ones, you have to wait longer.
11 Q. Five months wouldn't be unreasonable, for instance, to wait
12 for an SRS; right?
13 A. No. Five months wouldn't be unreasonable.
14 Q. And you're critical of Dr. Eliason's SRS assessment; right?
15 A. Correct.
16 Q. Now, you understand that Dr. Eliason had mostly been Edmo's
17 treating psychiatrist since 2012; right?
18 A. I saw a couple of notes from Dr. Eliason, but most of the
19 mental health notes that I saw in her chart weren't from him.
20 Q. You didn't see periodic treatment notes from Dr. Eliason
21 over the years?
22 A. I did, but there were a lot of other mental health notes,
23 so I didn't know if he was her primary.
24 Q. Okay. But you understand he was one of her treaters, her
25 treating psychiatrists, over the years since 2012; right?

1 A. Sure. On the mental health treatment team, that's
2 legitimate to say.
3 Q. And you realize that Dr. Eliason diagnosed Ms. Edmo with
4 GID in 2012; right?
5 A. Correct.
6 Q. And you understand that Dr. Eliason had been seeing
7 Ms. Edmo periodically to discuss her mental health care issues
8 and manage her medications, such as Zoloft, over the years since
9 2012; right?
10 A. I remember there were at least a couple of notes.
11 Q. Where he was managing her mental health care; correct?
12 A. Correct.
13 Q. And you acknowledge that Dr. Eliason spoke with Ms. Edmo at
14 the time of the April 2016 SRS evaluation and documented her
15 subjective reporting in that note; right?
16 A. Correct.
17 Q. All right. And you acknowledge that Dr. Eliason documented
18 his objective observations at the time; correct?
19 A. Correct.
20 Q. And you acknowledge that Dr. Eliason did an assessment on
21 plaintiff; right?
22 A. Correct.
23 Q. And you acknowledge that Dr. Eliason's plan was that a
24 combination of hormonal treatment and supportive counseling was
25 sufficient at that time for her gender dysphoria; right?

1 A. That he -- that he said that, yes.
2 Q. And you acknowledge that he says that he will -- would
3 continue to monitor and assess the inmate throughout her stay at
4 the facility where he worked?
5 A. Correct.
6 Q. Do you know where he worked?
7 A. The same facility where she was at, possibly others.
8 Q. Do you have an understanding of whether there is a
9 behavioral health unit at that facility that's separate from the
10 general population? Do you understand that?
11 A. Do you mean are prisoners at a behavioral health level at
12 that institution? Yeah.
13 Q. Do you have an understanding of whether there is a separate
14 behavioral health facility or section separate from general
15 population?
16 A. Like, to house the prisoners? Yes.
17 Q. Okay. And you acknowledge that Dr. Eliason staffed the
18 SR -- his note says he staffed the SRS decision with other
19 medical and mental health providers; right?
20 A. Other mental health providers, yes. But I don't remember
21 their exact credentials, so I'm not sure if one of them was a
22 medical provider other than Dr. Eliason.
23 Q. Okay. Why don't we pull up that note. It's probably in
24 the Dr. Eliason folder, Corizon records.
25 So this is the document you were talking with your counsel

1 about, the SRS assessment by Dr. Eliason?
2 A. Correct.
3 Q. All right. If you scroll down or if we could highlight the
4 first paragraph where it says, "A," there is -- "27-year-old
5 male," is what that paragraph starts with --
6 A. Correct.
7 Q. -- in the middle.
8 A. I see that.
9 Q. I'm just asking her if she can zoom in on that a little
10 bit.
11 So the note indicates, in the middle there:
12 "I staffed this case with Dr. Jeremy Stoddart,
13 Dr. Murray Young, Jeremy Clark, LCPC, clinical
14 supervisor and WPATH member, and they agreed with my
15 assessment."
16 Do you see that there?
17 A. I do.
18 Q. So he staffed this with others; right?
19 A. Yeah. But, like I said, I still didn't know if
20 Dr. Stoddart or Dr. Young are psychologists or other medical
21 providers, so...
22 Q. Well, you see the reference to Jeremy Clark, a clinician
23 who indicates has WPATH training; right?
24 A. Well, it says he is a WPATH member. There is no training
25 required to be a member.

1 Q. Well, you would agree that it's appropriate for Dr. Eliason
2 to staff the SRS decision with other providers, including a
3 clinician who was associated with WPATH; right?
4 A. You can be a member of WPATH by sending them a check and
5 filling out a form. So, I mean, I don't know Dr. Clark's
6 credentials.
7 I mean, it should be staffed with people who are
8 experienced in taking care of transgender individuals because
9 that's the issue at question.
10 Q. You wouldn't fault someone for consulting with someone that
11 has an understanding of WPATH standards; right?
12 A. No, but I don't know if Mr. Clark has that.
13 Q. And you acknowledge that his note states he considered
14 criteria and determined he did not meet the criteria for SRS;
15 right?
16 He mentioned --
17 A. He said -- yeah. He says "does not meet criteria for
18 medical necessity for sex reassignment surgery."
19 Q. Okay. And if we could scroll down just a little bit.
20 And Dr. Eliason documented Ms. Edmo's other mental health
21 disorders, including major depressive disorder and alcohol use
22 disorder, on the bottom there; correct?
23 A. Correct.
24 Q. Now, I want to switch gears a little bit and talk to you
25 about regret and suicide.

1 At least one of your --

2 We can clear out of that and maybe pull up another one here

3 in a second.

4 So you told me at your deposition at least one of your

5 patients who had SRS -- and I'm talking about sex reassignment

6 surgery -- was successful at committing suicide after the

7 surgery; correct?

8 A. I had a patient -- I think we talked about a patient of

9 mine who tried to do self-surgery who committed suicide after

10 surgery.

11 Q. You don't recall telling me that one of your patients who

12 had SRS was successful at committing suicide after surgery?

13 A. I mean, when you say "SRS," you mean a surgeon performed

14 it --

15 Q. Right.

16 A. -- not a patient?

17 Q. Right.

18 A. I can't recall someone right now, not that I referred to

19 get SRS.

20 Q. Okay. Could we pull up his deposition, page 246, line 22.

21 So you see at the bottom there, it says, question: "And of

22 those that have had SRS, there was one that was successful at

23 committing suicide; correct?"

24 And you responded "yes"?

25 A. The one I'm referring to is somebody who had SRS who had

1 SRS -- like, I didn't refer them for it; they got that back in
2 the day.
3 Q. I'm sorry. I'm not following you.
4 A. So it was somebody who had SRS, but it was not my referral
5 for SRS. They came to me having -- being status postsurgery.
6 Q. So it wasn't your patient, but you're aware of somebody
7 that had SRS that then committed suicide after; is that what
8 you're telling me?
9 A. Yeah, it was my patient. But, like, it wasn't like they
10 came to me, I diagnosed them with gender dysphoria, and then
11 they had surgery and then --
12 THE REPORTER: Would you slow down.
13 THE WITNESS: I'm sorry. It wasn't a patient that I
14 saw diagnosed, referred for, and they had surgery and then
15 committed suicide. It is somebody who previously had had
16 surgery before I saw them, before they became my patient; and
17 then, subsequently, they committed suicide.
18 Q. BY MR. EATON: Okay. And at your deposition, we talked
19 about three other of your patients have attempted suicide after
20 a vaginoplasty; correct?
21 A. Yes, but not completed.
22 Q. And you estimated a handful of your patients have attempted
23 suicide after their surgeries; right?
24 A. We're talking about the three and the one. So four, "a
25 handful"?

1 Q. Well, of all the patients that have had SRS to some degree,
2 you estimate that a handful of your patients have attempted
3 suicide after those surgeries; right?
4 A. I'm sure that's correct. That's fair.
5 Q. And you had one patient who expressed regret after an
6 orchiectomy --
7 Am I saying that right?
8 A. Correct.
9 Q. -- an orchiectomy, which is surgery to remove the
10 testicles, and then sued you and your clinic; correct?
11 A. Sued several people in my clinic, yes.
12 Q. Including you?
13 A. Yes.
14 Q. Could we please pull up the Defendants' Exhibit 2038, page
15 27. Let's look at this first page.
16 Doctor, do you remember discussing the Endocrine Society
17 guidelines with me?
18 A. Correct, yes.
19 Q. And if you scroll down just to the bottom of that page, it
20 will show that that's the 2017 guidelines; correct?
21 A. Correct.
22 Q. All right. Let's go to page 27.
23 Is the Endocrine Society -- that's a good guide; correct?
24 It's a helpful guide and resource for you and other doctors?
25 A. This particular guideline? Yes.

1 Q. Yes.

2 A. Yes.

3 Q. Okay. So I put a little highlight there next to the

4 paragraph. There is a sentence that says:

5 "Further insight into the characteristics of persons

6 who regret their decision postoperatively would

7 facilitate better future selection of applicants

8 eligible for sexual reassignment surgery."

9 Do you see that?

10 A. I do.

11 Q. You agree with that?

12 A. Yes.

13 Q. And then the next sentence says:

14 "We need more studies with appropriate controls that

15 examine long-term quality of life, psychosocial

16 outcomes, and psychiatric outcomes to determine the

17 long-term benefits of surgical treatment." And it's

18 referring to SRS.

19 Do you see that?

20 A. I do.

21 Q. And you agree with that?

22 A. Yes.

23 Q. Now, you acknowledge that Ms. Edmo -- you can take that

24 exhibit down.

25 MR. EATON: Your Honor, I would move to admit that.

1 THE COURT: What was the exhibit number again?
2 MR. EATON: Sorry. The exhibit is Defendant's Exhibit
3 2038. It's the Endocrine Society guidelines.
4 THE COURT: Any objection?
5 MS. WHELAN: No objection.
6 THE COURT: 2038 will be admitted.
7 (Defendants' Exhibit 2038 admitted.)
8 Q. BY MR. EATON: Do you knowledge that she -- Ms. Edmo
9 received a bra at the prison from early on, soon after she
10 received her hormones; correct?
11 A. I don't know the exact timing, but yes.
12 Q. She has had it for a long time, since soon after --
13 A. For years, yeah.
14 Q. -- sex -- or soon after the hormone therapy, correct,
15 started?
16 A. For years. I mean, soon -- I don't know what you mean by
17 "soon." So -- but, yes, she has it for quite some time.
18 Q. Sorry. We were talking over one another there. Let me try
19 it again.
20 So since 2012, Ms. Edmo has had access to a bra; correct?
21 A. I don't know if it was 2012, but that certainly sounds
22 reasonable.
23 Q. You're aware that she currently has access to panties;
24 correct?
25 A. Currently, yes.

1 Q. And she has had panties in the past at times; correct?
2 A. She has had panties that she has obtained or created for
3 herself but not that were given to her to treat her gender
4 dysphoria.
5 Q. And what is a gaff?
6 A. A gaff is an undergarment that is used by transgender women
7 to tuck the penis and the testicles against the perineum so
8 that, one, they don't sort of feel the penis and the testicles
9 as much and, two, so it makes it so that they don't appear to
10 have a penis and testicles.
11 Q. Are you aware of any record showing that Ms. Edmo requested
12 a gaff?
13 A. I think she may have. I'm not entirely sure, but that
14 sounds familiar. There were a lot of records.
15 Q. You don't know?
16 A. I'm not sure, yeah.
17 Q. Now, in your declaration, you indicated Ms. Edmo reports
18 wearing women's underwear almost exclusively and wearing either
19 women's clothes and feminine men clothes; she would dress
20 feminine and go out with her friends to parties. And that was
21 referring to preincarceration.
22 Do you recall that?
23 A. I do.
24 Q. Okay. That's accurate, from what she told you?
25 A. Correct.

1 Q. And she reported to you that she used extensive -- she
2 had -- she used makeup extensively before prison; correct?
3 A. Yes.
4 Q. Let's pull up the May 2018 declaration, paragraph 47. Can
5 you scroll up just a tiny bit.
6 Are you seeing this paragraph 47, Doctor?
7 A. Yes.
8 Q. Okay. That's your paragraph in one of your declarations;
9 right?
10 A. The first declaration, yes.
11 Q. Okay. And this first sentence says, quote:
12 "Prior to Ms. Edmo's first appointment with Dr. Alviso
13 in 2016, her medical records contain no real
14 transgender history," end quote.
15 Right?
16 A. That's correct.
17 Q. Is that a correct statement, Doctor?
18 A. No. As we talked about in my deposition, I didn't have the
19 Dr. Alviso and Dr. Lake records when I initially saw her. And
20 then I got the complete set of her medical records before the
21 second declaration I made, but the pages that were indicated
22 that these are the records that you didn't get initially,
23 actually didn't include Dr. Eliason's and Dr. Lake's notes.
24 So when I wrote this, I hadn't read those. So that's not
25 correct.

1 Q. Nevertheless, you made conclusions about Corizon and
2 IDOC --
3 Actually, scroll down, please, a little bit more.
4 You made assumptions, nevertheless, that -- this is the
5 last sentence:
6 "It is also possible, however, that the prison
7 officials failed to access this history because even
8 if they had it, they are precluded by prison policy
9 from providing adequate care, such as surgery and
10 access to female commissary items."
11 You came to that conclusion; right?
12 A. I said it was possible, yes.
13 Q. And that was -- and that sentence is referring to her not
14 having a transgender history; right?
15 A. Well, it is also true that even with those histories done,
16 the -- that statement actually still stands that it's possible
17 that you could change it to "Even though they assessed her
18 history, they were precluded by prison policy from providing
19 adequate care."
20 Q. So you are wanting to change your declaration; is that
21 right?
22 A. This particular -- well, what I'm saying is the first part
23 of that paragraph was incorrect because I didn't have those
24 records at the time.
25 The second part of the paragraph, that it's possible that

1 she was not -- that she was not provided that care because it
2 was precluded by prison policy.
3 Q. But that sentence is based on her not having a transgender
4 history; correct?
5 A. That -- yeah, I was particularly talking about it there,
6 but, yes.
7 Q. And again, you hadn't reviewed any prison policies at the
8 time of this declaration; right?
9 A. Well, what I read were responses in her medical record that
10 said, "No, you can't have this; that's against policy."
11 You know, so did I read the policy? No, when she was told,
12 you can't have this because of the policy.
13 So I assume the people who were responding to her -- I
14 don't even know what they are called -- the requests for
15 treatment that she puts in -- know the policy enough to be able
16 to state it.
17 MR. EATON: I'm going to move to strike that response
18 as narrative and nonresponsive. And I would ask the court if we
19 could get an answer to the question, please.
20 MR. HALL: Join.
21 THE COURT: Restate the question.
22 Q. BY MR. EATON: My question was: At the time you executed
23 the declaration, this document 62-1 -- I believe we talked about
24 this earlier -- you had not read any Idaho Department of
25 Correction policies or procedures; correct?

1 A. Policies or procedures, no.
2 Q. Correct?
3 A. Correct.
4 Q. And why is it important to have transgender history?
5 A. It's important in every clinical situation where you're
6 treating a patient to have a history so that you can base their
7 care on that.
8 Q. And you acknowledge now that Dr. Eliason and Dr. Lake both
9 provided a transgender history in their documents in 2012 when
10 they were assessing her for GID; correct?
11 A. Correct.
12 Q. Doctor, you don't know one way or another the
13 qualifications of Jeremy Clark, the clinician that we were
14 talking about that was referenced in Dr. Eliason's record;
15 right?
16 A. From his record, I mean, it has his educational -- I mean
17 the letters after his name. I mean --
18 Q. It shows he's --
19 A. -- I don't know what training he had or what school he went
20 to, no.
21 Q. Right. So you don't know, one way or another, his
22 qualifications -- Jeremy Clark's; correct?
23 A. Well, I know some of his qualifications in that he is
24 licensed --
25 Q. You just know --

1 A. -- as a clinician.

2 Q. Sorry. You just know his label after his name; correct?

3 A. Yes, that he is licensed as a clinician.

4 MR. EATON: Your Honor, I don't believe I have any

5 further questions at this time.

6 THE WITNESS: Your Honor, could I get a bathroom

7 break?

8 THE COURT: Yes.

9 Counsel, why don't we -- we will probably end up taking two

10 breaks since we're going to go I think until 3:00 or

11 thereabouts. Why don't we take a 15-minute break now, and then

12 we'll see how that plays out.

13 We will be in recess for 15 minutes.

14 (Recess at 11:59 a.m. until 12:20 p.m.)

15 THE COURT: Dr. Gorton, I'll remind you you are still

16 under oath. And I will ask you to speak a little more slowly, a

17 little more clearly to make it easy on the court reporter.

18 I think -- Mr. Hall, I think we are ready for your cross.

19 MR. HALL: No additional cross for defendants.

20 THE COURT: All right. You made it easy.

21 Ms. Whelan, redirect.

22 MS. WHELAN: Thank you.

23 REDIRECT EXAMINATION

24 BY MS. WHELAN:

25 Q. Dr. Gorton, there was a question about why you are working

1 pro bono on this case and just being compensated for expenses.
2 Do you remember that?
3 A. I do.
4 Q. Can you explain why you're doing that.
5 A. I'm very well compensated as an ER doctor, and I think it's
6 an ethical requirement as a professional, as a healthcare
7 provider that, if you're able to, you should do some pro bono
8 work.
9 So all the work that I have done at Lyon-Martin is pro
10 bono. And because of my experience working at the clinic, I
11 have a set of -- you know, a knowledge and skill set that is
12 sometimes useful in other situations.
13 And so I, you know, use that in situations like this. And
14 it's the same reason. I mean, I think if you're -- you know,
15 being a doctor has certain responsibilities, and I think one of
16 them is that you have to do some pro bono work in a society
17 where not everybody has access to care.
18 Q. Now, defense counsel asked you about a number of categories
19 of documents that you've now reviewed.
20 Do you recall that?
21 A. Yes.
22 Q. And since you have reviewed all of those documents, have
23 they changed your opinion about whether Ms. Edmo needs surgery?
24 A. No.
25 Q. And what is that opinion?

1 A. That she needs genital sex reassignment surgery.
2 MS. WHELAN: Thank you. I have no further questions.
3 THE COURT: All right. Give me just a moment,
4 Counsel.
5 All right. I guess I have none.
6 Any recross?
7 MR. EATON: Just one question, Your Honor.
8 THE COURT: Yes.
9 RECROSS-EXAMINATION
10 BY MR. EATON:
11 Q. Are you aware that Dr. Ettner, the other expert in this
12 case, charges a fee?
13 A. I know Dr. Ettner charges a fee. I don't know if she is
14 charging it in this case, but I assume so.
15 THE COURT: All right. You may step down. Thank you
16 very much, Dr. Gorton.
17 Plaintiffs may call their next witness.
18 MS. RIFKIN: That completes plaintiff's witnesses,
19 Your Honor.
20 THE COURT: I'm not sure who is going to go first from
21 the defense.
22 Mr. Hall.
23 MR. HALL: Your Honor, in the interest of time, we are
24 going to kind of mix up witnesses as to who is going to call
25 who.

1 THE COURT: All right.

2 MR. HALL: IDOC is going to call witness Jeremy Clark

3 at this time.

4 THE COURT: Mr. Clark, would you step before the clerk

5 and be sworn. Just come forward, sir. Ms. Bracke will place

6 you under oath. Step a little closer.

7 JEREMY JUNIOR CLARK, DEFENDANT'S WITNESS, SWORN

8 THE CLERK: Please take a seat in the witness stand.

9 Please state your complete name and spell your name for the

10 record.

11 THE WITNESS: Jeremy Junior Clark. J-E-R-E-M-Y,

12 J-U-N-I-O-R, C-L-A-R-K.

13 THE COURT: You may inquire, Mr. Hall.

14 MR. HALL: Thank you, Your Honor.

15 DIRECT EXAMINATION

16 BY MR. HALL:

17 Q. Good afternoon, Mr. Clark.

18 A. Good afternoon.

19 Q. How are you employed?

20 A. I'm employed with Idaho Department of Corrections.

21 Q. And in what position?

22 A. I'm a clinical supervisor.

23 Q. And how long have you had that position?

24 A. It will be six years this November.

25 Q. And what are your duties in that position?

1 A. I have supervised -- direct supervisors over our clinical
2 staff. I have supervised our behavioral health unit, our acute
3 mental health unit, provide consultation, clinical consultation.
4 I have also done sex offender treatment consultation.
5 I believe that's it.
6 Q. How long have you been employed with the Idaho Department
7 of Corrections?
8 A. Six years this November.
9 Q. And in that time period, have you held other positions?
10 A. I have been a member of our Management and Treatment
11 Committee. I have also -- shoot. That would be it.
12 Q. You mentioned a Management Treatment Committee. Can you
13 tell the court what that is, please.
14 A. It's a multiple-disciplinary team that the Department has
15 to address treatment and planning and security issues associated
16 with our transgender population, our inmates that have gender
17 dysphoria.
18 Q. Is that a specific committee set up to address the mental
19 health needs and housing of the gender dysphoric inmates?
20 A. Yes, that's correct.
21 Q. Okay. And when you started on that, approximately how many
22 inmates had a diagnosis of GD or GID?
23 A. Say, approximately 10.
24 Q. And has that since expanded?
25 A. Yes, it has. We're just over 30 currently incarcerated.

1 Q. So over the last six years, approximately, it's gone from
2 10 diagnosed to 30 now?
3 A. Yes, that is correct.
4 Q. And what is the role of the MTC?
5 A. We review when an appropriate assessor does an assessment
6 on somebody for gender dysphoria. The Management and Treatment
7 Committee reviews that assessment, determines if it's
8 appropriate, develops a treatment plan that would include mental
9 health services, medical services, and we recommend housing
10 placement.
11 Q. And does the MTC review the treatment and situations of all
12 of the GD offenders?
13 A. Yes, that is correct.
14 Q. And is that throughout the entire state in all
15 institutions?
16 A. Yes, that is correct.
17 THE COURT: Just so I'm clear, the 30 inmates you
18 refer to, is that throughout all the institutions or just at the
19 medium-security facility? Or does IDOC try to have all of the
20 gender dysphoric inmates housed at one facility?
21 There are a lot of questions in that, but I think you
22 understand.
23 THE WITNESS: Early on, we tended to keep them in one
24 facility, but now they are throughout all the facilities, even
25 in our current female facilities.

1 THE COURT: So the 30 includes inmates at all
2 facilities?
3 THE WITNESS: Yes, that is correct.
4 THE COURT: But the same Management and Treatment
5 Committee oversees treatment for all of them?
6 THE WITNESS: Yes.
7 THE COURT: All right. So I just wanted to get that
8 clarified before we moved on.
9 Q. BY MR. HALL: Does the Management Treatment Committee make
10 medical decisions?
11 A. No.
12 Q. Okay. And who makes those medical decisions?
13 A. They are referred to a medical provider to determine those
14 needs.
15 Q. I want to talk about your qualifications, Mr. Clark.
16 Placed in front of you is a copy of your CV marked as
17 Defendant's Exhibit 2019, page 1.
18 Do you recognize this document?
19 A. Yes, I do.
20 Q. Does that set forth accurately your qualifications?
21 A. Yes, it does.
22 Q. Okay. Did you create this document?
23 A. Yes, I did.
24 Q. And is this document current?
25 A. Yes.

1 MR. HALL: Your Honor, move to admit Defendant's
2 Exhibit 2019.
3 THE COURT: Any objection?
4 MS. RIFKIN: No.
5 THE COURT: The exhibit will be admitted.
6 (Defendants' Exhibit 2019 admitted.)
7 Q. BY MR. HALL: Are you familiar with the World Professional
8 Association for Transgender Health?
9 A. Yes, I am.
10 Q. And what is that organization, to your knowledge?
11 A. It's an international organization that addresses the needs
12 for transgender population and gender-nonconforming population
13 and individuals who have gender dysphoria.
14 Q. Now, there has been some testimony about membership.
15 Are you a member of the WPATH?
16 A. Yes, I am.
17 Q. What does that mean?
18 A. Essentially, I -- you pay a fee every month, but you have
19 all the resources available to you from that association;
20 articles. I receive periodic emails about updates about what's
21 going on within the association. You're notified about
22 conferences throughout the world that address transgender
23 health.
24 Q. And how long have you been a member?
25 A. Since late 2013.

1 Q. And are you aware that the WPATH provides some competency
2 requirements or criteria for individuals who are going to be
3 working with gender dysphoric patients?
4 A. Yes.
5 Q. Okay. Do you recognize the document --
6 A. I do.
7 Q. -- placed here in front of you marked Joint Exhibit 15,
8 page No. 28?
9 A. Yes, I do.
10 Q. Okay. And do you recognize that as the criteria that's set
11 forth by the WPATH?
12 A. Yes. It's in their Standards of Care Version 7.
13 Q. I would like to go through some of these. The first one is
14 a master's degree or its equivalent in a clinical behavioral
15 science field.
16 Do you meet that requirement?
17 A. Yes, I do.
18 Q. In what way?
19 A. I have a master's degree in counseling and guidance.
20 Q. And what is your -- what is your certification?
21 A. Do you mean my licensure?
22 Q. Your licensure.
23 A. I'm a licensed clinical professional counselor here in the
24 State of Idaho.
25 Q. LCPC; correct?

1 A. Yes, that is correct.
2 Q. Okay. Tell the court about that position or that
3 licensure.
4 Are you permitted to diagnose?
5 A. Yes, I am permitted to diagnose.
6 Q. And is it within your scope of practice to provide
7 psychotherapy?
8 A. Yes.
9 Q. And does that include individual therapy, group therapy?
10 A. And I have had training in family therapy as well.
11 Q. Okay. Let's take a look at the second criteria.
12 Do you have competence in using the Diagnostic Statistical
13 Manual of Mental Disorders?
14 A. Yes, I do have training.
15 Q. Is that the DSM?
16 A. Yes.
17 Q. And you've had training in that?
18 A. Yes.
19 Q. And where have you obtained training in that?
20 A. It started in my graduate school. I have had other
21 trainings because it changed to a different version about four
22 or five years ago, I believe. And I had training to update with
23 that. And I actually did some training at a lower level on
24 this; undergraduate level.
25 Q. And other than training, have you used the DSM in your

1 professional experience?
2 A. Yes, for the past 11 years as a licensed professional in
3 Idaho.
4 Q. Is that a document that you consult frequently in your
5 profession?
6 A. Yes.
7 Q. The third criteria is the ability to recognize and diagnose
8 coexisting mental health concerns and to distinguish these from
9 gender dysphoria.
10 Do you have competency in that?
11 A. Yes, I do.
12 MS. RIFKIN: Objection, Your Honor. Lacks foundation.
13 Mr. Clark has been named as a nonretained expert witness by
14 defendants.
15 THE COURT: Well, the witness -- okay. My
16 understanding is that counsel is trying to establish that the
17 witness has the credentials to meet the requirements for the
18 WPATH criteria to be a gender dysphoria treatment provider. And
19 I think that's all we're testifying to, not offering opinions,
20 per se.
21 MS. RIFKIN: Mr. Clark hasn't testified to any
22 experience with gender dysphoria at this point, which is a
23 prerequisite to answering a question, his opinion about No. 3
24 here, the ability to recognize and distinguish --
25 THE COURT: Well, he can have him explain what -- I'll

1 overrule the objection.

2 MR. HALL: Right. Right.

3 Q. BY MR. HALL: Mr. Clark, do you have familiarity in

4 recognizing and distinguishing coexisting mental health concerns

5 from gender dysphoria?

6 A. Yes, I do.

7 Q. Okay. And can you explain that.

8 A. Through my experience treating and talking with both

9 inmates, I have dealt with multiple mental health issues, and I

10 have also worked with the inmates that do have gender dysphoria

11 along with those other issues, such as schizophrenia and other

12 mood disorders.

13 Q. And have you reviewed the DSM's criteria for diagnosis of

14 gender dysphoria?

15 A. Yes.

16 Q. And have you applied that to patients who have diagnosis of

17 gender dysphoria?

18 A. Yes.

19 Q. So you would say you're familiar with gender dysphoria as

20 it's defined under the DSM?

21 A. Yes, I am.

22 Q. Okay. And what is your understanding as to coexisting

23 mental health concerns?

24 A. If someone has a diagnosis of gender dysphoria, it is

25 possible to have other identified mental health disorders, such

1 as mood disorders, possible personality disorders, psychosis,
2 and other identified mental health disorders. Substance abuse
3 would be another example.
4 Q. And is it your understanding that the WPATH is only
5 concerned with diagnoses or mental health concerns?
6 A. Mental health concerns.
7 Q. Okay. How do those differ from a diagnosis of a mental
8 health disorder?
9 A. From my standpoint, the diagnosis is a label, a name to put
10 on a set of behaviors. When you're talking about mental health
11 behaviors, you take all the issues that the person is having --
12 whether it's depression, anxiety, gender dysphoria -- and you
13 need to take that into consideration in your treatment.
14 Q. The fifth criteria is knowledge about gender-nonconforming
15 identities and expression in the assessment and treatment of
16 gender dysphoria.
17 Do you have knowledge about gender-nonconforming identities
18 and expressions?
19 A. Yes.
20 Q. Would you tell the court what your knowledge is.
21 A. When I was asked to become a WPATH member, at that time I
22 have attended four -- I believe it was four conferences, some
23 presented by WPATH, where I was able to get training in that
24 what is constituted as someone who is cisgender, gender
25 nonconforming, transgender. And I have also read several

1 articles that also talks about those distinctions.
2 Q. Can you name some of those articles? I think there is --
3 A. I presented a few. Osborne and Lawrence comes into play.
4 I can't think of the exact titles of the articles at this time.
5 Q. Mr. Clark, I have placed in front of you here Exhibit
6 No. 19 -- Joint Exhibit 19-1.
7 Do you recognize this article?
8 A. Yes. That's the article I was referring to, Osborne --
9 written by Osborne and Lawrence.
10 Q. And you have read this article; is that what your testimony
11 was?
12 A. Yes.
13 Q. Okay. And have you relied upon that article in your
14 profession?
15 A. I have.
16 Q. Mr. Clark, the sixth criteria speaks about continuing
17 education in the assessment and treatment of gender dysphoria.
18 Have you obtained continuing education in the assessment
19 and treatment of gender dysphoria?
20 A. I have, through those conferences presented by WPATH. I
21 have also started their global training -- I can't think of the
22 word, but their program where they are starting to provide more
23 specific training to professionals such as myself, to help us
24 better treat folks with gender dysphoria.
25 Q. And you mentioned WPATH trainings.

1 Describe for me those. What are those?
2 A. There have been several conferences. I have been to
3 Oakland. I've been to Chicago. I've been to Los Angeles where
4 they put on two- to three-day trainings where they provide
5 classes that address transgender, gender nonconforming, and
6 training for folks with gender dysphoria.
7 Q. And these trainings that were in Oakland, Chicago, and
8 Los Angeles, were those trainings put on by WPATH?
9 A. The one in Oakland was not, but it was sponsored. But the
10 others were sponsored by WPATH, yes.
11 Q. So the one in Oakland was sponsored by WPATH, but it wasn't
12 hosted by WPATH?
13 A. That's correct.
14 Q. Have you been to any other trainings over the last, say,
15 five years where you received experience in -- continuing
16 education in the assessment and treatment of gender dysphoria?
17 A. During this year, early this spring, we had our all
18 clinical staff training, and we had some people from the
19 Washington State DOC come and talk to us about their program for
20 assisting the transgender population of people with gender
21 dysphoria.
22 And I have provided some training for our staff, based on
23 the trainings I have been to, to help educate them as well.
24 Q. And have you provided training to mental health clinicians
25 at IDOC on gender dysphoria topics?

1 A. Yes, at least twice.
2 Q. And have you been involved in any trainings at IDOC that --
3 where outside speakers have come?
4 A. That one that happened this year, we brought people from
5 Washington State DOC.
6 Q. Okay. And do you remember who those people were from
7 Washington State DOC?
8 A. I cannot remember at this time.
9 Q. And what was the subject matter that those individuals
10 spoke on?
11 A. Mainly the management, how they were managing the inmates
12 with gender dysphoria, how they looked at it, how they assessed
13 it. They also had a multiple disciplinary team that was very
14 similar to our Management and Treatment Committee and how they
15 used that. And so we did a lot of comparison.
16 They also gave some basic stuff, like what -- definitions
17 of what gender nonconforming, transgender, and other topics like
18 that.
19 Q. And were you present during a presentation provided by a
20 Dr. Levine?
21 A. I was.
22 Q. Do you remember when that was?
23 A. It was in the summer of 2016.
24 Q. And do you recall what the subject matter of Dr. Levine's
25 presentation was?

1 A. It was his opinion on different paradigms associated with
2 people with transgender issues and gender dysphoria. And he
3 gave some suggestions on how to manage the inmates in prison.
4 And he quoted a lot from the Osborne and Lawrence article that
5 you had up earlier because that had just come out as well. And
6 so he used those topics.
7 Q. At part of that presentation, did you get the understanding
8 that Dr. Levine's opinion was that SRS surgery for a gender
9 dysphoric inmate is never appropriate?
10 MS. RIFKIN: Objection. Leading.
11 THE COURT: Sustained. Rephrase that question.
12 Q. BY MR. HALL: What were the -- did you arrive at any
13 conclusions as to the opinions that Dr. Levine had presented
14 during his presentation?
15 A. In general, it was talking about the different paradigms,
16 what might explain why a person experiences gender dysphoria.
17 In the end, it was suggestions that caution should be taken when
18 talking about things such as sexual affirming surgery, talked
19 about medical necessity and his opinions about that and also
20 time frames, making sure that you can address all the issues a
21 person may have in prison because it's a different environment
22 compared to the community.
23 Q. Do you recall Dr. Levine making any opinions as to the
24 appropriateness of surgery for a gender dysphoric inmate?
25 A. I felt he emphasized, actually, that it was appropriate and

1 that it needed to happen when it was appropriate.

2 Q. Did you ever hear Dr. Levine espouse an opinion at that

3 presentation that SRS is never appropriate for a gender

4 dysphoric inmate?

5 A. I did not.

6 Q. What is your understanding as to the criteria under the

7 WPATH for sexual reassignment surgery or gender confirmation

8 surgery?

9 A. Documented persistent gender dysphoria. They have to be of

10 the age of consent. They have to be able to give informed

11 consent.

12 MS. RIFKIN: Objection, Your Honor. Counsel has put a

13 document on in order to coach the witness about how to answer.

14 THE COURT: Well, isn't this --

15 MR. HALL: It's an admitted exhibit, Your Honor.

16 THE COURT: It's an admitted exhibit. I --

17 MS. RIFKIN: He asked his understanding and then put

18 the document in front of the witness.

19 MR. HALL: Well, I can ask it this way.

20 MS. RIFKIN: Between asking the question --

21 THE COURT: Well, Counsel -- Counsel, he has already

22 indicated his familiarity with the WPATH criteria. That's what

23 this is.

24 I suspect you did the same thing with all of the other

25 witnesses, as well, to give them a chance to go through item by

1 item.

2 I'm going to overrule the objection. I don't think

3 it's -- unless the test here is whether or not the witness has

4 an encyclopedic memory as to each of the WPATH standards, I

5 don't think it's an issue.

6 If that's what we're trying to get at -- but I suspect

7 that's not, and it's more just a discussion about his view of

8 what those criteria are. So I don't think showing it to him is

9 in any way improper.

10 Go ahead and proceed.

11 Q. BY MR. HALL: Mr. Clark, are you familiar with the document

12 that's been placed in front of you and marked as Joint Exhibit

13 15, page 66?

14 A. I am.

15 Q. And what is this document?

16 A. This is the criteria set up for a phalloplasty associated

17 by the WPATH standards in their Version 7.

18 Q. And are you familiar with the standards -- the six

19 standards or criteria presented there?

20 A. I am.

21 Q. Okay. Have you ever had an opportunity to apply those

22 standards to a gender dysphoric patient?

23 A. Yes, several times.

24 Q. Are you familiar with the plaintiff, Adree Edmo?

25 A. I am.

1 Q. Okay. And explain for me your familiarity with Ms. Edmo.
2 A. I have had occasional bump-ins, so to say, run-ins with
3 Ms. Edmo throughout the time. I have attended a couple of
4 groups where Ms. Edmo has attended.
5 But much of my information has come secondary through the
6 Management Treatment Committee and when I supervised the
7 clinicians who were providing treatment for Ms. Edmo.
8 Q. And has Ms. Edmo and her gender dysphoria been topics of
9 discussion at the MTC meetings?
10 A. Yes.
11 Q. And approximately how many times during those meetings
12 have -- where you have been present that Ms. Edmo was addressed?
13 A. Say, about a dozen.
14 Q. And is there a time range there? Is it beginning ever
15 since you were on the MTC committee?
16 A. Yes. From my best knowledge, yes.
17 Q. Over the last five years?
18 A. I would say that is correct, yes.
19 Q. Okay. And have you gained a familiarity with Ms. Edmo's
20 gender dysphoria and the treatment she has received at IDOC?
21 A. Yes.
22 Q. And what is your understanding as to Ms. Edmo's treatment
23 that she has received for her gender dysphoria?
24 A. Been attending groups for most of that five years that are
25 associated with gender -- other inmates that have gender

1 dysphoria; been provided hormone replacement therapy to
2 associate -- that was prescribed by a medical provider -- and
3 also, there has been individual contacts with clinicians over
4 the years with Ms. Edmo.
5 Q. You've had conversations with clinicians that have provided
6 direct contact with Ms. Edmo; is that what you're saying?
7 A. Yes.
8 Q. And have you reviewed any medical records or mental health
9 records for Ms. Edmo?
10 A. Periodically, yes.
11 Q. And have you reviewed the clinical notes from the mental
12 health contact she has had during her incarceration?
13 A. Not all of them, but some of them, yes.
14 Q. And have you reviewed or had an opportunity to review the
15 presentence investigation?
16 A. Yes, I have.
17 Q. And is it your understanding that that document was
18 produced prior to Ms. Edmo's incarceration?
19 A. Yes.
20 Q. Are there any other documents that you've reviewed
21 regarding Ms. Edmo and her gender dysphoria?
22 A. I looked at her assessments when she requested to be
23 assessed for gender dysphoria. That happened before my time on
24 the MTC. I have reviewed those records as well.
25 Q. And do you know who did that assessment?

1 A. I know -- I believe Dr. Eliason was one, and I can't
2 remember the other person.
3 Q. Does Claudia Lake ring a bell?
4 A. Yes.
5 MS. RIFKIN: Objection. Leading, Your Honor.
6 MR. HALL: Your Honor, I'm merely trying to get an
7 answer as to whether or not the witness --
8 THE COURT: Overruled. Generally, counsel is allowed
9 to ask leading questions on foundational matters. And, frankly,
10 in a proceeding before the court, as long as you're not putting
11 words in the witness's mouth, I'm going to give counsel some
12 leeway. I have tried to do it on both sides, do the same.
13 So proceed.
14 Q. BY MR. HALL: And from your review of Ms. Edmo's medical
15 records and your involvement on the MTC, have you gained a
16 familiarity with Ms. Edmo's coexisting mental health concerns?
17 A. I feel that I have, yes.
18 Q. And what are those, to your knowledge?
19 A. The main thing that's always stuck out is major depressive
20 order or her struggles with depression and anxiety. That was
21 noted in the PSI, the presentence investigation. And it appears
22 to be a constant issue for Ms. Edmo.
23 And there has also been addressed some personality trait
24 struggles, such as borderline traits, antisocial traits.
25 Q. Right. Can you name some of those borderline personality

1 trait disorders that you have noticed?
2 A. Interpersonal issues, self-harming behavior, sexual
3 offending, you know -- inappropriate sexual behaviors, and
4 manipulation.
5 Q. Are you familiar with Ms. Edmo's disciplinary history?
6 A. Yes.
7 Q. And do you find that Ms. Edmo's disciplinary history is
8 relevant in any way to your -- your profession as a mental
9 health clinician?
10 A. I feel that it is.
11 Q. In what way?
12 A. Much of any inmate's disciplinary issue, we have to look at
13 and see if mental health is a contributing factor into those
14 behaviors to help address that, such as interpersonal issues;
15 psychosis may play a role. And so we have to look into those
16 issues to ensure we're doing our part to help treat the mental
17 health side that might be associated with those misbehaviors.
18 Q. Are you aware of any DORs or disciplinary history that
19 Ms. Edmo has received that would indicate or suggest or be
20 consistent with borderline personality disorder traits?
21 A. Yes. There have been several DORs for sexually acting out,
22 assaulting other inmates, not following orders of the officers,
23 and struggling with other inmates within the facility.
24 Q. Did you have an opportunity to assess whether or not
25 Ms. Edmo has ever met the criteria of the WPATH for surgery?

1 A. Yes. That was looked at back in 2016.
2 Q. And describe for me how that -- how that occurred. How
3 were you involved in that?
4 A. I believe Ms. Edmo made the request, and Dr. Scott Eliason
5 said he would do the assessment. And once he completed the
6 assessment, he brought it before the MTC.
7 Q. And did you have an opportunity to apply Mrs. Edmo's mental
8 health conditions to the criteria of the WPATH at that time?
9 A. I did.
10 Q. Okay. And did you make a -- did you have an opinion at
11 that time as to whether or not Ms. Edmo met the criteria for
12 surgery?
13 A. I did.
14 Q. What was that opinion?
15 A. That surgery was not appropriate.
16 Q. And what is the basis for that opinion?
17 A. I personally felt and clinically felt that Ms. Edmo's
18 mental health issues were not well controlled.
19 Q. And what mental health conditions did you believe were not
20 well controlled?
21 A. The depression, the anxiety, along with the borderline
22 personality traits.
23 Q. Were there any particular traits of borderline personality
24 disorder that you felt were not well controlled at that time in
25 2016?

1 A. Within six months, there were several DORs; one was for
2 assaulting another inmate.
3 Also, at that time, Ms. Edmo had gone on suicide watch for
4 self-harming behaviors and was continuing to engage in
5 self-harming behaviors at that time.
6 Q. Do you know if -- around that time, in 2016, whether
7 Ms. Edmo had exhibited sexual acting-out in the prison?
8 A. Yes. There had been a -- there had been a DOR for sexual
9 activity within that six-month frame as well.
10 Q. Six months prior to the evaluation?
11 A. Yes.
12 Q. And were you aware of other DORs where Ms. Edmo was cited
13 for inappropriate sexual contact in a prison?
14 A. I believe there was two or three throughout her time in
15 incarceration.
16 Q. And why -- well, do you believe that prior to someone
17 meeting the criteria for surgery under the WPATH, that it's
18 important that their coexisting mental health concerns be well
19 controlled?
20 A. In my opinion, I really -- what really stood out for me
21 with the Osborne and Lawrence article was surgery is an
22 identified treatment for gender dysphoria, but there is no
23 evidence to indicate that surgery would alleviate major
24 depressive disorder, eliminate self-harming behaviors.
25 And so, in my opinion, I feel like that's why the WPATH

1 said the other cooccurring issues need to be well controlled
2 because the surgery is there to alleviate the gender dysphoria.
3 Q. And do you believe that it's important also to have these
4 coexisting mental health concerns well controlled prior to a
5 surgery because of the stressors that may come after a surgery?
6 A. I do feel that is accurate.
7 Q. Okay. And explain that to me.
8 A. I would say this really plays a big role in prison.
9 Because, based on current policy throughout the United States,
10 inmates are housed based on their primary genitalia.
11 So this would mean, naturally, a person would automatically
12 move to female facility, which has different dynamics, different
13 social transitioning issues that would come into play.
14 And also -- so needing to have that well controlled at that
15 time would be significant because I believe, especially in
16 prison, new stressors are going to arise even after prison --
17 after surgery.
18 Q. Is it your understanding that, for Ms. Edmo, sex
19 reassignment surgery will be an irreversible procedure?
20 A. Yes.
21 Q. Is it your understanding that it will be a significant
22 medical procedure for Ms. Edmo?
23 A. Based on the trainings I have seen and attended, yes.
24 Q. And do you feel that -- or did you feel in 2016 that
25 Ms. Edmo's mental health conditions -- coexisting mental health

1 conditions were well controlled such that she could cope with
2 the stressors postsurgery?
3 A. I did not feel that.
4 Q. Okay. Have you made any opinions or -- let me strike that.
5 Do you feel that Ms. Edmo has been compliant with her
6 treatment plan?
7 A. No.
8 Q. Do you feel that Ms. Edmo has been compliant with the
9 recommendations that her mental health conditions have made to
10 her over the years?
11 A. Not consistently.
12 Q. And in what ways?
13 A. Often will attend group for a while and then will quit.
14 Has often rejected our recommendations for other things to
15 address the interpersonal issues and the mood management issues.
16 And I believe Ms. Edmo feels this is all part of her gender
17 dysphoria, and we haven't been offered an opportunity to make
18 sure that if there is cooccurring stuff, that that's actually
19 affecting the behaviors as well.
20 Q. And you're familiar that in 2016, Dr. Eliason provided
21 a -- an assessment to Ms. Edmo as to whether or not she met the
22 criteria for sex reassignment surgery?
23 A. Yes.
24 Q. And did you have a conversation with Dr. Eliason at that
25 time?

1 A. I did, shortly after he did the assessment.
2 Q. And did he reach out to you to ask your opinion on
3 Ms. Edmo's mental health condition?
4 A. He did. He consulted with me.
5 Q. And did he consult with you as to whether or not you felt
6 it was appropriate for Ms. Edmo to have sex reassignment
7 surgery?
8 A. Yes. That was the topic of the conversation.
9 Q. And did you provide him with your thoughts at that time?
10 A. I did.
11 Q. And what did you -- what did you explain to Dr. Eliason at
12 that time?
13 A. Essentially what you -- we have been just talking about.
14 At that time, Ms. Edmo was engaging in a lot of misbehavior,
15 sexually acting out, self-harming behavior, wasn't attending
16 groups consistently.
17 In my opinion, at that time, her mental health was not well
18 controlled based on those factors.
19 Q. And is it your understanding that, after speaking with you
20 and with others, other medical or mental health providers, that
21 Dr. Eliason concluded that surgery for Ms. Edmo in 2016 was not
22 medically necessary or appropriate?
23 A. That is what I recall, yes.
24 Q. Are you familiar or are you aware that Ms. Edmo has been
25 engaging in some cutting behaviors over the last year?

1 A. I was informed of that by her treating clinician, yes.
2 Q. And who is that?
3 A. Ms. Krina Stewart.
4 Q. And have you had conversations with Ms. Stewart about
5 Ms. Edmo?
6 A. Throughout the past couple years, yes.
7 Q. And what was your understanding after speaking with
8 Ms. Stewart as to Ms. Edmo's cutting?
9 A. That a lot of times -- and probably in particular with
10 Ms. Edmo -- cutting is a form of coping with stress. And so our
11 conversations, we were talking about what other coping skills we
12 can encourage Ms. Edmo to engage in and how to address that
13 issue.
14 Q. And that Ms. Edmo was engaging in cutting, did that -- does
15 that affect your opinion either way at this point as to whether
16 or not Ms. Edmo's coexisting mental health concerns are well
17 controlled?
18 A. I feel that it supports my idea that it's not well
19 controlled.
20 Q. Do you believe that cutting is a helpful and safe coping
21 mechanism?
22 A. No, I do not.
23 Q. Do you think that cutting to someone's body is contrary to
24 a claim that their mental health conditions are well controlled?
25 A. Yes, I would consider that contrary.

1 Q. Okay. At this point, do you believe that Ms. Edmo's
2 coexisting mental health concerns are well controlled?
3 A. At this time, based on the information I have been given,
4 no, I do not feel that it's currently well controlled.
5 Q. Do you have any concerns for Ms. Edmo if she undergoes
6 surgery at this time when her mental health concerns are not
7 well controlled?
8 A. Yes. I believe the behaviors would continue even if the
9 surgery were to happen.
10 Q. And which behaviors in particular?
11 A. The cutting. I do feel that some of the mood disorder
12 stuff, the depression and anxiety, would be lessened, but I
13 don't think it would be alleviated as it hasn't been completely
14 addressed.
15 Q. Are you familiar with the policies and standard operating
16 procedures of the Department of Corrections?
17 A. Yes.
18 Q. And when you started at the Idaho Department of
19 Corrections, was there a policy dealing with gender identity
20 disorder, gender dysphoria?
21 A. Yes, there was.
22 Q. And were you familiar with that policy?
23 A. Yes, I was.
24 Q. Okay. And what is your understanding as to what that
25 policy said as to whether or not surgery, sexual reassignment

1 surgery, would be provided or made available to offenders with
2 gender dysphoria?
3 A. That it would require it to be medically necessary, and it
4 would be looked at on a case-by-case basis.
5 Q. Was there anything in that policy that you were aware of
6 that stated that IDOC would not provide sex reassignment surgery
7 under any circumstances?
8 A. To the best of my recollection, there was no language in
9 there that said that.
10 Q. And has that policy since been revised, the gender
11 dysphoria policy?
12 A. Yes.
13 Q. And when was that revised?
14 A. It was officially released October 5th, just last week.
15 Q. And are there any major differences between the 2011 policy
16 and the policy that was enacted last week?
17 A. Yes. In particular, in the areas of social transitioning,
18 needing to allow the inmates with gender dysphoria to have the
19 commissary -- all commissary.
20 So for our trans females, they can access makeup. They can
21 have traditional feminine hairstyles. They would be given
22 female undergarments. And then it would be vice versa for our
23 trans male population.
24 Q. And does this current policy, to your knowledge, still
25 provide that sex reassignment surgery will be provided to a

1 gender dysphoric inmate on a case-by-case basis?
2 A. Yes, also based on medical necessity.
3 Q. Okay. Thank you.
4 MR. HALL: No further questions. Thank you.
5 THE WITNESS: You're welcome.
6 THE COURT: Mr. Eaton, do you have any questions you
7 want to ask before I ask for cross?
8 MR. EATON: No, Your Honor. Thank you.
9 THE COURT: All right. Ms. Rifkin.
10 CROSS-EXAMINATION
11 BY MS. RIFKIN:
12 Q. Good afternoon, Mr. Clark.
13 A. Good afternoon.
14 Q. You have never provided direct treatment for any patients
15 with gender dysphoria or gender identity disorder; correct?
16 A. That is correct.
17 Q. In direct exam a few moments ago, you testified that you
18 were able to distinguish mental health concerns from gender
19 dysphoria; correct?
20 A. Yes.
21 Q. And you testified that you can do that based on your
22 experience treating patients; correct?
23 A. And also based on the diagnosis in the DSM.
24 Q. But you haven't actually treated any patients with gender
25 dysphoria; correct?

1 A. No, but I have given assessments where I have given a
2 diagnosis of gender dysphoria as well as other cooccurring
3 mental health disorders.
4 Q. You have never personally provided any assessments for sex
5 reassignment surgery; correct?
6 A. That is correct.
7 Q. You have never consulted with other providers regarding
8 assessments for sex reassignment surgery; correct?
9 A. I have consulted with Dr. Eliason when he did the
10 assessment for Ms. Edmo.
11 MS. RIFKIN: Your Honor, I would like to use the
12 deposition of Mr. Clark.
13 THE COURT: Yes. Let's have it published. Do you
14 have the original?
15 MS. RIFKIN: I do.
16 THE COURT: Perhaps Mr. Severson can get that, and
17 I'll direct Ms. Bracke to publish the deposition.
18 LAW CLERK: We don't have the sealed original. It's
19 in the office that's close.
20 THE COURT: Well, I assume there is no serious
21 objection.
22 MR. HALL: Your Honor, I don't -- I don't believe so.
23 This was a deposition that actually took place last week, and
24 currently we have not had an opportunity to have a
25 read-and-sign. So there may be some transcription errors that

1 the witness has not had an opportunity to review.
2 THE COURT: All right.
3 MS. RIFKIN: Your Honor, the dates being after the
4 cutoff were proposed by defendants for this witness. So we got
5 the deposition transcript processed.
6 THE COURT: I understand.
7 MR. HALL: That's not my issue. I just --
8 THE COURT: Yeah. Let's just solve the problem. We
9 don't need to say who is at fault. Let's just solve the
10 problem.
11 What I would suggest -- again, we have a court trial.
12 Let's go ahead and use the unsigned copy of the deposition.
13 I would indicate to the witness that if you have some
14 concern over how the question and answer -- whether it's
15 different from what you recall, you can so indicate, and then
16 we'll give you a chance to kind of correct the deposition on the
17 fly.
18 Do you understand?
19 THE WITNESS: Yes.
20 THE COURT: In other words, a court reporter like
21 Ms. Hohenleitner is taking it down, doing the best job they can.
22 Sometimes mistakes are made for that reason. A copy is given to
23 the person being deposed, given a chance to read it and then
24 make corrections. They can't change answers, but they can
25 indicate that when they said "the," they really meant "that," or

1 they thought they said "that," but the court reporter perhaps
2 didn't pick it up. So we can correct those kinds of things.
3 If you see a problem, let's note it. I may allow you to
4 confer with your attorney to go over that change as we proceed
5 along. My guess is there won't be any of those problems. That
6 would be quite rare, but I think we need to protect the
7 witness's right to review and correct the deposition.
8 And then when it is available, we need to publish it and
9 make it part of the court record. All right?
10 MS. RIFKIN: Yes. We can publish it to the court now
11 and the witness.
12 THE COURT: Well, typically, "publish" means we are
13 taking the final approved and signed deposition and now
14 publishing it as part of the court record. I don't know that we
15 can do that until we have been through that process.
16 So we are just going to use this copy. But at some point,
17 you will need to submit the final signed version of the
18 deposition to complete the court record. And if there is any
19 variation, we will need to note that for the record as well.
20 All right?
21 MS. RIFKIN: Understood, Your Honor.
22 THE COURT: Yes, let's go ahead and hand it to him.
23 We won't formally publish it since we don't have the original.
24 MS. RIFKIN: Can we display, please, Mr. Clark's
25 deposition, page 29.

1 THE COURT: It would be helpful if you zoom in
2 on -- that's a little hard to read.
3 MS. RIFKIN: Can we zoom in on lines 2 through 8,
4 please.
5 THE COURT: Okay. Now you should be able to read that
6 easily.
7 Q. BY MS. RIFKIN: Do you see those lines, Mr. Clark?
8 A. I do.
9 MS. RIFKIN: May I read them, Your Honor?
10 THE COURT: Well, you can ask him whether these
11 questions were asked and ask him whether he gave those answers.
12 Q. BY MS. RIFKIN: Do you see the question on line 2, "Have
13 you personally provided any assessments for sex reassignment
14 surgery or gender reaffirmation surgery?"
15 A. Yes, I do see it.
16 Q. And your answer was no?
17 A. That is correct.
18 Q. Is that -- is that accurate?
19 A. That is accurate.
20 Q. And the next line, line 6, question: "Have you consulted
21 with other providers regarding assessments for surgery?"
22 Answer: "No. I haven't had the opportunity."
23 Was that your answer?
24 A. It was. I believe in the context at the time, I was
25 thinking outside providers, not within the Department.

1 Q. Your experience providing supervision to clinicians who are
2 directly treating patients with gender dysphoria was mainly
3 while you were at ISCI, where Ms. Edmo is housed; correct?
4 A. Yes, at the time, because that's where most of them were
5 housed when I was a clinical supervisor.
6 Q. Okay. And I'm just going to ask you to make sure to answer
7 the question I ask and not give additional narrative unless it's
8 directly responsive to my question.
9 You were the clinical supervisor at ISCI for eight months;
10 correct?
11 A. Yes.
12 Q. Prior to that time, your experience with patients with
13 gender dysphoria was limited to supervising a clinician who had
14 a single patient with gender dysphoria; correct?
15 A. Yes.
16 Q. And you do not currently provide clinical supervision to
17 any clinicians who provide direct treatment to inmates with
18 gender dysphoria; correct?
19 A. Not at this time.
20 Q. You testified a moment ago in direct that Dr. Eliason --
21 that you provided consultation with -- to Dr. Eliason regarding
22 his assessment of Ms. Edmo for gender confirmation surgery;
23 correct?
24 A. Yes, that's correct.
25 Q. And you testified that you relied on the WPATH criteria for

1 medical necessity in consulting with Dr. Eliason; correct?
2 A. Yes.
3 Q. That consultation -- you have testified that that
4 consultation with Dr. Eliason was actually an informal consult;
5 correct?
6 A. Yes.
7 Q. It occurred when you ran into each other in passing at
8 ISCI; correct?
9 A. Yes.
10 Q. And it lasted no more than 15 to 20 minutes; correct?
11 A. From my best recollection, yes.
12 Q. And you didn't document this informal consultation
13 anywhere; correct?
14 A. I did not.
15 Q. And in your discussion with him about what medically
16 necessary entailed, you specifically recall telling Dr. Eliason,
17 "I don't know. That's kind of doctor things"; correct?
18 A. In particular to the topic of medically necessary, yes.
19 Q. And you didn't provide him an opinion about what medically
20 necessary means; correct?
21 A. No, I did not.
22 Q. You testified a moment ago that the MTC doesn't decide
23 whether surgery is medically necessary; correct?
24 A. From my -- I don't know what I testified to or said before,
25 but the MTC would be the multiple disciplinary team that would

1 take that assessment, address and assess where it's appropriate,
2 and then possibly refer surgery if it was felt it was
3 appropriate.
4 Q. Didn't you testify a moment ago that the MTC doesn't
5 consider -- doesn't decide whether surgery is appropriate; the
6 medical provider does that separately?
7 A. I thought that was about diagnosis, but I could be wrong.
8 Q. Is it your testimony that the MTC considered Ms. Edmo and
9 assessed her for surgery separate from what Dr. Eliason did?
10 A. No. At that time, we relied on Dr. Eliason's assessment.
11 Q. Did the MTC discuss and review Dr. Eliason's assessment for
12 Ms. Edmo?
13 A. Yes, that was done.
14 Q. If that had occurred, it would be in the minutes of the
15 MTC, wouldn't it?
16 MR. HALL: Objection. Foundation.
17 THE COURT: Just a moment.
18 MR. EATON: Join.
19 THE COURT: Overruled.
20 You may answer. You presided over the MTC; did I
21 understand that?
22 THE WITNESS: At that time, I was just a member.
23 THE COURT: Would you be familiar with the method by
24 which its meetings and transactions within the meetings are
25 memorialized?

1 THE WITNESS: I was not part of the minutes.
2 THE COURT: Well, that wasn't my question.
3 THE WITNESS: I'm sorry.
4 THE COURT: The question was: Are you familiar with
5 the way in which those meetings are documented?
6 THE WITNESS: Yes.
7 THE COURT: Okay. The objection is overruled. You
8 may inquire.
9 THE WITNESS: It should have been, is my response.
10 Q. BY MS. RIFKIN: Mr. Clark, I'm going to show you -- can you
11 read this document okay from your computer, Mr. Clark?
12 A. Yes.
13 Q. Okay. This is Joint Exhibit 7, page 78. It reads,
14 "Management and Treatment Team Committee Minutes," and it is
15 dated June 1, 2016.
16 Do you see that?
17 A. I do.
18 Q. Have you seen this kind of document before?
19 A. Yes, I have.
20 Q. And I would like to show you the third page of this
21 particular document. I'll show you the second page first so you
22 see the whole document. That's page 79 of Joint Exhibit 7.
23 And now I would like to show you the third page of Joint
24 Exhibit 7, page 80.
25 Do you see that "approved by"?

1 A. Yes, I do.
2 Q. And is that your name underneath?
3 A. It is.
4 Q. So you were involved in the minutes; isn't that right,
5 Mr. Clark?
6 A. I did not write them. I reviewed them and then should have
7 signed off on them.
8 Q. That was your responsibility, to review the minutes to make
9 sure that they are accurate and reflect the discussion of the
10 MTC; correct?
11 A. Yes.
12 Q. So I'm going to show you again the second page of this
13 document.
14 Do you see where it says "Edmo"?
15 A. Yes.
16 Q. Is there any documented consideration of Ms. Edmo --
17 Dr. Eliason's evaluation of Ms. Edmo for surgery?
18 A. No, there is not.
19 Q. These are the June 1, 2016, minutes for the MTC committee.
20 Do you think that that discussion would be documented in
21 another set of minutes for the MTC?
22 A. Possibly. I don't know.
23 Q. What month do you think? So Dr. Eliason's assessment was
24 in April 2016. What month do you think when the MTC met they
25 would have been discussing Dr. Eliason's assessment of Ms. Edmo

1 for surgery?
2 A. Possibly this one or the next one. I don't know.
3 Q. I'm going to show you what's been marked as Joint
4 Exhibit 7, page 81.
5 Do you see that these are the Management and Treatment Team
6 Committee minutes for September 7, 2016?
7 A. I do.
8 Q. Would that have been the next time the MTC met after June
9 2016?
10 A. More than likely.
11 Q. At this time, the MTC met every three months; is that
12 correct?
13 A. Yes.
14 Q. So I'm going to show you page 79 of Joint Exhibit 7.
15 Do you see the section where it says "Additional
16 discussion" and Ms. Edmo's name appears?
17 A. Yes.
18 Q. Is there any discussion documented of Dr. Eliason's
19 assessment of Ms. Edmo for surgery?
20 A. No, but it looks exactly like the one from the previous
21 minutes.
22 MR. HALL: I believe the witness has already been
23 shown this.
24 THE COURT: What's the concern, Mr. Hall?
25 MR. HALL: I think counsel might have a couple of

1 these pages just mixed up.

2 MS. RIFKIN: Oh, you're right. I'm sorry. Thank you

3 for the clarification.

4 Q. BY MS. RIFKIN: All right. I'm showing you page 84, which

5 is part of the September minutes. I apologize for that

6 confusion.

7 Do you see the additional discussion for Ms. Edmo there?

8 A. I do.

9 Q. Okay. That's the first bullet point.

10 Have you had a chance to review that?

11 A. Yes.

12 Q. I'm going to show you the next page, page 85.

13 Do you see the top, the continuation of the discussion for

14 Ms. Edmo?

15 A. I do.

16 Q. Is there a discussion of Dr. Eliason's assessment of

17 Ms. Edmo for surgery?

18 A. There is not.

19 Q. I'm going to show you the last page of these minutes, Joint

20 Exhibit 7, page 86.

21 That, again, has your name; correct?

22 A. Yes.

23 Q. At this time, you were responsible for reviewing the

24 minutes to make sure that they were accurate; correct?

25 A. Yes, I was.

1 Q. And neither of these minutes reflect any discussion by the
2 MTC of Dr. Eliason's assessment of Ms. Edmo for surgery;
3 correct?
4 A. That is correct.
5 Q. You have never provided direct treatment to Ms. Edmo;
6 correct?
7 A. That is correct.
8 Q. And you have never reviewed Ms. Edmo's preincarceration
9 medical records other than what was in the PSI report counsel
10 referenced; correct?
11 A. That is correct.
12 Q. You agree that Ms. Edmo continues to experience gender
13 dysphoria; correct?
14 A. Yes.
15 Q. And in your opinion, Ms. Edmo is not exaggerating her
16 gender dysphoria; correct?
17 A. I don't think so.
18 Q. You have never diagnosed Ms. Edmo as having borderline
19 personality disorder; correct?
20 A. That is correct.
21 Q. To your knowledge, no other IDOC or Corizon providers have
22 diagnosed Ms. Edmo with borderline personality disorder;
23 correct?
24 A. That is true.
25 Q. Over the six years that she has been in IDOC custody, none

1 of them have diagnosed her with borderline personality disorder;
2 correct?
3 A. Yes.
4 Q. You agree that Ms. Edmo is not psychotic; correct?
5 A. I do.
6 Q. To your knowledge, she has never been psychotic or
7 demonstrating psychosis; correct?
8 A. Not since I have known her.
9 Q. You believe Ms. Edmo is capable of forming informed consent
10 for medical procedures; correct?
11 MR. HALL: Object to form and foundation. It goes
12 beyond the scope of direct.
13 MS. RIFKIN: Mr. Clark testified --
14 THE COURT: Overruled. Overruled. The testimony was
15 as to WPATH standards, and this is directly relevant to that, I
16 think. So I'll overrule the objection -- or at least directly
17 relevant based upon Dr. Ettner's interpretation of the WPATH
18 standards, which counsel is free to dispute, but I think it's
19 within the scope.
20 Go ahead.
21 MR. HALL: You mentioned Dr. Ettner, Judge, just a
22 second ago.
23 THE COURT: Yes.
24 MR. HALL: I'm sorry. What did you mean by that?
25 THE COURT: I said that Dr. Ettner had indicated what

1 her understanding of that fourth requirement of serious mental
2 health concerns being well controlled, that that focused upon
3 competency to consent to treatment and a number of other
4 factors.
5 MR. HALL: Right. Mr. Clark, though.
6 THE COURT: I understand that. But I think it's
7 still -- counsel is simply using that understanding to
8 cross-examine the witness, which I think is appropriate.
9 I'm not in any way suggesting that Mr. Clark agrees with
10 that, but I think it's fair to ask questions using the standard
11 as another expert understands them.
12 MR. HALL: May I clarify my objection, Your Honor, on
13 one particular issue?
14 THE COURT: Yes.
15 MR. HALL: Ms. Rifkin is asking him to go through all
16 the criteria. He did not say that he believes Ms. Edmo meets
17 all those criteria. So he was actually never asked in direct
18 nor has he testified that she has informed consent.
19 THE COURT: But he has very specifically testified
20 that the one criteria that was not met was that she had serious
21 mental health concerns that were not well controlled. And
22 therefore, since that's what this question pertains to, based
23 upon Dr. Ettner's reading of that standard, the objection is
24 overruled.
25 MR. HALL: All right. Thank you, Your Honor.

1 THE COURT: Proceed.
2 Q. BY MS. RIFKIN: Mr. Clark, you believe Ms. Edmo is oriented
3 as to reality; correct?
4 A. Yes.
5 Q. And at ISCI, the institution where Ms. Edmo resides, there
6 are special mental health units for inmates who are not able to
7 function in the general population because of their mental
8 illness; correct?
9 A. Yes.
10 Q. And Ms. Edmo is housed in general population, not in one of
11 the mental health units; correct?
12 A. She has been housed in the BHU, yes.
13 Q. When was the last time she was housed in the behavioral
14 health unit?
15 A. Approximately two years.
16 Q. So for the last two years, Ms. Edmo has been housed in
17 general population; isn't that correct?
18 A. To my best recollection, yes.
19 Q. You testified that you relied in part on Ms. Edmo's
20 disciplinary record in opining she is not appropriate for
21 surgery; correct?
22 A. Yes.
23 Q. You believe her disciplinary record demonstrates
24 uncontrolled mental health concerns?
25 A. I do.

1 Q. And you testified that Ms. Edmo's DORs for sexual activity
2 and assault were related to mental health concerns and
3 borderline personality disorder; correct?
4 A. Border personality traits.
5 Q. And mental health --
6 THE COURT: Just a moment. Did you mean "borderline
7 personality traits?
8 THE WITNESS: Excuse me. Borderline.
9 THE COURT: I have been guilty of the same. Sometimes
10 when people saying "borderline personality disorder," I wish
11 they would change that term, because I initially thought that
12 meant you were on the edge of having a personality disorder
13 instead of a defined specific personality disorder. So I'm kind
14 of acutely sensitive to that.
15 So you are referring to borderline personality disorder?
16 THE WITNESS: Traits, yes.
17 THE COURT: Traits, as recognized in the DSM-5?
18 THE WITNESS: Yes.
19 THE COURT: All right. Go ahead. I apologize for
20 that little rant.
21 MS. RIFKIN: That's perfectly fine, Your Honor.
22 THE COURT: I have always wondered why they chose that
23 term. There has to be a better term.
24 MS. RIFKIN: So if we could show the witness what's
25 been marked as Joint Exhibit 1, page 524, please.

1 Q. BY MS. RIFKIN: Mr. Clark, you're familiar with this mental
2 health DOR recommendation form used by IDOC; correct?
3 A. Yes, I am.
4 Q. They have to be filled out for inmates with mental health
5 diagnoses when there is a DOR charged against them; is that
6 correct?
7 A. Yes.
8 Q. You supervise and train IDOC clinicians about how to fill
9 these out; correct?
10 A. I do.
11 Q. And one of the questions on this form asks whether mental
12 illness was a contributing factor in the incident leading to a
13 DOR; correct?
14 A. Yes.
15 Q. And there is also a box to check mental illness is not a
16 factor in the incident; correct?
17 A. That is correct.
18 Q. And you instruct IDOC clinicians that you supervise that if
19 any mental health issue played a role in the behavior, they have
20 to mark the "yes" box; right?
21 A. Yes, if they feel that's appropriate.
22 Q. So looking at the DOR recommendation right here, the
23 offense date is December 30, 2015; correct?
24 A. Yes.
25 Q. And the offense description is "sexual activity"?

1 A. Yes.
2 Q. This is one of the DORs you said shows that Ms. Edmo's
3 mental health concerns are uncontrolled; correct?
4 A. That's one of the behaviors, yes.
5 Q. Which box is checked for whether mental illness
6 contributed -- was a contributing factor in the incident?
7 A. This clinician felt that -- excuse me. Mental illness was
8 not a factor.
9 Q. So the box "no" for mental illness a contributing factor in
10 incident is checked; correct?
11 A. Yes.
12 Q. And also, the box "Mental illness is not a factor in
13 incident," that one is also checked; right?
14 A. That is correct.
15 Q. Can we show the witness Joint Exhibit 1, page 610. Zoom in
16 a little bit. Thank you.
17 This is another mental health DOR recommendation for
18 Ms. Edmo; correct?
19 A. Yes.
20 Q. This is dated March 30, 2017; correct?
21 A. Yes.
22 Q. This is for assault?
23 A. Yes.
24 Q. And this is another one of the DORs that you said shows
25 that her mental health concerns are not well controlled; right?

1 A. That's one of the behaviors.
2 Q. This DOR documents behavior that shows to you her mental
3 health concerns are not well controlled; right?
4 A. Can you rephrase that a little bit. Are you saying this
5 DOR or the behavior?
6 Q. The behavior.
7 You referenced that Ms. Edmo received DORs for assault;
8 correct?
9 A. Yes.
10 Q. And you said that that shows -- the fact that she got a DOR
11 for assaultive behavior shows that her mental health concerns
12 are not well controlled; correct?
13 A. The fact she assaulted somebody, yes.
14 Q. And you train a clinician that if the behavior for which
15 Ms. Edmo got a DOR is related to mental health, they have to
16 check the "yes" box on this form, Mental Health DOR
17 Recommendation; correct?
18 A. Yes.
19 MR. HALL: Objection. Foundation.
20 THE COURT: Overruled.
21 THE WITNESS: If it's found in each case.
22 Q. BY MS. RIFKIN: Can you answer the question, Mr. Clark?
23 You train IDOC clinicians that if they believe the behavior
24 for which a person receives a DOR is related to mental health
25 concerns, they have to check the "yes" box on this form;

1 correct?

2 A. Yes.

3 Q. And for this DOR for assault, which box is checked?

4 A. Mental illness was not a factor in the incident.

5 Q. It's checked, for "Mental illness contributing factor in

6 incident," "no"; correct?

7 A. Yes.

8 Q. And the next box, "Mental illness not a factor in

9 incident," that's checked "yes"; right?

10 A. Yes.

11 Q. So it wasn't a mistake on the clinician's part, accidently

12 checking the box; right?

13 A. Not that I'm aware of.

14 Q. You agree that Ms. Edmo has been compliant with her hormone

15 treatments since they started in September 2012; correct?

16 A. To the best of my knowledge, yes.

17 Q. And you agree that Ms. Edmo has been compliant with her

18 medication for depression; correct?

19 A. Yes.

20 Q. And you testified that when you learned that Ms. Edmo had

21 attempted to cut her testicle, you didn't know whether this was

22 related to her gender dysphoria; correct?

23 A. That is correct, because I didn't do the assessment on

24 Ms. Edmo to know that.

25 Q. You told counsel on direct that you attended a training by

1 Dr. Levine in 2016; correct?
2 A. Yes.
3 Q. And after that training, you created a training to train
4 other IDOC clinicians on gender dysphoria; correct?
5 A. Yes, I did.
6 Q. And for this training, you borrowed quite a bit from
7 Dr. Levine, didn't you?
8 A. Yes.
9 Q. You felt that using Dr. Levine's material was a good way to
10 talk about identities and different identity possibilities;
11 correct?
12 A. Yes.
13 Q. Can we show Plaintiff's Exhibit 1025, please.
14 Is this the training that you and your supervisor created
15 to give to IDOC clinicians in September 2017?
16 A. Yes.
17 THE COURT: Are you offering the exhibit before we
18 discuss it further?
19 MS. RIFKIN: Yes, Your Honor, I'm offering this.
20 THE COURT: Any objection?
21 MR. HALL: No, Your Honor.
22 THE COURT: Mr. Eaton?
23 MR. HALL: Sorry. We have stipulated to authenticity;
24 however, these are hearsay statements. So to that extent, I'll
25 object.

1 THE COURT: Mr. Eaton?

2 MR. EATON: I'll join that.

3 THE COURT: Well, as I understand it, this is

4 a -- some slide -- PowerPoint slides prepared for a presentation

5 to IDOC staff prepared at least in part by Mr. Clark with regard

6 to how to assess gender dysphoria.

7 Is that correct? Is that correct, Ms. Rifkin?

8 MS. RIFKIN: Yes, Your Honor.

9 THE COURT: And what is the date? I don't see a date

10 on the exhibit list.

11 MS. RIFKIN: Mr. Clark produced this at his deposition

12 and handwrote the date September 2017, Your Honor, which he

13 testified was the date of the presentation.

14 THE COURT: All right. I'll overrule the objection.

15 The exhibit will be admitted.

16 (Plaintiff's Exhibit 1025 admitted.)

17 THE COURT: I might note that it potentially could be

18 used for impeachment even if not offered to prove the truth of

19 the matter asserted, and it is proper impeachment based -- based

20 upon his prior testimony.

21 So go ahead and proceed.

22 MS. RIFKIN: All right. Can we show, please, page 5

23 of this exhibit. And I would like to zoom in on the lower

24 left-hand corner slide.

25 THE COURT: While you're doing that, I should note, as

1 well, that how the staff is actually trained is probably also an
2 issue in the case. So it has direct relevance as to proper
3 training. Even if not offered to prove the truth of the matter
4 asserted, it can be offered to show what training was actually
5 provided to staff concerning gender dysphoria assessments.
6 So I'd just state that as another grounds for the court's
7 decision.
8 MS. RIFKIN: I'm sorry, Your Honor. Just one minute.
9 THE COURT: I was just clarifying the record. Go
10 ahead.
11 Q. BY MS. RIFKIN: All right. This is one of the slides from
12 Dr. Levine that you took and put in your own training to IDOC
13 clinicians; correct?
14 A. Yes.
15 Q. And you took No. 2 from Dr. Levine.
16 The SOC, that refers to the WPATH standards of care;
17 correct?
18 A. That is correct.
19 Q. "SOC, which claims to be a scientific and minority
20 rights document, ignores the profound differences
21 between science and advocacy."
22 That's part of the training you presented to the IDOC
23 clinicians; correct?
24 A. Yes.
25 Q. And if we can go over to the slide directly next to that

1 one, bottom right-hand corner.
2 THE COURT: Could you back up? I apologize. Could I
3 see that prior blow-up that you had?
4 So the statement is that -- "SOC" is standard of care? Is
5 that what that means?
6 THE WITNESS: Yes, it does.
7 THE COURT: Standard of care which claims to be a
8 scientific and minority rights document ignores the difference
9 between science and advocacy.
10 So what you're saying is that the standard of care, rather
11 than to be neutral, is, in fact, an advocacy position taken by
12 someone with expertise in the field? Is that, in essence, what
13 you're saying there?
14 THE WITNESS: That's what Dr. Levine said.
15 MR. HALL: Objection.
16 THE COURT: Okay. But it's what you were then
17 presenting to the staff?
18 THE WITNESS: Yes.
19 THE COURT: All right. Okay. Go ahead.
20 Q. BY MS. RIFKIN: All right. If we can move over to the
21 bottom right-hand corner slide, please.
22 No. 5:
23 "Judges, who are schooled in civil rights, look to
24 professional societies like WPATH for guidance. It is
25 an uphill battle to convince them that a professional

1 society is wrong and a dissenting expert in the
2 courtroom is right."
3 That's another one of Dr. Levine's theories that you
4 trained IDOC clinicians on, isn't it?
5 A. Yes.
6 Q. If we can turn to page 6 of this exhibit.
7 Before I go to those, prior to providing this training, in
8 addition to attending Dr. Levine's training to IDOC, you also
9 had a direct conversation with him; correct?
10 A. No.
11 Q. You communicated directly with Dr. Levine after that
12 training; correct?
13 A. Oh, after training. Yes.
14 Q. And based on the conversation you and he had, he sent you
15 some additional slides to use for your own presentation to IDOC
16 clinicians; correct?
17 A. Not specifically for me to use them, but I chose to use
18 them.
19 Q. So he sent you some additional slides based on your
20 conversation, and you chose to include those slides in this
21 training that we're looking at; correct?
22 A. Yes.
23 Q. Okay. If we can zoom in on the upper right-hand corner
24 slide. Thank you. I think that's good.
25 Can you read -- can you read the words on that, Doctor --

1 Mr. Clark?
2 A. Yes.
3 Q. Okay. This is one of the slides that you testified
4 Dr. Levine sent you after the training that you chose to
5 include?
6 A. Yes.
7 Q. And the slide starts:
8 "The justice paradigm reminds us that the inmate is in
9 prison as a punishment for a crime, for the protection
10 of citizens, and for an opportunity for civic
11 rehabilitation."
12 Correct?
13 A. Yes.
14 Q. And No. 3 on this slide, bullet point 3, says:
15 "This paradigm might be alternatively labeled common
16 sense paradigm or a citizens paradigm."
17 Correct?
18 A. Yes.
19 Q. And under No. 2, this slide says:
20 "Most individuals -- professional, government
21 officials and laypersons -- do not support the surgery
22 and express bafflement and outrage when they learn of
23 court decisions to mandate it for inmates at public
24 expense."
25 Correct?

1 A. That's what it says, yes.
2 Q. And this is information you included when training IDOC
3 clinicians about gender dysphoria; correct?
4 A. Yes.
5 Q. And treatment for gender dysphoria?
6 A. Yes.
7 Q. And how to treat people within their care for gender
8 dysphoria; correct?
9 A. It was part of the training, yes.
10 Q. You became familiar with the Osborne and Lawrence article
11 and proposed extra requirements for prisoners who want gender
12 confirmation surgery through Dr. Levine's training; correct?
13 A. No. I had the article prior to that.
14 Q. Didn't you testify a few moments ago on direct that
15 Dr. Levine's training to you included the Osborne and Levine
16 *[sic]* standards and, based on that, you rely upon them?
17 A. It wasn't based on that. I had the article prior to that
18 training.
19 Q. Okay. Are you aware of any professional associations that
20 had endorsed or accepted the standards proposed by Osborne and
21 Lawrence for treating patients with gender dysphoria?
22 A. I'm not aware of any, no.
23 Q. And IDOC has never provided gender confirmation surgery to
24 a prisoner; correct?
25 A. Not to my knowledge.

1 Q. And out of the 30 patients with gender dysphoria at IDOC,
2 not one has been referred for gender confirmation surgery;
3 correct?
4 A. That is correct.
5 MS. RIFKIN: No more questions at this time.
6 THE COURT: Redirect.
7 MR. HALL: Yes, Your Honor.
8 Excuse me, Madam Clerk. Is there a magic button I need to
9 press here? Thank you.
10 THE CLERK: You're welcome.
11 REDIRECT EXAMINATION
12 BY MR. HALL:
13 Q. Mr. Clark, I want to refer you back to the competency of
14 mental health professionals under the WPATH. We discussed this
15 previously. It is Joint Exhibit 15, page 28.
16 Do you see that there in front of you?
17 A. Yes, I do.
18 Q. Do you see anywhere where it says in order to be competent,
19 you must have provided an assessment for sex reassignment
20 surgery?
21 A. I do not see that.
22 Q. I have placed before you Joint Exhibit 15, page 66.
23 Do you see that in front of you there?
24 A. Yes, I do.
25 Q. Looking at the criteria for surgery, do you see anywhere

1 there where it says the words "medical necessity"?
2 A. I do not.
3 Q. Let's talk a little bit about these mental health DOR
4 recommendations, in particular, this one, Joint Exhibit 1, page
5 524.
6 Do you see that in front of you?
7 A. Yes, I do.
8 Q. Now, these aren't done for every offender who gets a -- let
9 me rephrase that.
10 Are these mental health recommendation for DORs done for
11 every offender in the Idaho Department of Corrections who
12 receives a DOR?
13 A. No.
14 Q. Who are they done for?
15 A. For folks that -- the inmates that have a certain level of
16 care associated with their mental health.
17 Q. What does that mean, the level of care for their health?
18 A. We have several levels of medical care that we provide.
19 For example, we have some that are just med management only;
20 like your neighbor on Zoloft, for example. But others attend
21 groups, have to be put in a mental health unit. And these
22 recommendations are associated for people that are at that
23 higher level of mental health need.
24 Q. Okay. And was Ms. Edmo at that higher level of mental
25 health need?

1 A. Yes.
2 Q. Okay. Does it say anywhere on here that Ms. Edmo does not
3 have a mental health illness? And I'm referring to Joint
4 Exhibit 1, page 525.
5 A. It does not say that.
6 Q. Is there any conclusion here that -- well, let me talk to
7 you about this.
8 At the top here, it says, "Documented history, mental
9 illness that could impair decision-making."
10 Do you see that?
11 A. Yes.
12 Q. What does that mean?
13 A. Meaning there is a history that the particular inmate has
14 demonstrated issues of mental health.
15 Q. And that box was marked "yes" for Ms. Edmo; correct?
16 A. Yes.
17 Q. Okay. Who reviews these forms?
18 A. I don't know who -- the clinicians complete those, and then
19 they are given to a duty officer.
20 Q. Okay. That's my question.
21 A clinician is going to complete these forms after
22 reviewing the DOR; is that correct?
23 A. Reviews the DOR. They are supposed to review the medical
24 file and any other history.
25 Q. And then they complete it, and they pass it off to

1 security?
2 A. That is accurate, yes.
3 Q. And then does someone review that in the process as to
4 determining whether or not to affirm or overrule the DOR?
5 A. That's on the responsibility of the security staff.
6 Q. Okay. Is it your understanding that the security staff
7 uses this form not to determine if mental illness was involved
8 but whether or not mental illness should be a mitigating factor
9 in either affirming or overruling the DOR?
10 A. Yes. That's the intention.
11 Q. Okay. So the intention is not to make a statement that the
12 person is not suffering from any mental health concerns at the
13 time; is that fair?
14 A. That is accurate.
15 Q. And you didn't complete this form; correct?
16 A. I did not.
17 Q. Sorry. Marked as Joint Exhibit 1-524.
18 A. I did not.
19 Q. Now, have you provided more training to IDOC staff other
20 than the slides that were discussed with you by Ms. Rifkin
21 marked as Plaintiff's Exhibit 1025?
22 A. I believe that was the last one that I did, but we have
23 future ones planned.
24 Q. Right. And do you believe that when you present training,
25 that you present only one side of a debate or an issue?

1 A. Absolutely not.
2 Q. And was it your intention in including information from
3 Dr. Levine to present the WPATH and another side of the debate?
4 A. No.
5 Q. Do you think it's good training to provide staff with a
6 balanced look at both sides of a debate?
7 MS. RIFKIN: I'm sorry, Your Honor. I'm going to
8 object as leading the witness here.
9 THE COURT: I'm sorry. You're objecting to leading?
10 MS. RIFKIN: Leading the witness, yes, as this is
11 direct.
12 THE COURT: Rephrase the question.
13 Q. BY MR. HALL: Do you find it important to present both
14 sides of a debate?
15 A. Yes, I do.
16 Q. Why?
17 A. I feel like all of the things need to be on the table to
18 empower my staff to make the best decisions possible based on
19 all the information.
20 Q. Do you feel that the WPATH has adequately addressed how to
21 apply the standards in a prison context?
22 MS. RIFKIN: Objection as beyond the scope of cross.
23 MR. HALL: I think it goes directly to cross and the
24 basis and foundation for the presentations and the training that
25 he has provided to IDOC clinicians.

1 THE COURT: Overruled. You may answer.
2 THE WITNESS: I feel it covers a lot of what we can do
3 in prison for this population, but I do feel it is missing areas
4 on how to deal with specific issues associated with prisons.
5 Q. BY MR. HALL: And do you believe that Levine and Osborne
6 and Lawrence have attempted to try and comment on how to apply
7 the WPATH in the context of a prison?
8 A. That was how I interpreted it, yes.
9 Q. And you've -- you have reviewed Osborne and Lawrence's
10 article; correct?
11 A. Yes.
12 Q. And have you ever presented any opinions to IDOC staff that
13 the IDOC should not ever provide sex reassignment surgery to a
14 gender dysphoric inmate?
15 A. I have never said that, no.
16 Q. Do you believe that?
17 A. I do not.
18 Q. Okay. Did you present in this slide, this presentation,
19 Plaintiff's Exhibit 1025-1, that it's actually Dr. Levine's
20 opinion that SRS should never be provided in a prison?
21 A. No, I never presented that to them.
22 Q. Do you believe that there may be gender dysphoric inmates
23 at the Idaho Department of Corrections who may one day meet the
24 criteria for sex reassignment surgery?
25 MS. RIFKIN: Objection. Calls for speculation, beyond

1 the scope.

2 THE COURT: Well, I'm going to allow it because I was

3 going to ask that question myself. So I guess that defines

4 relevance.

5 So you can answer.

6 THE WITNESS: I do believe there will come a time

7 where we will have a person incarcerated that will meet the

8 criteria for surgery.

9 Q. BY MR. HALL: And is it your opinion that if someone meets

10 the criteria under the WPATH, that it would be appropriate to

11 provide sex reassignment surgery or refer to a physician who

12 could make that determination?

13 A. Yes, I do feel that would be appropriate.

14 Q. But going back to your opinion, while that may be possible

15 for some offender someday, you don't believe that Ms. Edmo meets

16 the criteria for sex reassignment surgery; correct?

17 A. That is correct.

18 Q. And in 2016, that was your opinion at that time; correct?

19 A. Yes, that was my opinion.

20 Q. And you weren't lying when you said that you considered the

21 WPATH in 2016 and in assessing whether or not Ms. Edmo had

22 mental health concerns that made SRS inappropriate, were you?

23 A. No, I was not.

24 Q. You had a conversation with Dr. Eliason?

25 A. Yes, I did.

1 Q. And have you seen Dr. Eliason's note from that assessment?
2 A. Yes, I have.
3 Q. And did you see where he referenced you in there as a WPATH
4 member and that he had specifically staffed it with you?
5 A. Yes, I did.
6 MR. HALL: Okay. No further questions.
7 THE COURT: All right. I was going to ask some
8 questions, and I should have asked them after Ms. Rifkin's
9 questions. But I'll do it now and give both sides a chance to
10 follow up if I ask anything that raises a concern.
11 EXAMINATION
12 BY THE COURT:
13 Q. Just to be clear, the training that you provided to the
14 IDOC staff, it was not training to assist the staff in making a
15 gender dysphoria assessment, because that's not their role;
16 correct?
17 A. No. That particular one for September 2017 was for a group
18 of clinicians that we were training to do assessments.
19 Q. So it was to do assessments?
20 A. Yes.
21 Q. And was the upshot of the training that you use the WPATH
22 criteria to determine whether or not a person should, in fact,
23 receive gender-conforming surgery?
24 A. I don't recall if I covered surgery in the further slides
25 or not. I think I was focusing mainly on the assessments.

1 Q. In other words, to assess whether or not a person suffers
2 from gender dysphoria?
3 A. Yes.
4 Q. Is that all you're doing?
5 A. Yes.
6 Q. You're not recommending a particular treatment program?
7 That's not the role of the assessment?
8 A. For that training, no, that was not the purpose of it.
9 Q. Okay. Well, the second question, I think I understood
10 that -- just earlier today, that apparently as of the last
11 Friday, there was a change in IDOC policy allowing female
12 underwear, makeup, and hairstyles according to an inmate's
13 desired gender and directing correctional officers to address
14 them according to that desired gender.
15 First of all, did I get that right? And secondly, were you
16 involved in that change in policy? Or do you know? Maybe you
17 don't even know.
18 A. Yes. First of all -- okay. Remind me your first question.
19 I apologize.
20 Q. Well, it was basically, there has been a change in IDOC
21 policy. You were aware of that?
22 A. Yes.
23 Q. And were you involved in creating that change in policy?
24 A. Yes, I was involved in that process.
25 Q. So was that your recommendation?

1 A. To offer those?
2 Q. Make those changes.
3 A. Yes, it was.
4 Q. Okay. Was that a -- well, let me just leave it at that.
5 Maybe I don't need to go any further because it's not directly
6 relevant to the issue before the court.
7 Let me ask now just a couple questions about, I guess, the
8 WPATH standards.
9 In the last few questions asked by Mr. Hall, you talked
10 about whether there would be someone at some point who IDOC
11 might well approve for gender confirmation surgery. And I'm
12 assuming that that person would need to qualify under the WPATH
13 standards; that would be maybe the or at least a criteria for
14 making that determination.
15 Is that --
16 A. I would rely on those standards heavily, yes.
17 Q. WPATH standards?
18 A. Yes, the WPATH standards.
19 Q. All right. And you agree that, as I understand your
20 testimony, that other than that fourth requirement that any
21 serious existing or serious mental health concerns be well
22 controlled, that the plaintiff, Ms. Edmo, qualifies under the
23 WPATH standards?
24 A. From my opinion, yes.
25 Q. Okay. So let me ask -- and I have no idea what the answer

1 to this is. First of all, gender dysphoria -- and I want to be
2 careful on terminology. I know that DSM-5 at least provides the
3 standard for diagnosing gender dysphoria, but would gender
4 dysphoria by itself constitute a serious mental health concern?
5 A. I think it can, yes.
6 Q. But you would agree that if that is the only uncontrolled
7 serious mental health concern, that should not be a
8 disqualifying factor under the WPATH standards; or, otherwise,
9 you have complete circular reasoning?
10 A. Yes, that is correct.
11 Q. All right. Then, if all of Ms. Edmo or any inmate's
12 existing mental health concerns are either gender dysphoria or
13 other recognized mental health issues which were a direct
14 consequence of gender dysphoria or greatly exacerbated by gender
15 dysphoria, would that, in your view, be disqualifying under that
16 fourth requirement of the WPATH standards?
17 A. I think that would have to be taken in great consideration
18 if you can really establish the gender dysphoria as the basis of
19 it.
20 Q. Well, that's my next question, is that you, presumably, as
21 a licensed mental health professional but not having a Ph.D. or
22 not being a psychiatrist, I'm assuming that you don't know how
23 we would ever differentiate between those mental health issues
24 which are directly tied to gender dysphoria and those which are
25 not?

1 A. I think it can be difficult with some people, yes.
2 Q. Okay. But you would agree that, at least potentially, if
3 they are, in fact, directly tied to gender dysphoria, those also
4 should not be considered in making that assessment under that
5 fourth requirement of the WPATH?
6 A. Yeah.
7 THE COURT: All right. Counsel, go ahead.
8 Again, Mr. Hall and Mr. Eaton, I assume you will follow up
9 on my questions. That's one of the great advantages of being up
10 here; I have a question, I get to ask it.
11 Go ahead.
12 MS. RIFKIN: Thank you, Your Honor. If we can show
13 Mr. Clark Joint Exhibit 8, please.
14 RECROSS-EXAMINATION
15 BY MS. RIFKIN:
16 Q. Mr. Clark, this is the IDOC policy relating to GD -- folks
17 in prison with GD that was operative until last Friday; correct?
18 A. Yes.
19 Q. Okay. And if we can turn to what is I believe page 3 of
20 this exhibit. And can we zoom in on "Qualified gender identity
21 disorder evaluator," please.
22 In this policy which has been operative right up until
23 Friday and was operative in 2016 when Ms. Edmo was assessed for
24 surgery, this was the definition of qualified gender identity
25 disorder evaluator employed under IDOC policy; correct?

1 A. Yes.
2 MR. HALL: Your Honor, I'm going to object. This line
3 of questioning goes well beyond the scope of the initial cross
4 or the court's questions.
5 THE COURT: It seems like it does. I don't know --
6 can you tie it back in?
7 MS. RIFKIN: I can, Your Honor. Mr. Hall put the six
8 criteria in front of Mr. Clark and stated that he -- that he had
9 been able to assess Ms. Edmo. The questions are about his
10 assessment of Ms. Edmo for surgery and his qualifications to do
11 that, and this directly addresses that.
12 THE COURT: Your objection is -- oh, go ahead,
13 Mr. Hall.
14 MR. HALL: Your Honor, the line of questioning was
15 dealing solely with the WPATH criteria, whether he was competent
16 under the WPATH, not this policy.
17 I think this takes it well beyond the WPATH and to a policy
18 which is no longer in effect. And I have offered nothing to
19 suggest that Mr. Clark -- well, really, no analysis as to
20 whether he qualifies under that definition.
21 MS. RIFKIN: Your Honor, if counsel will stipulate
22 that Mr. Clark was not qualified as of prior to last Friday
23 under IDOC policy to assess patients with gender dysphoria as to
24 appropriateness or medical necessity for sex reassignment
25 surgery -- if they will stipulate that he was not qualified

1 under their own policy, I'll withdraw the questions.
2 THE COURT: Mr. Eaton -- or are you willing to concede
3 that you are not arguing that, in any event? You're not arguing
4 that he, in fact, was qualified to do assessments?
5 MR. HALL: Well, that takes it out of context. But we
6 never -- we have never presented any testimony that, under this
7 definition, that Mr. Clark meets that. He is not a doctor of
8 philosophy, so I don't see what the point is.
9 But there are other physicians that may qualify in that --
10 Claudia Lake, Dr. Eliason.
11 THE COURT: All that is being asked here is whether or
12 not IDOC is arguing that Mr. Clark was, in fact, a qualified
13 gender dysphoria evaluator.
14 And you're not arguing that he is; correct?
15 MR. HALL: Under that definition, no.
16 THE COURT: You're trying to qualify it. So let's
17 flesh out why -- under what definition. Today, he is.
18 Apparently, there was a change made on Friday. And are you
19 saying now that he is qualified?
20 MR. HALL: Under this policy, it describes qualified
21 gender identity disorder evaluator as a doctor of philosophy or
22 a psychiatrist -- sorry -- a medical doctor, a physician
23 licensed by a state board of medicine.
24 I think Mr. Clark has not testified that he is a doctor of
25 philosophy nor has he testified that he is a medical doctor.

1 THE COURT: The question, though, is whether or not
2 you are going to argue Mr. Clark is, in fact, a -- I'll use the
3 word, well, gender identity disorder evaluator. And you're not
4 offering him as such or suggesting, in fact, he has made that
5 evaluation in a way that was operative in this proceeding?
6 MR. HALL: Correct, Your Honor.
7 THE COURT: Okay. I don't know what more we can do.
8 Frankly, I now know what the IDOC policy is, so let's just move
9 on.
10 MS. RIFKIN: That's fine.
11 Q. BY MS. RIFKIN: Mr. Clark, you testified about the policy
12 change and that you were involved in the policy change.
13 You -- based on your own experience, IDOC started the process to
14 revise its GD policy in 2016; correct?
15 A. That was the approximate time, yes.
16 Q. And so after two-and-a-half or more years in the process of
17 revising its policy, it happened to adopt a new policy last
18 Friday; correct?
19 A. Officially, yes.
20 MR. HALL: Objection, Your Honor. This is also going
21 beyond the scope of cross and the court's questioning. She had
22 the opportunity to cross about the policy.
23 THE COURT: I understand. And I injected some of that
24 into the case by asking about the change in policy.
25 I'm going to allow some leeway, Counsel, but my questions

1 were tied to changes regarding how the correctional officers
2 were to refer to the inmate and the physical aspects of this.
3 So I think we need to limit it to that.
4 MS. RIFKIN: I'll move on, Your Honor.
5 THE COURT: All right.
6 MS. RIFKIN: May I have -- I would like to be able to
7 show Mr. Clark the exhibit, Plaintiff's Exhibit 1025, that we
8 have been talking about. I would like him to be able to look
9 through that entire document to be able to answer questions.
10 May I approach the witness?
11 THE COURT: Yes. Mr. Severson will -- if you have a
12 hard copy, we'll provide that to him so he can review it.
13 Counsel, we need to take one more short break, and we'll
14 probably limit it to just five minutes, and then we'll go
15 through until 3:00, a little after 3:00 maybe. Will that work?
16 MS. RIFKIN: Take a break in five minutes or now?
17 THE COURT: Well, the reason I'm suggesting that, too,
18 is if you want Mr. Clark to review the entire thing, he can do
19 that on the break.
20 MS. RIFKIN: Sure.
21 THE COURT: Then you can come back and ask questions
22 about it.
23 MS. RIFKIN: That works, Your Honor.
24 THE COURT: All right. Let's take a 10-minute break.
25 And we'll probably run until 3:00 or 3:10 to try to catch up the

1 time we lost yesterday.

2 THE WITNESS: I have a question. I'm supposed to

3 review this whole thing?

4 THE COURT: I'm assuming you're only talking about one

5 exhibit, which is Exhibit 1025.

6 THE WITNESS: Okay. Thank you.

7 MS. RIFKIN: I mean, I'm tempted to say yes. But, no,

8 just 1025.

9 THE COURT: Ms. Rifkin, you're so generous.

10 Yeah, just Exhibit 1025, which I think is the PowerPoint

11 slides you looked at earlier, but she wants you to look at all

12 of them.

13 Right? Okay.

14 MR. HALL: Your Honor, just one question --

15 THE COURT: Yes.

16 MR. HALL: -- so I don't run afoul of anything. Would

17 it be permissible if Mr. Clark leaves the witness stand during

18 this?

19 THE COURT: Oh, yes. No. We are going to take a

20 10-minute break. So he can -- we'll take a break and, yes, he

21 can --

22 MR. HALL: You're not sequestering him there?

23 THE COURT: No, not at all.

24 MR. HALL: He's able to talk to his attorneys?

25 THE COURT: No, not at all.

1 MR. HALL: Thank you.
2 THE COURT: All right. We'll be in recess for 10
3 minutes.
4 (Recess at 2:02 p.m. until 2:17 p.m.)
5 THE COURT: Mr. Clark, I'll remind you you are still
6 under oath.
7 Ms. Rifkin, you may resume your examination.
8 MS. RIFKIN: Thank you, Your Honor.
9 Q. BY MS. RIFKIN: Mr. Clark, have you had a chance to review
10 Plaintiff's Exhibit 1025?
11 A. Yes.
12 Q. Okay. And it's there in front of you?
13 A. Yes.
14 Q. Okay. You told the court before the break that this
15 training was about assessment and not surgery; correct?
16 A. Yes.
17 Q. Can you please turn to what's labeled page 6 of
18 Exhibit 1025.
19 A. I'm there.
20 Q. So looking at the slide in the upper left-hand corner, this
21 slide discusses surgery; right?
22 A. Yes.
23 Q. "Assumes that genital surgery will cure the problem
24 and withholding SRS constitutes a gross violation of
25 the Eighth Amendment."

1 That's the top part of this slide?
2 A. Yes.
3 Q. And it ends with:
4 "This paradigm assumes that SRS is a cure that if
5 withheld constitutes a gross violation of the Eighth
6 Amendment."
7 A. Yes.
8 Q. And the next slide, "Is there a fifth hidden paradigm,"
9 this is one of the ones we talked about earlier. This also
10 talks about surgery; correct?
11 A. Yes.
12 Q. And the next slide, "Is there a fifth hidden paradigm -- a
13 justice paradigm?" this slide also talks about surgery; correct?
14 A. Yes.
15 Q. So you chose to include these slides from Dr. Levine with
16 perceptions -- his perceptions about providing surgery for
17 inmates with gender dysphoria in a training about assessment of
18 gender dysphoria; correct?
19 A. Yes.
20 Q. I'm going to represent to you that, besides the cover
21 slide, there are 38 slides in this PowerPoint.
22 Do you know how many of those slides you took from
23 Dr. Levine's presentation?
24 A. The majority.
25 Q. Does 32 out of the 38 slides sound like the right number?

1 A. Yes.

2 Q. And it's the only slides you didn't take from Dr. Levine
3 were the ones where you presented the WPATH standards of care
4 for medical professionals, the DSM-5 criteria, and what the MTC
5 does; is that accurate?

6 A. That's accurate.

7 Q. You and Mr. Hall suggested that you included Dr. Levine's
8 slides in here to present both sides of the debate; isn't that
9 accurate?

10 A. Yes.

11 Q. Where is the other side of the debate in this presentation,
12 Mr. Clark?

13 A. If you look at the slides, he presents what the -- what
14 each one is presenting and what the limitations or possibilities
15 would be.

16 I put them in there specifically for talking points, so we
17 could address the issue, not to take a side anywhere.

18 Q. Isn't it true, Mr. Clark, that you testified in your
19 deposition that you don't recall expressing disagreement with
20 any of Dr. Levine's opinions in these slides?

21 MR. HALL: Objection.

22 THE WITNESS: I don't recall that.

23 THE COURT: Just a moment. Just a moment.

24 MR. HALL: I think that misstates the deposition
25 testimony. If we could see --

1 THE COURT: Well, let's ask the question whether he
2 disagrees or not. And then if he gives an answer contrary to
3 his deposition, you can impeach.
4 Go ahead.
5 Q. BY MS. RIFKIN: Do you recall testifying at your deposition
6 that you didn't discuss your disagreement with any of
7 Dr. Levine's slides during the training?
8 A. I don't recall that, no.
9 MS. RIFKIN: No further questions, Your Honor.
10 THE COURT: Mr. Hall.
11 MR. HALL: Your Honor, a couple brief questions.
12 Madam Clerk, could I have this converted over. Thank you.
13 FURTHER REDIRECT EXAMINATION
14 BY MR. HALL:
15 Q. I want to show you again Joint Exhibit 15, page No. 28.
16 Again, these are the competencies under the WPATH of being
17 able to work with someone who is gender dysphoric; correct?
18 A. Yes.
19 MS. RIFKIN: Objection. This is beyond the scope of
20 the recross.
21 MR. HALL: Can I have a little leeway, Your Honor?
22 THE COURT: I'm going to give you some leeway. Go
23 ahead and proceed.
24 Q. BY MR. HALL: The court asked you some questions about
25 whether or not the roles of a psychologist versus a clinician,

1 the role of a medical doctor, psychiatrist versus a clinician.
2 Under Joint Exhibit 15, page No. 28, does it say in there
3 anywhere that to be competent under the WPATH, you have to be a
4 medical doctor?
5 A. No.
6 Q. Does it say you have to be a Ph.D.-level provider or
7 professional?
8 A. No, it doesn't.
9 Q. Okay. And do you -- to your knowledge, can only a
10 psychiatrist or a psychologist determine the relationship
11 between gender dysphoria and other coexisting mental health
12 concerns?
13 A. No.
14 Q. And in your profession, within your scope of care, can you
15 determine the difference between a gender dysphoric -- gender
16 dysphoria and other coexisting mental health concerns?
17 A. Yes. I have that experience.
18 Q. Okay. And the WPATH expects you to do that, doesn't it?
19 A. Yes.
20 Q. And I just want to ask one more question, maybe two, about
21 the slides under Plaintiff's Exhibit 1025.
22 This is the title right here of the presentation, "Gender
23 Dysphoria Assessment"; correct?
24 A. Yeah.
25 Q. And just to make it very clear, because I don't think it's

1 been very clear -- I just want to make it very clear -- this
2 presentation was not about treatment options, including surgery;
3 right?
4 A. That is correct.
5 Q. It was about training for diagnosis of gender dysphoria; is
6 that correct?
7 A. Yes.
8 MR. HALL: Thank you. No further questions.
9 THE COURT: Anything else?
10 MS. RIFKIN: No, Your Honor, not from plaintiff.
11 THE COURT: All right. Mr. Clark, you may step down.
12 Thank you.
13 THE WITNESS: Am I free?
14 THE COURT: You are.
15 I assume he is released from any subpoena, not subject to
16 recall.
17 MR. HALL: Right, Your Honor.
18 THE COURT: Well, presumably you know where to find
19 him if need be. So you are released.
20 MR. HALL: I think he is taking off. He will be in
21 the mountains.
22 THE COURT: That's right. It is that time of the
23 year.
24 THE WITNESS: Thank you.
25 THE COURT: Call your next witness, Mr. Eaton.

1 MR. EATON: Yes, Your Honor. The defendants call
2 Dr. Eliason.
3 THE COURT: Sir, would you step before the clerk and
4 be sworn.
5 SCOTT ELIASON, M.D., DEFENDANTS' WITNESS, SWORN
6 THE CLERK: Please take a seat in the witness stand.
7 Please state your complete name and spell your name for the
8 record.
9 THE WITNESS: Scott Eliason, S-C-O-T-T, E-L-I-A-S-O-N.
10 THE COURT: You may inquire.
11 MR. EATON: Thank you, Your Honor.
12 DIRECT EXAMINATION
13 BY MR. EATON:
14 Q. So I have been saying it right. It's Eliason; right?
15 A. Yes.
16 Q. I told everybody the first time I met you, you said, "I'm a
17 psychiatrist. I listen."
18 It's Eliason; is that right?
19 A. That's right.
20 Q. Okay. Well, I know you have been ill this week, so I'm
21 glad you can be here, and I hope you're feeling better.
22 A. Thanks.
23 Q. How are you employed?
24 A. I'm employed by Corizon full time, but also I -- I work at
25 Ada County Jail. And then I have a small consulting business

1 called Boise Forensic Psychiatry where I consult with lawyers on
2 cases.
3 Q. Okay. And what is your job title with Corizon?
4 A. I'm the regional psychiatric director.
5 Q. Okay. And is that a full-time job?
6 A. Yes.
7 Q. Okay. And how long have you been employed with Corizon?
8 A. I have been with Corizon before it was Corizon, but it used
9 to be called Correctional Medical Services. And I joined them
10 the end of 2009.
11 Q. Okay. And then that was a name change eventually?
12 A. Yeah. Then it became -- it merged with some other company
13 and changed to Corizon.
14 Q. Okay. And have you been the psychiatric director
15 since -- since 2009?
16 A. It was really -- it was the spring of 2010 that I became
17 the director.
18 Q. Okay. And what did you do before that for Corizon?
19 A. I just -- I just saw patients as a psychiatrist.
20 Q. Okay. And the official title, again, is?
21 A. Regional psychiatric director.
22 Q. Okay. So as the regional psychiatric director, what are
23 your duties?
24 A. Primarily, I see patients for 90 percent of the time. And
25 then I oversee the psychiatric providers throughout the state.

1 So that includes psychiatrists and nurse practitioners and
2 physician's assistants throughout the state.
3 Q. When you say "throughout the state," is that at state
4 prisons?
5 A. Yes, throughout the state prison system. That's right.
6 Q. And so you have a supervisory role over those
7 psychiatrists. And do you call them "mid-levels"?
8 A. Yeah, that's right.
9 Q. Okay. And do you have administrative roles?
10 A. Yes. I do peer reviews, read credentialing interviews.
11 I'm involved with the hiring process and interviewing, things
12 like that.
13 Q. And then if I understood you, the majority of your time is
14 spent treating and caring for patients?
15 A. Yes.
16 Q. And what does that entail?
17 A. The treating patients? Sitting down, talking with
18 patients, reviewing their records, and prescribing treatments.
19 Q. And at what facilities do you do that?
20 A. I give direct care on a regular basis at Idaho State
21 Correctional Institution and Idaho Maximum Security Institution.
22 Q. And is there a specific unit that you provide the direct
23 care at ISCI?
24 A. There is two units. I work at the behavioral health unit
25 at ISCI, and I also work at the receptions and diagnostic unit.

1 Q. And is that separate from the general population?
2 A. Yes. That's the arrival area.
3 Q. And the behavioral health unit is separate from the general
4 population as well?
5 A. Yes.
6 Q. And what do you do for Ada County?
7 A. For Ada County, I provide some direct patient care, and
8 then I oversee a nurse practitioner who works there, too.
9 Q. Okay. Could we pull up Dr. Eliason's CV. This is -- can
10 you scroll down a little bit. This is Defendant's Exhibit 2022.
11 Dr. Eliason, do you see this?
12 A. Yes.
13 Q. Okay. Is this your CV?
14 A. Yeah, this is my CV.
15 Q. Do you want us to scroll through it?
16 Why don't you scroll through it just briefly so he can see
17 it.
18 Is that your CV?
19 A. Yes.
20 Q. Did you write that?
21 A. Yes.
22 Q. Okay. And is it accurate?
23 A. Yes.
24 MR. EATON: All right. We would move to admit the CV,
25 Your Honor.

1 THE COURT: Any objection?

2 MS. SHANBHAG: No objection, Your Honor.

3 THE COURT: What's the exhibit number again?

4 MR. EATON: 2022 of Defendants' exhibits.

5 THE COURT: 2022 is admitted.

6 MR. EATON: Thank you, Your Honor.

7 (Defendant's Exhibit 2022 admitted.)

8 Q. BY MR. EATON: The court has your CV now, but I would still

9 like to talk to you and highlight a little bit of your

10 background. So let's talk about your education first.

11 Did you graduate from medical school?

12 A. Yes.

13 Q. Where was that?

14 A. Medical College of Wisconsin.

15 Q. Okay. And when was that?

16 A. In 2003.

17 Q. Okay. And then why don't you walk me through your formal

18 training -- excuse me -- formal education.

19 A. I did a psychiatric residency at the University of

20 Washington, where I did my first two years in Seattle and then

21 my last two years in Spokane.

22 And then I did a forensic psychiatry fellowship at the

23 University of California, San Francisco, where I trained at

24 several facilities, but I primarily worked at San Quentin

25 Prison.

1 And then -- and then I graduated from training. I worked
2 at the Department of Health and Welfare for the first
3 year-and-a-half out of training, and then I got the job at the
4 prison.
5 Q. Which prison?
6 A. With Corizon here in Idaho.
7 Q. And when was that? That was in 2009?
8 A. 2009.
9 Q. And you mentioned a fellowship.
10 In any of that education, did you encounter any gender
11 dysphoria or, I guess, it may have been gender identity disorder
12 patients at that time?
13 A. Yes. At San Quentin, I didn't directly treat patients, but
14 I shadowed my attending, who did have patients that were
15 transgender.
16 Q. Can you scroll down one page.
17 On this page, you mention NCCHC.
18 Do you see that in the middle?
19 A. The recent CME?
20 Q. Yes.
21 A. Yes.
22 Q. What is that?
23 A. NCCHC stands for National Commission, I think, of
24 Correctional Health Care.
25 Q. Can you just explain what you're referencing there?

1 A. I reference a conference that specializes in correctional
2 healthcare that I had attended.
3 Q. Okay. And are you board certified?
4 A. Yes.
5 Q. In what?
6 A. In forensic psychiatry and general psychiatry.
7 Q. Okay. What's the difference?
8 A. General psychiatry is the psychiatric treatment of adults
9 and also children but doesn't specialize in children.
10 And then forensic psychiatry is really the interface of
11 mental health and the legal system. And so you're trained in
12 all sorts of different aspects of psychiatry when it has to do
13 with the law. And as an offshoot of that forensic psychiatry is
14 considered the fellowship training for correctional
15 psychiatrists.
16 Q. And do you have any certifications or credentialing related
17 to providing treatment and care to prisoners?
18 A. Yes. Through the NCCHC, I am what's called a "CCHP," which
19 stands for a Certified Correctional Healthcare Provider. And I
20 both have the physician certification and the mental health
21 certification for that.
22 Q. And I assume, through your training and education and
23 experience, you are familiar with the DSM?
24 A. Yes.
25 Q. And what is that?

1 A. That's the Diagnostic and Statistics Manual, which is the
2 textbook full of psychiatric disorders and their diagnostic
3 criteria.
4 Q. And what version are we on now?
5 A. Version 5.
6 Q. Of the DSM?
7 A. Yes.
8 Q. Okay. And so through your training, education, and
9 experience, are you familiar with the disorders and criteria of
10 mental health disorders in the DSM?
11 A. Yes.
12 Q. Does that include previously gender identity disorder?
13 A. Yes.
14 Q. And has that changed, that diagnosis?
15 A. Yes. It's now called gender dysphoria.
16 Q. Okay. And do you have an appreciation as to why that
17 changed?
18 A. You know, there is -- mental health disorders are somewhat
19 difficult to define and often have a lot to do with society.
20 Like, if you look back at the earlier editions of the DSM, you
21 might find things like homosexuality in there, but now we know
22 that to just be a normal variant of human behavior.
23 And so over time, some things that have in the past been
24 considered mental disorders become not mental disorders.
25 And there has been some movement, I think, with the

1 transgender population to destigmatize or depathologize
2 transgender behavior.
3 And I think that the change from gender identity disorder
4 to gender dysphoria was to kind of support that and to help
5 de-stigmatize the transgender population.
6 Q. But is gender dysphoria still a -- do you call it a
7 diagnosis?
8 A. Yeah. It is still a diagnosis that you can find in the
9 DSM.
10 Q. Okay. I would like to pull up his records. I think it's
11 the second page.
12 So do you know Ms. Edmo, who is the plaintiff in this case?
13 A. Yes.
14 Q. And how did it come about that you know Ms. Edmo
15 originally?
16 A. Originally, I was asked to evaluate Ms. Edmo for gender
17 identity disorder.
18 Q. And how did that process work at that time?
19 A. Usually the inmate would bring to the attention of the
20 Department of Corrections that they wanted to be evaluated for
21 gender identity disorder, and that usually had to go through the
22 chief psychologist, who was Dr. Craig at that time. And then
23 Dr. Craig would assign people to do the evaluations.
24 Q. Actually, can we scroll up one record.
25 So here we have a Health Services Request form; correct?

1 A. Yes.
2 Q. And this is Joint Exhibit 1-12.
3 And what -- is that Ms. Edmo asking for something --
4 A. Yes.
5 Q. -- can you tell?
6 What is she asking for?
7 A. She said, "I would like to speak to Dr. Eliason about
8 hormone therapy. Thank you."
9 Q. And what's the date on that?
10 A. It looks like -- oh, 6 -- June 13, 2012.
11 Q. And to your knowledge, is that how it came about that you
12 were assessing Ms. Edmo?
13 A. Well, I'm not sure if there were prior communications about
14 this as well. I think this could have led to it. But if you go
15 to my note below that you just had --
16 Q. Yeah, let's go to that.
17 A. -- the date is June 25th. And so it could have been that,
18 but it could have also been some prior communications.
19 Q. In any event, was Ms. Edmo referred to you for an
20 assessment?
21 A. Yes.
22 Q. An assessment of what?
23 A. An assessment of her gender identity disorder.
24 Q. Okay. And so what -- the court has this note, so I don't
25 want you to read it all.

1 But can you walk us through generally what the subjective
2 section and what she was saying to you at that time that was
3 significant to your assessment.
4 A. Just that, primarily, she had always felt feminine and felt
5 that she was supposed to have been born a female and not a male
6 and that she used to think that that meant that she was supposed
7 to be a homosexual, but that now that she thought that she
8 wasn't a gay man but really a woman.
9 Do you want me to go further?
10 Q. Yeah. What else was significant to you in that
11 conversation?
12 A. And so then we talked about her sexual orientation some and
13 then about how she interacted and felt about being a man versus
14 being a woman and the kinds of things she felt comfortable
15 doing.
16 And then we also talked about some about her mental health
17 medications.
18 Q. So what mental health medications was she on at that time?
19 A. She was taking a medicine called Lamictal.
20 Q. What's that for?
21 A. Lamictal is a mood stabilizer that's primarily indicated
22 for bipolar disorder but used in depression as well.
23 Q. Anything else in the subjective section that you found
24 significant?
25 A. Not really.

1 Q. And then you have an objective section.
2 What did you do there and document?
3 A. So objective is basically like my physical exam or, in
4 psychiatry, we call it our mental status exam, which is when we
5 describe what we see related to their mental health.
6 So I noted that she appeared feminine in demeanor and
7 interaction style.
8 Q. And you also indicate in there --
9 Can you stop moving it, please. Thank you.
10 And then in there, you also indicate "mood depressed";
11 right?
12 A. Yes.
13 Q. All right. And so did you have an assessment?
14 A. Yes.
15 Q. And what was your assessment?
16 A. Well, first I commented about her mood disorder and that
17 she reported that she had done better on Zoloft. Then I said
18 that I thought that she met criteria for gender identity
19 disorder and that it was consistent with presentation and his
20 reported -- her reported history.
21 Q. And then did you make an assessment?
22 A. Yes.
23 Q. What was that?
24 A. Well, that was my assessment. Then I made a diagnosis down
25 here.

1 Q. Okay.

2 A. And under diagnosis for axis 1, which is where we would put

3 major mental illnesses at the time, I put "alcohol dependence,

4 mood disorder not otherwise specified."

5 Q. Let's stop there for a second.

6 So what was the basis for that assessment or that

7 diagnosis?

8 A. The alcohol dependence? That was based on previous records

9 that I was provided.

10 Q. And then did you have another diagnosis as well?

11 A. Yes. Mood disorder not otherwise specified.

12 Q. What was the reason for that diagnosis?

13 A. That was partially based on what we talked about, but also

14 prior records as well.

15 Q. Okay. What about any other diagnosis?

16 A. And then I put here "GID," which stands for gender identity

17 disorder.

18 Q. Why did you make that assessment?

19 A. I made that assessment based on my objective evaluation and

20 then her report.

21 Q. And then you -- did you prescribe any medications?

22 A. Yes. I stopped her Lamictal and started Zoloft.

23 Q. And why did you do that?

24 A. Basically because she felt like she had done better on

25 Zoloft.

1 Q. Okay. And so now that Ms. Edmo had a diagnosis from you of
2 gender identity disorder, what were the next steps, if any, in
3 the process?
4 A. So in the process in the Department of Corrections, you
5 would get two evaluations, one by -- it was usually by me and
6 then one by a psychologist.
7 And then the two evaluations would be brought to the MTC,
8 the management and treatment team, and we would discuss the
9 evaluations. And then if -- the Department of Corrections
10 oftentimes would also have more information based on outside
11 records or outside interviews with collateral people. And then
12 we would use that information to determine whether or not the
13 diagnosis of gender identity disorder was appropriate.
14 Q. And so do you have any understanding as to whether Ms. Edmo
15 received another assessment by a psychologist?
16 A. Yes.
17 Q. And who was that?
18 A. That was Claudia Lake.
19 Q. Have you reviewed that?
20 A. Not recently, but I have.
21 Q. Okay. And you mentioned the MTC, the Management Treatment
22 Committee. I believe the court heard Mr. Clark testify about
23 that committee.
24 But, generally, what was the makeup of that committee?
25 A. It was a multidisciplinary committee, meaning that we had

1 people from security, usually a deputy or warden; but we also
2 had people from mental health, which was the primary clinicians
3 who interact on a daily or weekly basis with their patients; and
4 then we also had medical representation.
5 And I was on that committee as kind of a combination since
6 I was a psychiatrist; but I worked for Corizon, so I was from
7 the medical portion and the mental health portion.
8 Q. What did you understand your role was on the MTC?
9 A. My role was to provide assistance and some expertise and
10 commentary and insight into the different patients.
11 Q. Okay. And do you know whether the MTC met after your
12 diagnosis and Dr. Lake's diagnosis of GID?
13 A. Yes, it did meet.
14 Q. And what happened at that point, at that meeting regarding
15 the GID assessment?
16 A. I believe it was agreed by the committee that Ms. Edmo did
17 have gender identity disorder.
18 Q. Okay. And do you have any appreciation as to whether
19 hormones were started after that?
20 A. They were started after that. I can't remember how
21 quickly, but they were.
22 Q. Okay. Were you involved in providing the hormone therapy?
23 A. No. The committee would basically decide whether or not
24 the patient should be put into the medical clinic to then be
25 seen if it was appropriate to be put on hormones. The medical

1 provider would then sit down with them and determine if there
2 was any contraindications or reasons why they shouldn't be on
3 them.
4 Q. Now, did you see Ms. Edmo after the GID diagnosis?
5 A. Yes.
6 Q. Okay. Did you see her continuously in the months following
7 or the years following?
8 A. Yeah, fairly regularly.
9 Q. Can you explain, elaborate on that.
10 A. So as long as she was housed in the behavioral health unit,
11 I saw her at a minimum of every three months, and provided her
12 psychiatric care.
13 There was a little bit of a difference with the care and
14 treatment of gender identity disorder and gender dysphoria.
15 Q. How is that?
16 A. And that was in my ongoing interactions with her, although
17 I may assess some of the gender dysphoria components or
18 symptoms, the treatment for gender dysphoria was primarily
19 driven through the MTC. And the treatment for the other mental
20 health conditions, the medication, the prescriptions was done in
21 those monthly -- every-three-month visits.
22 Q. Okay. So in the month -- in the year after your GID
23 diagnosis -- so 2012 to 2013 -- did Ms. Edmo have other mental
24 health disorders?
25 A. I don't recall without looking at my notes, but I think so.

1 Q. Well, I guess what I'm asking is: Did you have any
2 diagnosis -- and I think we have talked about this some
3 already from your first note -- other than GID?
4 A. Yes.
5 Q. And so what were those?
6 A. I think the diagnosis was called "mood disorder not
7 otherwise specified," but the primary symptom that we were
8 treating was depression.
9 Q. And, in fact, you periodically would meet with Ms. Edmo
10 over the years after GID to treat her underlying mental health
11 issues; right?
12 A. Yes.
13 Q. Can we scroll down to Joint Exhibit 1-370.
14 So I'm showing you now what is marked, I believe, as
15 Joint Exhibit 1-370.
16 Can you scroll up, please. Thank you.
17 Do you recognize this?
18 A. Yes.
19 Q. What is it?
20 A. It's a letter to the Department of Transportation.
21 Q. And how did this letter come about?
22 A. I remember Ms. Edmo was trying to get her driver's license
23 changed so, when she got released, it would reflect that she was
24 a female. And I guess part of that procedure was you had to
25 have a letter from a doctor.

1 Q. And so you were willing to do that?

2 A. Yes.

3 Q. Okay. Is this that letter?

4 A. Yes.

5 Q. Is that your signature?

6 A. It is.

7 Q. What did you indicate in that letter?

8 A. I indicated that Ms. Edmo was -- now considered herself
9 mentally a female and that she was on hormone replacement
10 therapy, which was equivalent to a change of gender.

11 Q. Okay. Can we go down to Joint Exhibit 1-438.

12 So I noticed in some of your earlier records, that you
13 reference in your notes and referred to plaintiff Edmo as "he";
14 is that right?

15 A. Yes.

16 Q. Okay. And then in this note dated September 17 of 2014,
17 did you reference her by a different pronoun?

18 A. Yes.

19 Q. And what were you using there?

20 A. I -- most of the time in this note, I used the female
21 pronoun.

22 Q. Okay. And so why is it that you started using that
23 pronoun?

24 A. Well, through, you know, some continuing training and
25 education about treating patients with gender dysphoria, one

1 thing I learned was the importance and power of words. And, you
2 know, at this point, I felt it was warranted to call Ms. Edmo a
3 "she" in there.
4 Q. Were you always consistent with that in your records?
5 A. No. I mean, you can see here, you know, I clearly have
6 changed at the top. But in the objective portion, I said
7 "appears feminine in his demeanor," you know. So it wasn't
8 100 percent consistent, but --
9 Q. Did you mean any ill intent by referring to Ms. Edmo as
10 "he"?
11 A. No.
12 Q. In fact, you were trying to recognize the she pronoun, and
13 you transitioned with that; right?
14 A. Yes.
15 THE COURT: Counsel, could I just inquire? You
16 indicate "return of depressive symptoms with decrease of dose."
17 That's decrease of Zoloft; correct?
18 THE WITNESS: Yes; that's right.
19 THE COURT: All right.
20 Q. BY MR. EATON: And I'm not going to walk through each one
21 of your notes when you're addressing her depression and other
22 mental health records, but this was an example that I wanted to
23 talk to you about.
24 Could we bring up Joint Exhibit 1-538. This is the
25 April 20, 2016 note. There we go.

1 So you're now being shown Joint Exhibit 1-538.
2 Do you see that?
3 A. Yes.
4 Q. Okay. And what is this note?
5 A. Well, this is basically my assessment of Ms. Edmo for the
6 medical necessity of gender reassignment surgery.
7 Q. And how did that come about?
8 A. Ms. Edmo requested to be evaluated for sexual reassignment
9 surgery and had sent several concern forms to several people.
10 And then so in the MTC, we discussed it.
11 And as part of the Idaho Department of Corrections standard
12 operating procedures, it says something to the effect of gender
13 reassignment surgery would not be provided unless deemed
14 medically necessary.
15 And so the committee felt like I was the best
16 representative to determine whether or not it was medically
17 necessary, since I was the one with medical training.
18 Q. And did you understand that the Idaho Department of
19 Corrections required -- their standard operating procedure
20 required a qualified GID evaluator?
21 A. Yes.
22 Q. Okay. And do you know what that required, what it meant to
23 be a qualified GID provider?
24 A. At least what I remember from the earlier testimony, it
25 said "physician" but that also had the expertise and familiarity

1 with gender identity disorder, I think it was.
2 Q. Did you consider yourself a qualified GID evaluator --
3 A. Yes.
4 Q. -- to assess Ms. Edmo?
5 A. Yes.
6 Q. Why is that?
7 A. Because, you know, I have extensive training in all sorts
8 of mental health disorders, but I have also treated patients
9 with gender identity disorder prior to working in the Department
10 of Corrections.
11 And I don't know how many I had assessed prior to Ms. Edmo
12 at this time, but I'm sure I had assessed at least a handful of
13 inmates with gender identity disorder.
14 Q. Okay. And so let's talk about the subjective section in
15 this note.
16 What -- what did you discuss with Ms. Edmo that was
17 significant to you regarding your assessment for SRS?
18 A. We talked about several things.
19 Can we zoom in on that a little bit?
20 Q. Yeah. Let's zoom in.
21 First, before we talk about that, I believe you indicated
22 this was an SRS assessment; right?
23 A. Yes.
24 Q. Can you elaborate and explain what that means.
25 A. So this is an assessment to determine whether or not

1 surgery was needed to treat her gender dysphoria.
2 Q. Okay. What kind of surgery?
3 A. By "surgery," it's a very blanket term. At this point, we
4 were primarily talking about a surgery to remove the penis and
5 put in a vagina and -- but there are several other surgeries
6 that gender reassignment surgery could entail.
7 Q. Is that a vaginoplasty? Is that what you're referring to?
8 A. Yeah, that's the term for it.
9 Q. I have been learning.
10 So I was asking you about your subjective section.
11 So what was significant in that regarding your conversation
12 with Ms. Edmo?
13 A. Well, what was important? I felt like it was all important
14 because I put it there.
15 Q. Why don't you just go through that with us.
16 A. You know, I felt like -- so she said she was doing all
17 right. And so, subjectively, she felt like things were going
18 well. She was eligible for parole, but this had not been
19 granted because there were multiple DORs. And she had mentioned
20 that she had received DORs for makeup and feminine appearance.
21 And she was really frustrated by this because, I mean, how
22 do you determine if somebody appears too feminine? You know,
23 which makes sense. It's kind of a blurry line; right? But she
24 found that frustrating.
25 And she wanted to discuss sex reassignment surgery. She

1 had been on hormone replacement for the last year-and-a-half but
2 felt that she needed more than just the hormones. And she said
3 that the hormones had helped her gender dysphoria but was still
4 frustrated by her current anatomy, which meant her genitals.
5 And then she said that she had made several attempts to
6 mutilate her genitals the past fall, which means cutting on
7 them, because of that distress that she felt.
8 Q. She reported that to you?
9 A. Yes.
10 Q. Do you have any understanding as to when that may have
11 happened in relation to your meeting here, your appointment?
12 A. I think it was the preceding September or something around
13 there.
14 Q. And what specifically are you referring to?
15 A. Her cutting on her genitals.
16 Q. Okay. So that was several months before?
17 A. Yes.
18 And then she also requested to be assigned to a different
19 housing unit and didn't want to be in the behavioral health unit
20 anymore.
21 And then we both talked about the importance of having
22 intact genitals for a successful sexual reassignment surgery.
23 And I kind of brought that up and talked to her about it, hoping
24 it would be kind of a deterrent to the self-mutilation.
25 And then I also consulted with the prison staff about the

1 inmate's behavior. And they had noted that she seemed pleasant
2 and didn't see any, like, overt depressive symptoms.
3 And I had also seen Ms. Edmo in several different settings
4 and appear her looking -- I say here "did not observe
5 significant dysphoria." In layman's terms, that would mean that
6 she looked pleasant and had a good mood.
7 Q. Okay. And she was on medications at the time of this
8 assessment?
9 A. Yes.
10 Q. And what was she on?
11 A. She was on Effexor and Remeron, which are two different
12 antidepressants.
13 Q. Why was she on those?
14 A. Because of her history of depression.
15 Q. All right. Let's scroll down a little bit.
16 You made some observations; is that right?
17 A. That's right.
18 Q. What observations did you make?
19 A. That she had eyebrows colored in with black pencil. Her
20 hygiene was good. She was wearing foundation. She appeared
21 feminine in demeanor and interaction style. And her thoughts
22 were logical and linear. And she denied any suicidal or
23 homicidal thoughts. And she had no overt delusions, which means
24 she wasn't discussing openly that she was paranoid or...
25 Her affect, which means like her expressed emotions, had a

1 full range, so a healthy range, what were generally euthymic,
2 which means generally pleasant but, yet, frustrated with the
3 whole process, which is what I mean by that, frustrated.
4 And then her speech was regular in rate, rhythm, and
5 volume, which means she had a regular quality of speech and that
6 her mood was, quote, "doing all right."
7 Q. Okay. And then did you make an assessment?
8 A. Yes.
9 Q. And how did you go about making that assessment?
10 A. So I incorporated what I had available to me, which was
11 prior history, my interaction with the patient, her clinicians,
12 and so her regular treating counselors and therapists.
13 Q. Let me stop you there.
14 So you have access to the clinicians' records at that time?
15 A. Oh, yes. I mean, I rely on those heavily.
16 If you look at my notes, they are fairly brief compared to
17 if you looked at some community evaluations or some of the
18 evaluations like in this case, some of the experts who have
19 written. They will have really long evaluations.
20 But in correctional medicine, it's a little bit different
21 because we have access to a wide variety of information right in
22 our system. And the therapist and the clinicians and all of
23 their information is all available to us.
24 Q. And did you review that at this time?
25 A. Yes. And so I incorporated all of that.

1 Q. Okay.
2 A. And then I also staffed this case with multiple people.
3 And what I tried to do is I tried to staff it with people that I
4 thought would come from differing backgrounds and different
5 viewpoints. So I --
6 Q. Why don't we walk through those that you staffed with.
7 A. I staffed it first with Dr. Jeremy Stoddart. I chose him
8 because he was a psychiatrist who wasn't the person doing the
9 evaluation, so it wasn't me.
10 Then I chose Dr. Murray Young, because he was the regional
11 medical director, so he had the medical expertise.
12 And then I chose Jeremy Clark because Jeremy Clark was a
13 WPATH member and had been to several WPATH conferences and was
14 somebody who I felt knew a lot about WPATH and their standards.
15 Q. Okay. And when did you staff this?
16 A. With all those people?
17 Q. Yes.
18 A. Oh, right after I did the -- that day.
19 Q. Okay. And what did -- and you say, "and they agreed with
20 my assessment"; is that right?
21 A. Yes; that's right.
22 Q. And "they" is referring to the various folks that you
23 staffed it with?
24 A. Yes.
25 Q. All right. And you heard Jeremy Clark testify today;

1 correct?
2 A. Yes.
3 Q. And he testified about your conversation with him?
4 A. Uh-huh.
5 Q. Is that a "yes"?
6 A. Yes. Sorry.
7 Q. Okay. What do you recall -- did that refresh your
8 recollection as to your conversation with Mr. Clark?
9 A. Yes, a little bit.
10 Q. And what do you remember about it, if anything?
11 A. This is a couple years ago, so it's a little bit foggy.
12 But I remember beforehand deciding who I wanted to staff it
13 with. And then if my -- if my memory is correct, I was walking
14 out of the prison and walked past Jeremy. And I was like, "Oh,
15 my gosh. I need to talk to you about something." And then we
16 discussed this case.
17 Q. Okay. And do you remember what he --
18 A. And then the other two I called on the phone.
19 Q. Okay. Do you remember what Jeremy Clark said to you at
20 that time?
21 A. Well, the way that medical consultations and staffings like
22 this happen is the person asking for help presents the case;
23 right?
24 So to these three people, I presented Ms. Edmo's case,
25 discussed what I knew about it and discussed, you know, my

1 observations, interactions and then what I thought would be the
2 right choice. And then they would ask questions if they wanted
3 to and then tell me if they agree or disagree or what points
4 they disagree.
5 Q. Okay. What else, if anything, did you do for your
6 assessment?
7 A. You know, I also did research, and I reached out to staff
8 throughout the country.
9 You know, I'm a regional psychiatric director, so that
10 means I'm involved in meetings with psychiatric directors of
11 other states. And I have been to several different NCCHC, which
12 is the national commission on health care for correctional
13 providers.
14 And in those meetings, I've both presented and been to
15 different presentations of people who have struggled with how to
16 treat the transgender population in the prison setting. And
17 it's something that the correctional profession is really trying
18 to grapple with how to do appropriately.
19 And so, you know, I acquired a certain level of expertise
20 about it through all of that. And then I went online, and I
21 searched also for healthcare insurances and looked up Medicare
22 and Medicaid and what they were doing with sex reassignment
23 surgeries and just trying to basically figure out how do you
24 decide this.
25 And, you know, if you read -- there is a second paragraph

1 in my assessment.
2 Q. Why don't you talk to us about that.
3 A. And where I basically talk about how to define medical
4 necessity for sexual reassignment surgery. And I know this is
5 very contested -- this is probably, you know, the whole crux of
6 this --
7 Q. Well, just talk about the facts.
8 A. -- case.
9 But, to me and to many of my colleagues in the correctional
10 healthcare, we don't feel as if the medical necessity for sexual
11 reassignment surgery in the inmate population has been very well
12 defined.
13 Q. Why is that?
14 A. Well, because, you know, in the community, you have the
15 WPATH standards that are fairly clear. And then you have
16 insurance companies and different groups who lay out this
17 criteria for what they think is appropriate for somebody before
18 they can get a sexual reassignment surgery.
19 But the inmate population is a very different population,
20 and it's a very strange environment. And to try to just squeeze
21 every person in the inmate population and say it's exactly the
22 same, it's not; it's very different.
23 And so it's not very well defined. And I think that in
24 each case, you have multiple things you can rely on, but you
25 also -- you rely on these things, and then you also rely on your

1 clinical judgment with the patient sitting in front of you in
2 the correctional environment, and you try to determine if it's
3 well defined -- if it's medically necessary.
4 And here I listed several cases where I thought this would
5 be an example of something which may meet medical criteria for
6 necessity. And I say in here that there was some sort of birth
7 defect or ambiguous genitalia that required some sort of
8 reconstructive or reparative surgery. Or I list in here "severe
9 and devastating dysphoria primarily due to genitals," and say
10 that that could also potentially meet criteria, which is
11 somewhat similar to one of the WPATH standards.
12 THE COURT: Just so I'm clear, Doctor, are you
13 suggesting those three criteria that you point out here would be
14 the things that you think maybe should be added onto the WPATH
15 criteria in the inmate population?
16 THE WITNESS: No, I don't think that's what I was
17 doing. I think primarily what I was doing is I was trying to
18 say: Are there cases when I think it would meet medical
19 necessity? And I am saying, yes, there are cases; and here are
20 a few examples of some cases.
21 THE COURT: So you are suggesting this in lieu of the
22 WPATH criteria for noninmate populations?
23 THE WITNESS: No. I was just -- I was basically
24 trying to come up with a couple examples of cases where I would
25 say there are cases that would meet medical necessity; here are

1 some examples.

2 THE COURT: Did I understand you to say, though, that

3 you felt that the WPATH criteria just doesn't fit comfortably

4 with the inmate population?

5 THE WITNESS: Yeah, depending on how you look at the

6 WPATH standards. Because in the WPATH standards themselves --

7 THE COURT: Let me tell you, to avoid -- I am going to

8 ask you at some point to tell me what you think needs to be

9 changed in the WPATH standards to fit the inmate population. So

10 be thinking about that, or counsel can cover that. Because it's

11 certainly something that's nagging at me a bit.

12 So go ahead, Mr. Eaton.

13 MR. EATON: Maybe one way to at least partially

14 address that is --

15 THE COURT: And we are going to take a break for the

16 evening in about seven minutes. So I don't want to cut -- go

17 ahead. I didn't mean for that question to get you off your

18 stride. We can cover that at a later point. So go ahead.

19 Q. BY MR. EATON: So maybe one way to address that, or at

20 least in part, is: So what ultimately did you conclude with

21 this assessment?

22 A. Ultimately, I concluded that Ms. Edmo did not meet criteria

23 for medical necessity at that time.

24 Q. And why?

25 A. Primarily for two reasons. It was my opinion, number one,

1 that Ms. Edmo's mental health concerns were not fully in
2 adequate control.
3 And then, number two -- and this, to me, was even the more
4 important of the two -- is that I didn't feel like it was doing
5 Ms. Edmo any service to rush through getting gender reassignment
6 surgery in that current social situation.
7 The WPATH standards talk about a 12-month period of living
8 in your identified gender role. And in my knowledge of
9 Ms. Edmo, she had not really done that yet.
10 And although it's -- you know, gender reassignment surgery
11 can be very helpful for people who are transgender and have
12 gender dysphoria, there is a real important study that was done
13 that showed that even in postoperative transgender population,
14 those patients are still very likely -- much more likely than
15 the general population -- to kill themselves.
16 And the author of that paper goes on to say that it's
17 important to note that it's not because gender reassignment
18 surgery is bad; right? She is not saying that in this paper.
19 But what she was saying was that society and people's social
20 networks aren't supporting people enough through their
21 transitions; and that if people are better supported through
22 their transitions, then this huge increase in suicide over the
23 general population could be decreased.
24 And my main goal for my patients -- and primarily in this
25 case, Ms. Edmo -- is to have a happy, healthy life. And I think

1 that Ms. Edmo at this time was parole eligible. She could very
2 soon have been getting out and, at worst-case scenario, I
3 believe, tops out in 2021.
4 And it's my opinion that at this time, that I thought that
5 it would be most helpful to, number one, spend time getting her
6 mental health under better control; and then, number two, to get
7 her to have the experience around her real social network -- her
8 family and friends on the outside -- living as a woman to
9 determine whether or not she felt like that was her real
10 identity and to not make that determination in prison when I
11 felt like she could get out and would get out.
12 Q. And you also in the top -- this first paragraph under
13 assessment, the last couple of lines, you talk about the plan;
14 is that right?
15 A. Okay. Wait. Where are we looking here?
16 Q. The first paragraph with assessment, last couple of lines.
17 A. Okay. Yeah. Where I said --
18 Q. You say, "That being said..." If you could go over that.
19 A. "That being said." Yeah.
20 "That being said, I will continue to monitor and
21 assess this inmate for the medical necessity of SRS
22 throughout their stay here. For the time being, it is
23 my opinion that the combination of hormone treatment
24 and supportive counseling is sufficient for her gender
25 dysphoria."

1 Q. And in this note, did you identify other mental health
2 disorders?
3 A. Yes.
4 Q. And what did you identify?
5 A. Down below, you can see it says "MDD," which stands for
6 major depressive disorder, and also alcohol use disorder.
7 Q. And so what happened after you completed this assessment?
8 Do you know?
9 A. So after I completed this assessment, it was -- it weighed
10 heavily on my mind. And I -- I met with Ms. Edmo again soon
11 thereafter. And I had decided that I didn't want to, like, be
12 the lone person saying no for something that was this
13 potentially important and something that was very political and
14 something that I thought I needed some help.
15 And so I decided to form a committee of physicians who
16 could be trained on how to decide whether or not sexual
17 reassignment surgery was necessary.
18 So I met with Ms. Edmo, and I said, "Hey, so we're going to
19 do this differently. We're going to form a committee." And I
20 told her about the committee.
21 And then I put together a training with Dr. Stephen
22 Levine -- Levine.
23 Q. How did that training come about?
24 A. Well, he had been identified to me as someone who was an
25 expert in the field and also had some correctional experience,

1 and that it was in an NCCHC training and from the Department of
2 Corrections from Massachusetts who had been, you know, recently
3 sued about the same kind of issue and that they consulted
4 frequently with Dr. Levine, from Case Western.
5 And so I reached out to Dr. Levine on my own and said,
6 "Hey, how would you like to come out and do a day-long training
7 to me and some fellow physicians?" And he agreed to do it.
8 And then we opened that up to also the Department of
9 Corrections, and the MTC committee members also attended that.
10 And so the plan was to make this committee to help me
11 determine medical necessity for sexual reassignment surgery.
12 And I had identified several different physicians that were
13 going to be on it. They all came. They got trained.
14 Q. And I have a note for that. So let's pull up the --
15 THE COURT: Counsel, we're right at where we take the
16 break. I'll let you follow up with these questions, and then
17 we'll have to take the break.
18 MR. EATON: Okay. Thank you.
19 Q. BY MR. EATON: So there is a Levine list of attendees.
20 Is this what you're talking about?
21 A. Yes.
22 Q. And are those people that you understand attended the
23 Levine presentation?
24 A. Yes, that's right.
25 Q. And there has been some testimony in this case by experts

1 that Levine was an outlier, maybe didn't, like, follow or was
2 not a member of the WPATH.
3 Did you appreciate that at the time?
4 A. You know, I think probably determining if someone is an
5 outlier depends on where you start from. But Dr. Levine, at
6 least from my experience, is not at all someone who is opposed
7 to gender reassignment surgery.
8 And he has, I think, 35 or more years in running a
9 transgender health clinic and is very successful and very well
10 liked by his patients and frequently recommends gender
11 reassignment surgery.
12 And so in the presentation that he gave that day, I never
13 once felt like he was saying don't give inmates gender
14 reassignment surgery. I do feel like he might have posed some
15 questions to say, like, here are some --
16 MS. SHANBHAG: Objection. Hearsay.
17 THE COURT: Just a moment. I'm sorry. I was not
18 thinking along those lines.
19 Well, the witness is characterizing what his understanding
20 of the message, not necessarily what was actually said. The
21 witness can be cross-examined on that assessment, I think,
22 without getting into the substance. So I'll allow it.
23 The objection is overruled, but it is a close question.
24 Is it Ms. Shanbhag?
25 MS. SHANBHAG: Shanbhag, yes.

1 THE COURT: Shanbhag. Okay. I apologize. I wanted
2 to make sure I had that right.
3 Go ahead. But, again, you have got about one or two more
4 questions, and then we'll have to call it a day.
5 MR. EATON: Okay.
6 Q. BY MR. EATON: You were talking about --
7 A. I'm going to say --
8 Q. Hold on. You were talking about your impressions with --
9 A. -- that I never once felt like he didn't want inmates to
10 receive gender reassignment surgery, and would oftentimes pose
11 some opposing arguments to why it might not be a safe option or
12 might not be a good option but would also talk about how it was
13 necessary.
14 Q. Are you aware of whether Corizon received other trainings
15 from other people regarding gender dysphoria?
16 A. Yes. After that, one of the attendees, Dr. Stoddart, said
17 he worked with the local physician who treated the majority of
18 the transgender population in Boise and offered to get him to
19 come and present education.
20 MS. SHANBHAG: Objection.
21 THE COURT: Just a moment.
22 MS. SHANBHAG: Hearsay.
23 THE COURT: Sustained.
24 The witness can testify as to what he did or didn't do.
25 But what someone said, I mean, unless it has independent

1 relevance, would be hearsay.
2 Q. BY MR. EATON: Did you attend any other trainings regarding
3 gender dysphoria through Corizon other than the Levine
4 presentation?
5 A. Yes. There was a presentation by a Dr. Alviso from here in
6 town.
7 Q. And what was your understanding of that presentation?
8 A. Dr. Alviso talked about his experience in the treatment of
9 the transgender population and how he treated them.
10 Q. Okay. And did you appear for that?
11 A. I attended by phone.
12 MR. EATON: Okay. Your Honor, I know you're wanting
13 to call it. So I can --
14 THE COURT: I think we can't get Dr. Eliason done
15 today, unfortunately. And I hope you are feeling better,
16 Dr. Eliason.
17 Counsel, let's take a break. We'll recess [*sic*] at 8:30.
18 I think I kind of messed up the clock by asking questions that
19 can't be charged to anyone. So I'll have Mr. Severson visit
20 with counsel and see how much time we need to spend tomorrow to
21 give you the allotted time. But we do need to wrap up tomorrow
22 because, as I said, I'm going to be in trial for the next three
23 week on different matters. So if we can't wrap it up tomorrow,
24 we would have to come back more than a month from now.
25 All right. We will be in recess, then, until 8:30 tomorrow

1 morning.

2 (Court recessed at 3:22 p.m.)

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1 CERTIFICATE OF OFFICIAL REPORTER
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6 I, Tamara Hohenleitner, Federal Official Realtime
7 Court Reporter, in and for the United States District Court for
8 the District of Idaho, do hereby certify that pursuant to
9 Section 753, Title 28, United States Code, that the foregoing
10 is a true and correct transcript of the stenographically
11 reported proceedings held in the above-entitled matter and that
12 the transcript page format is in conformance with the
13 regulations of the Judicial Conference of the United States.
14
15 Dated this 19th day of October, 2018.
16
17
18 /S/ TAMARA I. HOHENLEITNER
19 TAMARA I. HOHENLEITNER, CSR NO. 619, CRR
FEDERAL OFFICIAL COURT REPORTER
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Case Nos. 19-35017 and 19-35019

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

ADREE EDMO,
Plaintiff-Appellee,
v.
IDAHO DEPARTMENT OF CORRECTIONS, ET AL.,
Defendants-Appellants.

On Appeal from Orders of the United States District Court
For the District of Idaho
(No. 1:17-cv-00151-BLW)

EXCERPTS OF RECORD
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Lawrence G. Wasden,
Attorney General State of Idaho
Brady J. Hall,
Special Deputy Attorney General
Marisa S. Crecelius
Moore Elia Kraft & Hall, LLP
P.O. Box 6756
Boise, ID 83707
(208) 336-6900
brady@melawfirm.net
marisa@melawfirm.net
Attorneys for Defendants-Appellants Idaho Department of Corrections, Henry Atencio, Jeff Zmuda, Howard Keith Yordy, Richard Craig, and Rona Siegert

Dylan Eaton
J. Kevin West
Parsons Behle & Latimer
800 West Main Street
Suite 1300
Boise, ID 83702
(208) 562-4900
Deaton@parsonsbehle.com
KWest@parsonsbehle.com
Attorney for Defendants-Appellants Corizon, Inc., Scott Eliason, Murray Young, and Catherine Whinnery

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The Shoshone-Bannock Tribes
Counseling & Family Services
PO Box 306 Fort Hall, Idaho 83203
208-237-5631
INTAKE ASSESSMENT

Client Name:	**Mason D Meeks Edmo**		
Client Address:	**RR 2 Box 169T**		
	Pocatello, Idaho 83202		
Client Phone:	**(208) 840-0437**	**Client ID#:**	**12555**
Client SS#:		**Date of Admission:**	**05/19/2011**
Interview Date:	**05/19/2011**	**Needed By:**	**05/19/2011**

PRESENTING SITUATION

Mason Meeks Edmo is a 23-year-old American Indian male born on October 29, 1987. He said he considers himself part of the Shoshone-Bannock. He said his religious preference is Christian. Mr. Meeks Edmo has lived at the address listed above, which is owned by him or his family, for 20 years, but he has been in psychiatric treatment four of the last 30 days.

Voluntary hospitalization at PBH for 4 days, following a suicide attempt. The suicide attempt was on 5-15-11, he was drinking and tried to OD. His sister's boyfriend found him, he was tranported by ambulance. This was his 2nd suicide attempt, last attempt was in July of 2010, that was with a knife on his arm.

MEDICAL STATUS

Mr. Meeks Edmo said he has been hospitalized two times in his life for medical problems. His most recent hospitalization was one month ago for suicide attempt. He reported no chronic medical problems that interfere with his life, but said he takes Cylexa on a regular basis for Antidepressant. He said he receives no financial compensation for a physical disability. Mr. Meeks Edmo said he has experienced medical problems during four of the past 30 days. He reported feeling considerably troubled by medical problems in the last 30 days, but he expressed no need for medical treatment.

His hospitalization was for the suicide attempt. Other than that he is pretty healthy.

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EMPLOYMENT/SUPPORT STATUS

Mason Meeks Edmo said he has completed 11 years of education and an additional 12 months of training or technical instruction. He named Nursing, CNA program, didn't finish as his profession, trade or skill, and said his usual or last occupation was as a Records technician. He said he has a valid driver's license but does not have an automobile available for use.

Mr. Meeks Edmo said his longest full-time job lasted two years. He described his usual employment pattern as being unemployed, and reported no gross income for last year. Mr. Meeks Edmo said he earned no wages during the past 30 days. However, he reported receiving the following amounts of money from the sources listed below during this time period:

$ 200 welfare
$ 100 mate, family or friends

According to Mr. Meeks Edmo, his Mom & sister contributes to his financial support, and this support constitutes the majority of his income. He said no one depends on him for the majority of their food, shelter and other needs. He reported feeling extremely troubled by employment problems in the past 30 days and sees himself as having an extreme need for employment counseling.

Working with Voc Rehab program in Pocatello, has been working with them since Feb. 2011.

DRUG/ALCOHOL USE

Mr. Meeks Edmo said his first use of a substance was at the age of 17 when he tried alcohol, beer. He admitted to using the following substances during the past 30 days:

alcohol-any use at all -10 days
alcohol-to intoxication - 8 days

He admitted to using the following substances on a regular basis in his lifetime:

alcohol-any use at all - 7 years
alcohol-to intoxication - 7 years
amphetamines - 1 year
cannabis - 2 years

He said he has never used a needle to administer drugs, and does not consider himself an I.V. drug user. A problem with alcohol was identified by the interviewer during the assessment interview. Mr. Meeks Edmo said his last voluntary abstinence from his drug of choice lasted

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for three months and this abstinence ended one month ago. He said he has had delirium tremens on three occasions, and he has overdosed on drugs one time. Mr. Meeks Edmo said he was treated for alcohol abuse one time. He also said one of these times was for detoxification from alcohol. According to Mr. Meeks Edmo, he last attended 120 days of inpatient treatment three months ago at Cottonwood, North Idaho Correctional Ins, Cottonwood. He said he successfully completed the treatment. He stated he was last evaluated for alcohol/drugs at Cottonwood on or about June 21, 2010.

Mr. Meeks Edmo reported spending $20 on alcohol during the past 30 days. He said he has received no outpatient counseling, nor has he attended AA/NA during this time period. He reported no drug problems in the past 30 days; however, he reported 10 days of alcohol problems during the same time period. Mason said he has been extremely bothered by alcohol problems and not bothered by drug problems during the past 30 days. He said he sees an extreme need for alcohol treatment and does not see a need for drug treatment.

Mason is scheduled for an intake at FDTC next week.

LEGAL STATUS

Mr. Meeks Edmo admitted to being charged with the following crimes during his life:

shoplifting/vandalism/theft 1 time
parole/probation violations 4 times
other crimes 1 time

He also admitted he was under the influence of drugs and/or alcohol when committing the following crimes:

parole/probation violations
other crimes

He said one of these charges resulted in a conviction. Mr. Meeks Edmo reported six charges for public intoxication, three charges for driving while intoxicated and one charge for minor in possession. According to Mr. Meeks Edmo, he has been incarcerated a total of 12 months in his life. His most recent incarceration, which was for other crimes, lasted zero months. He said he is currently on probation. He described his legal problems as extremely serious, and said counseling or referral for these legal problems is extremely important.

On probation with the State for three year, it started June of 2010. He has to take aftercare completion program and come in for counseling at FDTC and AA meetings.

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FAMILY HISTORY

Mason Meeks Edmo said the following members on his mother's side of the family have had significant problems with:

grandfather: -alcohol
mother: -alcohol
aunt: -alcohol -drugs -psychiatric
uncle: -alcohol

He reported the following members on his father's side of the family have had significant problems with:

grandfather: -alcohol -drugs -psychiatric
father: -alcohol -drugs -psychiatric

He said his siblings have had significant problems with:

sister #1: -alcohol
sister #2: -psychiatric

Mr. Meeks Edmo said he has one brother and two sisters.

Refer to Genogram.

FAMILY/SOCIAL RELATIONSHIPS

Mr. Meeks Edmo, who has been single, said he is not satisfied with this situation. He reported having no children. He said he has been living primarily alone for the past three years and said he is satisfied with these circumstances. He said he lives with someone who has a current alcohol problem.

Mr. Meeks Edmo reported having five close friends, and said he has had close, reciprocal relationships with his:

mother
brothers/sisters
sexual partner
friends

He said he spends most of his free time with family and is satisfied with spending free time this way. Mason considers English to be his first language. He reported he does not

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understand or speak his native language. According to Mason, he has not been given his Indian name. He said he was raised on the reservation, which he described as a positive experience because It has been good and bad, it was good because he lived with his family but he got caught up in reservation life with partying. Mason reported that he or a family member attended a boarding school, an experience he said was a positive one because Mason went to Sherman Indian High School- he liked it he went for 10th and 11th grade. It was his choice to go to boarding school and he liked it but came back to work and chose that over finishing his education. He finished his GED in 2005. According to Mr. Meeks Edmo, he has experienced serious problems in the past 30 days with his:

father
Grandma

He reported that during his lifetime he has experienced serious problems getting along with his:

mother
father
sexual partner/spouse
Grandma
close friends

He also suggested that alcohol and/or drugs have negatively impacted his relationships with his:

mother
sexual partner/spouse
Grandma
close friends

Mr. Meeks Edmo reported no abuse in the past 30 days. He said that during his lifetime he has been abused:

emotionally by a significant family member

He reported no serious conflicts with family members or others in the past 30 days. Mason said he is not at all bothered by social or family problems. He indicated that treatment or counseling would not be important for his social or family problems.

Mason lives with his mom and has for the last year, prior to that he lived on his own for the past three years.

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PSYCHIATRIC STATUS

Mr. Meeks Edmo said he has been treated for psychological difficulties on one occasion. He reported having experienced the following psychological problems during the past 30 days:

serious depression
serious anxiety or tension
trouble understanding, concentrating or remembering

He said he has experienced serious thoughts of suicide in the past 30 days and has attempted suicide during this time period. According to the client, he has been prescribed medication for a psychological/emotional problem in the past 30 days.

Mr. Meeks Edmo reported having experienced the following psychological problems during his lifetime:

serious depression
serious anxiety or tension
trouble understanding, concentrating or remembering

He also said he has experienced serious thoughts of suicide during his lifetime and has attempted suicide in the past. He reported experiencing psychological or emotional problems 30 days in the past 30. Mr. Meeks Edmo said he has been extremely troubled by psychological or emotional problems in the last 30 days, and he expressed an extreme need for treatment for these problems.

Mason was just d/c from PBH today and he has came in for a followup appointment, this is his first time coming in for counseling.

SPIRITUALITY

Mason expressed belief in the Creator and described his relationship with his Creator as good relationship. He said he is comfortable with his spirituality. He described the spiritual teachings he has been given as Sweats and Christian bible teachings. and said these have influenced his life by The influence his positively, they help him feel like there is more hope out there. He reported that he attends both church and traditional ceremonies and that he last attended on About a year ago. According to Mason, he participates in the sweatlodge ceremony and Bible readings., and he said they are important to him because Helps him gain hope. Mason said he consults neither medicine people nor traditional practitioners when he needs help. Asked how the use of alcohol and/or drugs has affected his spirituality, he responded "It makes him tear away from them."

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INTERVIEWER'S ASSESSMENT

Mason is a 23 yo male. He was discharged from Portneuf Behavioral Health, where he spend 4 days on a voluntary basis, following a suicide attempt. He has a history of alcohol abuse and last year spend 4 months on a rider at Cottonwood. He is now on 3 years probation and will need to attend outpatient counseling as a term of that probation. He lives at home with his mom, and has a close relationship with her. He also states he has 5 close friends and currently is not in a relationship. He would like to attend counseling to address his emtional concerns.

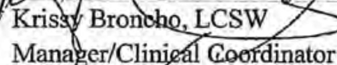
DIAGNOSTIC IMPRESSION

DSM-IV		
Axis I	296.32	Major Depressive Disorder, Recurrent, Moderate 303.90 Alcohol Dependence
Axis II	799.9	Diagnosis Deferred on Axis II
Axis III		None reported.
Axis IV		Problem related to Primary support group and legal system as well as employment issues.
Axis V	57	
	57	

RECOMMENDATION FOR TREATMENT

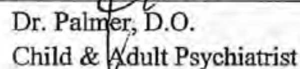
Ct. will go to FDTC for an alcohol evaluation. He will start individual counseling with AMarshall and will f/u with Dr. Palmer for medication evaluation.

Care Level Recommendations: Level I - Outpatient treatment.



5/9/11

Krissy Broncho, LCSW — Date
Manager/Clinical Coordinator



25 May 11

Dr. Palmer, D.O. — Date
Child & Adult Psychiatrist

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********** CONFIDENTIAL PATIENT INFORMATION **********

PCC BEHAVIORAL HEALTH ENCOUNTER RECORD Printed: May 26, 2011@17:35:25

*** Computer Generated Encounter Record ***

****

Date: May 19, 2011 Primary Provider: BRONCHO,KRISSY
Arrival Time: 13:00
Program: MENTAL HEALTH
Clinic: MENTAL HEALTH Appointment Type: APPOINTMENT

Community: FT HALL TWNS Number Served: 1 Activity/Service Time: 120 minutes
Activity: 12-ASSESSMENT/EVALUATION-PATIENT PRESENT
Type of Contact: OUTPATIENT

CHIEF COMPLAINT/PRESENTING PROBLEM: New intake, f/u from d/c from PBH.

S/O/A/P:
S: Ct. stated, "I took a bunch of pills and my sister boyfriend found me...I had to be in the ICU for a while before I went to the behavioral unit."
O: Ct. was dressed in jeans and a black sweatshirt. He was on time for the appt. and asked if he could make a call on his ride when the appt. was almost done.
A: Ct. was very open during the assessment, he just got done doing a rider in Cotton Wood for alcohol related charges. He stated this was his 2nd suicide attempt and that he really wanted help now.
P: Ct. completed intake assessment he will come back and see AMarshall for individual therapy.

PROVIDER SIGNATURE: /es/ Krissy Broncho
Signed: May 26, 2011 17:35:19

COMMENT/NEXT APPOINTMENT:

BH POV CODE OR DSM DIAGNOSIS	PURPOSE OF VISIT (POV) [PRIMARY ON FIRST LINE]
311.	DEPRESSIVE DISORDER NOS
305.00	ALCOHOL ABUSE, UNSPECIFIED

MEDICATIONS PRESCRIBED:

PROCEDURES (CPT):

****

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********** CONFIDENTIAL PATIENT INFORMATION **********
PCC BEHAVIORAL HEALTH ENCOUNTER RECORD   Printed: May 26, 2011@17:39:04
*** Computer Generated Encounter Record ***

Date: May 25, 2011   Primary Provider: MARSHALL,JESSIE A
Arrival Time: 11:00
Program: MENTAL HEALTH
Clinic: MENTAL HEALTH   Appointment Type: APPOINTMENT

Community: FT HALL TWNS   Number Served: 1   Activity/Service Time: 30 minutes
Activity: 13-INDIVIDUAL TREATMENT/COUNSEL/EDUCATION-PT PRESENT
Type of Contact: OUTPATIENT

CHIEF COMPLAINT/PRESENTING PROBLEM: New client for writer, depression and alcohol depend.

S/O/A/P:
S: "I want to stop drinking, I am just sick and tired of it." Client was alert and oriented.

O: Client came to CFS about 15 minutes late for appt. Clients mood was serious, affect congruent with mood. Client was pleasant and cooperative. Expressed the need to help himself get better, change his friendships, seek alcohol treatment and would like to go out of state for treatment. Client has good support from his mother and sister.

A: Client admitted he has a problem with alcohol and has two serious suicide attempts r/t his use of alcohol and lack of coping skills when things take a downward spiral.

P: Will cont. to meet with client for support and offer coping skills. Will cont. to gain trust and build rapport. Client will f/u with FDTC and Voc-Rehab. He will also consult with Dr. Palmer as the citalopram is causing an increase in anxiety and lack of sleep.

PROVIDER SIGNATURE: /es/ J. Annie Marshall, MSW
Signed: May 26, 2011 17:38:54

COMMENT/NEXT APPOINTMENT:

BH POV CODE OR DSM DIAGNOSIS	PURPOSE OF VISIT (POV) [PRIMARY ON FIRST LINE]
296.32	MAJOR DEPRESSIVE DISORDER, RECURRENT, MODERATE
303.90	ALCOHOL DEPENDENCE, UNSPECIFIED

EDMO,MASON D   HRN: 12555 DOB: May 25, 2011

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BROWSE PATIENT'S VISITS   Jul 13, 2018 08:23:42

Patient Name: EDMO,MASON D   DOB:
HRN: 12555

****

Visit Date: Jul 14, 2011@16:13   Provider: PALMER,KELLY
Activity Type: INDIVIDUAL BH EHR VISIT   Type of Contact: OUTPATIENT
Location of Encounter: FORT HALL TRIBAL PROGRAMS
Chief Complaint/Presenting Problem:
POV's:
V68.9   Cancelled appt

TIU DOCUMENTS

TIU DOCUMENT: BEHAV HEALTH
AUTHOR: PALMER,KELLY
SIGNED BY: PALMER,KELLY   STATUS: COMPLETED
LOCATION: AA CFS
Patient Name: EDMO,MASON D   Patient HRN: 01-25-55 Visit Date: 07/14/11
16:13

POV: Cancelled appt;

****
****

Meds prescribed today:

Comments (if any):
/es/ KELLY DO PALMER
Signed: JUL 14, 2011@16:14:15

COMMENT/NEXT APPOINTMENT:

Medications Prescribed:
****

Visit Date: Jul 06, 2011@11:40   Provider: BACON,ANNIE
Activity Type: INDIVIDUAL TREATMENT/COUNSEL Type of Contact: OUTPATIENT
Location of Encounter: FORT HALL TRIBAL PROGRAMS
Chief Complaint/Presenting Problem: No show
POV's:
8   FAILED APPOINTMENT/NO SHOW

SUBJECTIVE/OBJECTIVE:
CLient did not show for appt. Incarcerated in Bannock County.

COMMENT/NEXT APPOINTMENT:

Medications Prescribed:

****

Visit Date: Jun 09, 2011@08:55   Provider: BACON,ANNIE

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Activity Type: INDIVIDUAL TREATMENT/COUNSEL Type of Contact: OUTPATIENT
Location of Encounter: FORT HALL TRIBAL PROGRAMS
Chief Complaint/Presenting Problem: No SHow

POV's:
8 FAILED APPOINTMENT/NO SHOW

SUBJECTIVE/OBJECTIVE:
Client did not show or call to reschedule appt.

COMMENT/NEXT APPOINTMENT:

Medications Prescribed:

****

Visit Date: Jun 02, 2011@16:06 Provider: PALMER,KELLY
Activity Type: INDIVIDUAL BH EHR VISIT Type of Contact: OUTPATIENT
Location of Encounter: FORT HALL TRIBAL PROGRAMS
Chief Complaint/Presenting Problem:
POV's:
296.32 MENTAL HEALTH

TIU DOCUMENTS

TIU DOCUMENT: BEHAV HEALTH
AUTHOR: PALMER,KELLY
SIGNED BY: PALMER,KELLY STATUS: COMPLETED
LOCATION: AA CFS
Patient Name: EDMO,MASON D Patient HRN: 01-25-55 Visit Date: 06/02/11 16:06

POV: MENTAL HEALTH;

****
****

Meds prescribed today:
CITALOPRAM TAB 40MG TAKE ONE-HALF (1/2) TABLET BY MOUTH EVERY DAY AVOID ALCOHOL Quantity: 15 Refills: 0
FLUOXETINE CAP,ORAL 10MG TAKE ONE (1) CAPSULE BY MOUTH EVERY DAY AVOID ALCOHOL Quantity: 30 Refills: 3 Dispense as Written: NO *UNSIGNED*

Comments (if any):
/es/ KELLY DO PALMER
Signed: JUN 02, 2011@16:09:29

Addendum
AUTHOR: DIXEY,WANDA
SIGNED BY: DIXEY,WANDA STATUS: COMPLETED
LOCATION: AA CFS
Chief Complaint: Depression, alcohol abuse

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ID: 23 year old male hospitalized ~10 days ago after and overdose attempt with Elavil and alcohol. Pt reported he was intoxicated and has no memory of event. Hospital x 5 days. Started on Celexa but felt it increase anxiety so stopped. Now complains of depression but no SI. Currently on probation, attends aftercare program. Evaluation with Four Directions. No enjoyment. Reported supportive parent. No manic. Occassional panic like symptoms "when I worry." Increase HA, no BROW

delusions. Denied abuse as a child. Alcohol abuse.

PMH: good health, NKMA
FH: anxiety, depression
Develoop: grad HS, college started, would like to be RN

MSE- AFO, mood depressed, no SI, no SH, no psychosis.

F/u with Annie for counseling
Prozac
4-6 weeks follow up
/es/ WANDA DIXEY
Signed: JUN 03, 2011@12:15:36

COMMENT/NEXT APPOINTMENT:

Medications Prescribed:
****

Visit Date: May 27, 2011@09:00 Provider: ORTIZ,SANDRA
Activity Type: INFORMATION AND/ OR REFERRAL Type of Contact: OUTPATIENT
Location of Encounter: FORT HALL TRIBAL PROGRAMS
Chief Complaint/Presenting Problem:
POV's:
8 FAILED APPOINTMENT/NO SHOW

SUBJECTIVE/OBJECTIVE:
D.CLIENT WAS REFERAL FROM PORTNUEF MEDICAL CENTER ON 5/19/2011. CLIENT WAS IN THE HOSPITAL FOR SUICIDAL IDEALATION WHILE UNDER THE INFLUENCE OF ALCOHOL.

A.CLIENT DID MAKE HIS APPT TO HAVE AN ASSESSMENT TODAY WITH COUNSELOR SANDRA ORTIZ. A SPECIAL TIME WAS MADE 5/27/2011 TO COMPLETE THE ASSESSMENT. HOWEVER CLIENT WAS A NOS SHOW.

CLIENT HAD COMPLETED AN INTAKE ON JULY 19, 2010 WITH COUNSELOR DAN FORKENBROCK. HE HAS MADE SEVERAL APPTS IN THE PAST AND WAS NO SHOW.

P.CLIENT WIL FOLLOW TREATMENT PLAN.

COMMENT/NEXT APPOINTMENT:

Medications Prescribed:
****

Visit Date: May 25, 2011@11:00 Provider: BACON,ANNIE
Activity Type: INDIVIDUAL TREATMENT/COUNSEL Type of Contact: OUTPATIENT
Location of Encounter: FORT HALL TRIBAL PROGRAMS
Chief Complaint/Presenting Problem: New client for writer, depression and alcohol depe

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nd.
POV's:
  296.32   MAJOR DEPRESSIVE DISORDER, RECURRENT, MODERATE
  303.90   ALCOHOL DEPENDENCE, UNSPECIFIED

SUBJECTIVE/OBJECTIVE:
S: "I want to stop drinking, I am just sick and tired of it." Client was alert and oriented.

O: Client came to CFS about 15 minutes late for appt. Clients mood

was serious, affect congruent with mood. Client was pleasant and cooperative. Expressed the need to help himself get better, change his friendships, seek alcohol treatment and would like to go out of state for treatment. Client has good support from his mother and sister.

A: Client admitted he has a problem with alcohol and has two serious suicide attempts r/t his use of alcohol and lack of coping skills when things take a downward spiral.

P: Will cont. to meet with client for support and offer coping skills. Will cont. to gain trust and build rapport. Client will f/u with FDTC and Voc-Rehab. He will also consult with Dr. Palmer as the citalopram is causing an increase in anxiety and lack of sleep.

COMMENT/NEXT APPOINTMENT:

Medications Prescribed:

****

Visit Date: May 24, 2011@09:00   Provider: BURRELL,DREW
Activity Type: ASSESSMENT/EVALUATION-PATIEN Type of Contact: OUTPATIENT
Location of Encounter: FORT HALL TRIBAL PROGRAMS
Chief Complaint/Presenting Problem: Provider cancelled-re-scheduled
POV's:
  8.2   PROVIDER CANCELLED, RESCHEDULED

SUBJECTIVE/OBJECTIVE:
Provider out for sick leave-pt rescheduled for next day.

COMMENT/NEXT APPOINTMENT:

Medications Prescribed:

****

Visit Date: May 19, 2011@13:00   Provider: BRONCHO,KRISSY
Activity Type: ASSESSMENT/EVALUATION-PATIEN Type of Contact: OUTPATIENT
Location of Encounter: FORT HALL TRIBAL PROGRAMS
Chief Complaint/Presenting Problem: New intake, f/u from d/c from PBH.
POV's:
  311.   DEPRESSIVE DISORDER NOS
  305.00   ALCOHOL ABUSE, UNSPECIFIED

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SUBJECTIVE/OBJECTIVE:
S: Ct. stated, "I took a bunch of pills and my sister boyfriend found me...I had to be in the ICU for a while before I went to the behavioral unit."
O: Ct. was dressed in jeans and a black sweatshirt. He was on time for the appt. and asked if he could make a call on his ride when the appt. was almost done.
A: Ct. was very open during the assessment, he just got done doing a rider in Cotton Wood for alcohol related charges. He stated this was his 2nd suicide attempt and that he really wanted help now.
P: Ct. completed intake assessment he will come back and see AMarshall for individual therapy.

COMMENT/NEXT APPOINTMENT:

Medications Prescribed:

****

Visit Date: Apr 13, 2011@14:00 Provider: WADSWORTH,MATT J
Activity Type: ASSESSMENT/EVALUATION-PATIEN Type of Contact: OUTPATIENT
Location of Encounter: FORT HALL TRIBAL PROGRAMS
Chief Complaint/Presenting Problem: intake/self-referral
POV's:
8 FAILED APPOINTMENT/NO SHOW

SUBJECTIVE/OBJECTIVE:
Ct. did not attend his appt. or call in to resch.

COMMENT/NEXT APPOINTMENT:

Medications Prescribed:

****

Visit Date: Sep 30, 2010@01:00 Provider: BRONCHO,KRISSY
Activity Type: ASSESSMENT/EVALUATION-PATIEN Type of Contact: OUTPATIENT
Location of Encounter: FORT HALL TRIBAL PROGRAMS
Chief Complaint/Presenting Problem: Client did not show/reschedule
POV's:
8 FAILED APPOINTMENT/NO SHOW

SUBJECTIVE/OBJECTIVE:

COMMENT/NEXT APPOINTMENT:

Medications Prescribed:

****

Visit Date: Aug 19, 2010@13:00 Provider: BURRELL,DREW
Activity Type: ASSESSMENT/EVALUATION-PATIEN Type of Contact: OUTPATIENT

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Location of Encounter: FORT HALL TRIBAL PROGRAMS
Chief Complaint/Presenting Problem: Intake Assessment-No Show
POV's:
  8        FAILED APPOINTMENT/NO SHOW

  SUBJECTIVE/OBJECTIVE:
  Ct called previously and apologized for missing appointment and
  rescheduled for today.  Ct again missed appointment, no call, no show.

  COMMENT/NEXT APPOINTMENT:


Medications Prescribed:
  BROWSE PATIENT'S VISITS                              Jul 13, 2018 08:23:42
                              Page:   6 of   7
+------------------------------------------------------------------------------
*******************************************************************************

Visit Date: Aug 13, 2010@08:00             Provider: BURRELL,DREW
Activity Type: ASSESSMENT/EVALUATION-PATIEN Type of Contact: OUTPATIENT
Location of Encounter: FORT HALL TRIBAL PROGRAMS
Chief Complaint/Presenting Problem: Intake Assessment-No Show
POV's:
  8        FAILED APPOINTMENT/NO SHOW

  SUBJECTIVE/OBJECTIVE:


  COMMENT/NEXT APPOINTMENT:


Medications Prescribed:

*******************************************************************************

Visit Date: Jul 19, 2010@13:30             Provider: FORKENBROCK,DANIEL
Activity Type: SCREENING-PATIENT PRESENT    Type of Contact: OUTPATIENT
Location of Encounter: FORT HALL TRIBAL PROGRAMS
Chief Complaint/Presenting Problem:
POV's:
  29.1     SCREENING FOR ALCOHOLISM
  29.2     SCREENING FOR DRUG ABUSE

  SUBJECTIVE/OBJECTIVE:
  D - Ct was on time for intake
  A - Ct read, discussed, and signed all intake paperwork, and completed
  AAIR & GPRA
  P - Ct will make an appointment with Sandra Ortiz for an assessment

  COMMENT/NEXT APPOINTMENT:

Medications Prescribed:
*******************************************************************************

Visit Date: Dec 17, 2009@13:30             Provider: ORTIZ,SANDRA
Activity Type: ASSESSMENT/EVALUATION-PATIEN Type of Contact: OUTPATIENT
Location of Encounter: FORT HALL TRIBAL PROGRAMS
Chief Complaint/Presenting Problem:
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POV's:
8 no show

SUBJECTIVE/OBJECTIVE:
d.client had a schduled assessment today at 1:30pm.
a.client was a no show for his assessment.
p.client will need to contact FDTC for services.

COMMENT/NEXT APPOINTMENT:

Medications Prescribed:
****

Visit Date: Nov 26, 2003@10:00 Provider: BACON,ANNIE
Activity Type: ASSESSMENT/EVALUATION-PT NOT Type of Contact: OUTPATIENT
Location of Encounter: FORT HALL TRIBAL PROGRAMSBROWSE PATIENT'S VISITS

+--

Chief Complaint/Presenting Problem:
POV's:
8 FAILED APPOINTMENT/NO SHOW

SUBJECTIVE/OBJECTIVE:

COMMENT/NEXT APPOINTMENT:
This is a follow up on an outreach call placed to client and his mother on 11/24/03. This worker received a phone call from Portneuf ER, social worker, Star Baird. Client was transported to Portneuf ER via ambulance for an apparent overdose. Alcohol was a factor. This worker made contact with client on 11/25/03. He agreed to complete an intake and follow up with therapy. Client scheduled for an intake on this day and was a no show, he did not call to reschedule.

Medications Prescribed:
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Portneuf MEDICAL CENTER

MRN: 000287606
Visit ID #: II
Attending : EHAB ABDALLAH
Name: MEEKS EDMO, MASON
DOB: Gender: M Age: 23
Admit Date: 05/16/2011

PORTNEUF MEDICAL CENTER BHU DISCHARGE SUMMARY

DATE OF DISCHARGE: 05/19/2011

ADMISSION DIAGNOSES
Axis I:
Alcohol dependence.
Depressive disorder, not otherwise specified, versus substance-induced mood disorder.

Axis II:
Deferred.

Axis III:
Elevated glucose level and liver function tests on admission.

Axis IV:
Social stressors.
Financial and occupational stressors.

Axis V:
Global assessment of functioning of 40.

DISCHARGE DIAGNOSES
Axis I:
Alcohol dependence.
Depressive disorder, not otherwise specified.

Axis II:
Deferred.

Axis III:
None.

Axis IV:
Social, financial, and occupational stressors.

Axis V:
Global assessment of functioning of 50.

REASON FOR ADMISSION/BRIEF HISTORY
The patient is a 23-year-old Native American male who, while intoxicated, was suicidal and took an amitriptyline overdose. He was brought to the emergency department when found to have decreased responsiveness by a family member, placed in the ICU until he was medically stable, and then transferred to the Behavioral Health Unit. On intake at Behavioral Health, he reported that he had been depressed lately (which he rated 6/10), but had not noted any

MRN: 000287606
Visit ID #: II
Attending : EHAB ABDALLAH
Name: MEEKS EDMO, MASON
DOB: Gender: M Age: 23
Admit Date: 05/16/2011

significant changes in the pleasure he gets from things that interest him, reported that his appetite, sleep, and concentration were normal. He reported feeling guilty and worthless. He denied any manic symptoms. He reported his stressors as a tumultuous relationship he has had with his boyfriend, no job, disappointments while looking for a job over the last year, and financial struggles. He has previously been assaulted by his ex-boyfriend, who went to jail for this episode of domestic violence, but continues to have a "on and off again" relationship, which he realizes contributes to his feeling poorly. He denied anxiety symptoms consistent with an anxiety disorder, and he also denied any psychotic features.

The patient stated that he drinks to inebriation every weekend and has been doing so for many years. He has had legal, occupational, and relationship difficulties due to alcohol use. He has felt the need to cut down, but has not been able. He feels that he has an inability to control his alcohol use, and feels guilty about its use. He denied difficulties with any other substances.

HOSPITAL COURSE
The patient was admitted to the Behavioral Health Unit and placed on level 2 with 15-minute checks, which continued throughout his admission. He was begun with thiamine, folate, and multivitamin supplementation. Labs and EKG were reviewed, and were within normal limits. Some mild sinus tachycardia on EKG. His TCA levels had been decreasing since he reached the emergency room, and on admission were down from 56 to 31. No further TCA levels were drawn. His vital signs remained stable throughout his admission. We began treatment with citalopram 20 mg daily for depression, with the intent to continue this as an outpatient. We began referrals for alcohol treatment, which the patient thought was a good idea. The patient did well while he was on the unit, and demonstrated fairly good insight into his need for treatment and actually contacted some of the treatment centers on his own. In addition, he contacted his parole officer to let him know that he was an inpatient and to keep him informed of his whereabouts.

CONDITION ON DISCHARGE
The patient was alert and oriented to person, place, time, and situation. He established good eye contact. He denied paranoia, delusions, or hallucinations. He denied any active suicidal ideation. His mood was good, and affect congruent with mood. Thought processes were linear and goal-directed. No psychomotor abnormalities were noted. Hygiene was fair. Speech was within normal limits. Judgment was fair and had improved since admission, and he was actively seeking treatment for his alcohol dependence. Insight was also fair and had improved, regarding the consequences of his alcohol use. He had no homicidal ideation.

DISCHARGE MEDICATIONS
Citalopram 20 mg orally daily.

MRN: 000287606
Visit ID #: II
Attending : EHAB ABDALLAH
Name: MEEKS EDMO, MASON
DOB: Gender: M Age: 23
Admit Date: 05/16/2011

DIET
As tolerated by the patient.

PHYSICAL ACTIVITY
As tolerated by the patient.

PROGNOSIS
Fair-to-good, upon compliance with substance treatment, therapy, and abstinence.

DISPOSITION
1. Discharged to home of mother, where he currently lives.
2. Followup appointment with Four Directions - patient will have intake on Friday, May 27, with Sandra Ortiz (phone number: 236-1008) at 9 a.m.
3. The patient agrees, in the interim, to go to the Alcoholics Anonymous group called Brown Baggers, located in Fort Hall. The patient will be receiving mental health services from Counseling and Family Services, and has an appointment with Krissy Broncho, LCSW, at 1 p.m. today.
4. Parole officer (Paul Sorenson; 237-9194, extension 242) will meet with the patient today at 3 p.m. Parole officer was contacted to brief the patient on his discharge plans.
5. Tried to do a family meeting, but mother or sister either did not return calls or were unable to meet due to their schedules. Mother was called and message was left to update her on discharge plan and given cell phone number if she is in need of contacting me.

TIME USED: 35 minutes

I have seen and evaluated patient with resident. I agree with findings and recommendations.

Job ID: 5000816
Document ID: 466631928
DD: 05/19/2011 10:18:22/Brian Smart, MD Resident
DT: 05/19/2011 13:54:50/MedQ
Authenticated and Edited by Brian Smart, MD Resident On 5/23/11 12:15:44 PM
Authenticated and Edited by Ehab Abdallah, MD On 5/23/11 12:57:38 PM

PORTNEUF MEDICAL CENTER INPATIENT PSYCHIATRIC EVALUATION
NAME: MEEKS EDMO. MASON D
D.O.B.: MRN: 000287606 VISIT ID NO: 4761015
AGE: 23Y GENDER: M REVISION: 0
ADMIT DATE: 05/16/2011
DISCHARGE DATE:
ATTENDING PHYSICIAN: EHAB ABDALLAH
DICTATOR: Brian Smart
IDENTIFICATION
A 25-year-old Native American male with recent Amitriptyline overdose.
CHIEF COMPLAINT
Alcohol and depression.
HISTORY OF PRESENT ILLNESS
The patient states that he was drinking heavily with friends throughout the evening last Saturday (2 days prior to this admission). They drank through the night and into the morning and dropped off patient at his sister's house at about 6:00 or 7:00 a.m. The patient was by himself thinking that his life was not going the way he wanted it to go with "no job, past crazy relationship just going on and off" and reports that he got "super depressed" and took a handful of his sister's Amitriptyline. He reports that this was an attempt to end his life. He was brought to the Emergency Department and placed in ICU until he was medically stable and transferred to the Behavioral Health Unit.
The patient reports that he has been depressed lately and rates his rate as a 6 out of 10 with 10 being the worst, but states that this is "about normal". He has not noticed any changes in pleasure he gets from things that interest him, including playing with his niece and nephews, listening to music, talking to friends on the phone, or using the internet. He reports his appetite is normal, his sleep is normal (about 8 hours a night), and his concentration and memory are normal. His energy level is decreased a bit. He also feels somewhat guilty and worthless. When assessing for mania, he reports that he "felt up" but this was described more like his depression getting better than feeling particularly euphoric. He states he felt up because he was getting a possible job lead and had been "on again" with his boyfriend. He reported that he has been physically assaulted by his ex-boyfriend who went to jail for domestic violence once while they have been together for 30 days, but does not have symptoms of reexperiencing this trauma, hyperarousal, or avoidance. He denied anxiety consistent with generalized anxiety, specific phobia or social phobia. He denied any auditory or visual hallucinations and denied paranoia.
PAST PSYCHIATRIC HISTORY
Inpatient, he reports this is his second inpatient admission here. The first one was really for a detox and lasted a few days. He reports no other history of outpatient care. He reports he had been diagnosed with depression sometime in the past, but did not remember by whom. He denied taking any medications for mental illness or substance abuse. He had a suicide attempt last year where he cut his right arm at the antecubital fossa. This was again in the context of heavy alcohol use.
SUBSTANCE, ALCOHOL
The patient has had no substance rehabilitation. He stated he started drinking at approximately 16-years-old and has had 2 DUIs, with one in 2006 when he was 19 and another one in 2007 when he was 20. He reports that he binges every weekend to the point of intoxication and has felt the need to cut down, an

inability to control his alcohol use and guilty about its use. He denied having any withdrawal seizures or symptoms. He reports that he used methamphetamine once, maybe at about 17 or 18-years-old. He has no history of IV drug use. He has used tobacco intermittently, but is not using any now. Caffeine use is very minimal and he denied any supplement use.

FAMILY HISTORY

Both his mother and his father have heavy alcohol use and his father, additionally, has a history of methamphetamine abuse. He denied any suicides in the family. He denied any other mental illnesses in the family.

SOCIAL HISTORY

He was born and raised in Fort Hall. He is the youngest of 4 children, with 2 sisters and 1 brother. The family and his parents and his siblings all live relatively close by in Wyoming and Idaho. His parents divorced at 10 and he moved in with his mother and one of his sisters. He finished high school and went to ISU for one year of college. After leaving college, he went to work at Fort Hall Casino as a floor attendant, which he did for about 7 months. He then worked for travel attorneys for approximately 6 months. He then returned to the casino as a cashier, but went to prison for forging a check. His last work was in March 2009. He reports that he presently lives with his mother and is trying to get a job going through Job Service, internet, and communicating with friends.

PAST MEDICAL HISTORY

None.

MEDICATIONS

None.

ALLERGIES

None.

LABORATORY DATA

Urinary tox was normal. A urinalysis was within normal limits. CBC was within normal limits, other than a slightly elevated hemoglobin at 18.2. Acetaminophen was normal. A CMP demonstrated elevated glucose at 121, elevated ALT at 51 and elevated AST at 38. TCA blood level on 05/15 was 53. This trended downward to 31 this morning on 05/16. Alcohol blood content at admission was 295.

ASSESSMENT

AXIS I

1. Alcohol dependence.
2. Depressive Disorder, NOS vs. Substance-Induced Mood Disorder

AXIS II

Deferred.

AXIS III

Elevated glucose level, elevated liver function test.

AXIS IV

1. Social stressors.
2. Financial and occupational stressors.

AXIS V

Global assessment of function of 40.

PLAN
1. This is a 23-year-old Native American male with a long history of alcohol abuse without any history of treatment. The plan will be to admit to Behavioral Health Unit, place on level 2 with every 15 minute checks.
2. We will order Thiamine, Folate, and Multivitamin supplementation.
3. EKG reported as normal, but do not have EKG print out yet and will review when gets to floor.
4. We will treat depression with Citalopram 20mg daily.
5. As TCA levels are decreasing and were reported as 31 today, will not follow these levels unless vital sign discrepancies.
6. We will make appropriateplacement for alcohol treatment.
7. Treatment planwill be discussed with treatment team.
Estimated time of admission 3 to 5 days.
Job ID: 533103
DOCUMENT ID: 170484
DD: 05/16/2011 16:15:55 / Brian Smart
DT: 05/16/2011 21:07:48 / mjc
I have seen and evaluated patient with resident. I agree with findings and rexcommendations. cc:
Ehab Abdallah, MD+, Attending Physician
Authenticated and Edited by Ehab Abdallah, MD On 5/17/11 7:55:18 AM
Authenticated and Edited by Brian Smart, MD Resident On 5/17/11 10:17:02 AM

Interdisciplinary Treatment Plan

Patient Name: Mason Meeks Edmo,Mason Admission Date: 5-16-11 ELOS 5 Days

Treatment Team Meeting Date: 5-19-11 Review Date: 5-23-11

Status: Voluntary Admit From: PMC Emergency Financial: Indian Health Services

Patient reason for admission: Recent overdose of SSRI and amitriptline

Patient Strengths: Patient has access to health services.

Patient Limitations: Recent ending of a relationship.

Initial Treatment Plan summary: Patient will be admitted to Portneuf Medical Center's Behavioral Health Unit. Patient will be placed on suicide precautins, level II with restriction to the unit. we will continue the following medications: Citalopram 20 mg daily, folate, thiamine and multiviatam supplementation. Reviewed vital signs, which have been stable and we will continue to review viatl signs for evidence of withdrawal. we will begin to arrnge alcohol rehabilitation treatment, most likely at Fort Hall. We will continue to encourage group activity participation. Brief psychoeducation was done about medication and substance treatment during the interview time. Brief psychotherapy was also done during the interview time.

Criteria For Discharge: Patient will be stable on his medications, patient will have a stable and even mood with a better outlook on his life. Patient will have medication management in place counseling and resources for his recovery efforts. and

Prognosis: Fair

Diagnosis

Axis I: Major Depressive Disorder, Alcohol dependence.

Axis II: Deferred.

Axis III: Allergies: Medical issues: Elevated glucose and liver function tests,

Axis IV: Financial and occupational stressors. Social stressors.
Axis V: Current Global Assessment of Functioning (GAF): 40
Past GAF:

Problems Identified for Treatment Plan

Problem 1: Depressed Mood as evidenced by: Suicidal thoughts/plan

Problem 2: Withdrawal Symptoms as evidenced by: Physically Acting Out alcohol use

Problem 3: Discharge Planning as evidenced by: Medication management

Therapeutic Interventions

Physician

Assess and adjust medications daily and/or needed to alleviate symptoms of depression and alcohol recovery
Interview patient on individual basis daily for supportive therapy and to assess level of symptoms
Monitor and educate regarding precautions, risks, benefits, and side effects of medications
Refer to ISU Family Practice: Complete history and physical with admitting lab work and any medical procedures necessary
Collaborate with patient's physician and/or psychiatrist:
Comments:

Nursing

Pt will be placed: Suicidal **precautions, Requires:** 15 minute checks
Suicidal Ideation: Monitor for suicidal ideations Q shift.
Self-harming behaviors: Be consistent in setting rules and expectations
Safety Issues: None. None Monitor Q 15 minutes for safety. **Mobility Issues:** ambulates independently
Vital signs will be taken As needed daily.
Withdrawal/Chemical Dependency Issues: Encourage attendance of on unit AA groups. Monitor symptoms of withdrawal.
Allergies:
Anxiety: Educate patient on 0-10 pain rating scale. Encourage the use of relaxation techniques. None.
PTSD: Assist pt with sensory bag anger
1 to 1 structured program: 1:1 staff interaction to allow patient to express feelings, use silence and active listening.
Encourage patient to participate in daily activities and groups.
Provide a structured environment, set firm and realistic limits to let patient know what is expected of him.
Dietary Intake: Regular **Weight management:** Record daily weight.
Pain Management: Educate patient on 0-10 pain rating scale.
Grief Group: Encourage attendance when offered.
Sleep issues: Monitor and record sleep hours. Offer PRN medication if ordered.

Self-care issues: Prompt pt to complete personal hygiene
Behavior &/ or Indicators of Mood: Monitor any aggression and document
Confusion: Administer MOCA and/or MMSE as ordered.
Compliance: Educate patient of importance of taking medication and relationship to symptom management.
Medication Education: Educate pt on medication and side effects and obtain consent for any psychotropic medication ordered prior to first dose.
Medication response: Monitor pt side effects and report effectiveness
Offer PRN medications per Physician order to treat symptoms of: Alcohol withdrawal
Additional needs:
Family Education:
Physician and/or Psychiatrist:
Pharmacy:
Education and information regarding the patient's illness will be provided prior to discharge date. Information will be provided on Social Services follow-up as needed for counseling, medication management, and any other services as determined by treatment team.
Comment:
Nursing Staff: Sandy Kluza, RN **Date initiated:** 5-16-11 **Date updated:**

Social Worker/Case Management/Therapist: Sheila McHugh, LCSW

Complete psychosocial assessment to identify patient issues during admission. Primary issues of concern are relationship issues, recovery efforts, depression
Groups 5 times weekly for process, education related to Axis I diagnosis, social, financial, legal issues relationships, grief, chemical dependency, relaxation and stress management. Specific focus on recovery and related resources.
Assess for suicidal thoughts, self-harm, harm to others, and interventions daily
Provide 1 psychotherapy group on suicide prevent during patient stay.
Provide collateral contact with patient's family member, physician, care providers or clinicians for gathering information.
Family meeting (s) for support & education regarding diagnosis and discharge needs.
Chemical Dependency Issues: AA
Coordinate discharge appointments with providers:

Therapeutic Recreation:

Socialization: Provide group to increase positive interactions. and positive use of distraction as a coping skill 5 x week
Cognitive: Provide group to identify thinking distortions. 1 hour 1 x week
Behavioral: Provide group to increase concentration.
Emotional: Provide group for increasing self-esteem. 1 hour 1 x week
Physical: Provide education on general fitness.
Discharge Planning: Provide one hour of instruction on how to use discharge planner

Initial Treatment Team Meeting or Review Date: 5-19-11

Problem 1: Depressed Mood with suicidal ideation rates mood a 2 of 10

Long-term goal: no suicidal ideation

Short-term goal: by date:

Pt said he is motivated to alcohol recovery. Pt said he will not harm himself

Review of progress towards goals	Status of Problem key
☐ Unchanged ☐ Slight improvement ☒ Improved ☐ Date Resolved:	☒A – Active ☐C - Chronic ☐D – Deferred/continue after discharge

Problem 2: Suicidal ideation and alcohol dependence.

Long-term goal:

Short-term goal: by date:

Pt is willing to work on his recovery and has appointments in place & Pt not worried at all - anger is under control

Review of progress towards goals	Status of Problem key
☐ Unchanged ☐ Slight improvement ☒ Improved ☐ Date Resolved:	☒A – Active ☐C - Chronic ☐D – Deferred/continue after discharge

Problem 3: Discharge Planning

Long-term goal: patient will have in place a plne for his recvery including medication management, counseling and resources for his alcohol related issues.

Short-term goal: Patient will idenitfy a medical provider, counseling , and a resources for his recovery efforts by date: 5-23-11

Pt will see his P.O. at 1500 - Pt sees Kris Bosch at 1:00pm — Dr Palmer will follow for meds - Pt sees Sandy Ortiz at 900 at four directions May 27,

Review of progress towards goals	Status of Problem key
☐ Unchanged ☐ Slight improvement ☐ Improved ☐ Date Resolved:	☒A – Active ☐C - Chronic ☐D – Deferred/continue after discharge

I have had the opportunity to provide input into my treatment plan and it has been reviewed with me. I understand the treatment plan as written. Copies of my treatment plan will be supplied to me.

Date: 5-19-11

Patient Signature: Mason Meeks Edmo

Doctor's Signature: ____________________

Dr. Abdallah

Staff in Attendance Signatures & Discipline

Nursing: Alex [illegible] RN
Social Work: Sheila McHugh, LCSW Judith Deffinger, LCSW
Therapeutic Recreation: John C. Rainey, CTRS J Rainey CTRS
Other:

Portneuf Medical Center
651 Memorial Drive
Pocatello, Idaho 83201

3CP

BHS Treatment Plan

Page 5 of 5

DOC NO BS00334

4751015
000287606
Phys: ABDALLAH, EHAB
MEEKS EDMO, MASON 05/16/2011 13:30
DOB: Male 23Y

DO NOT PLACE LABEL BELOW THIS LINE

PLEASE PLACE IN THE PROGRESS NOTES SECTION OF CHART!

BEHAVIORAL HEALTH ASSESSMENT

4643260
PORTNEUF MEDICAL CENTER
BEHAVIORAL HEALTH ASSESSMENT

NOTE: I HAVE SPOKEN WITH THE PATIENT'S PROBATION OFFICER, WHO HAS INSTRUCTED ME THAT THE PATIENT IS NOT TO BE RELEASED. WHEN HE IS DISCHARGED FROM THE BEHAVIORAL HEALTH UNIT, HE IS TO BE TAKEN DIRECTLY TO JAIL. PLEASE CALL CLIFF CUMMINGS UPON DISCHARGE: 237-9194 ext 236, or 221-4506

****

NAME: Mason Meeks
DATE & TIME: 8/5/2010 11:40 AM
****

RECOMMENDED DISPOSITION: Inpatient psychiatric Admission
JUSTIFICATION FOR DISPOSITION: Patient was brought to the Emergency Department due to a self inflicted laceration. The laceration was significant enough to require Dr. Wills, a reconstructive surgeon to complete the repair. Patient continues to report no reason to live, and "wanting to go out with a bang."
****

LIVING SITUATION: Homeless. "I stay wherever I want to."
CONTACTS: Mother: Michaeline Edmo (840-0437), Sister: Mia Edmo (Contact mom for phone number), ex-boyfriend: Brady.
EMPLOYMENT: Unemployed.
LEGAL STATUS: Recently released from jail 2 months ago for writing bad checks (6/25/2010). Mother reports that the checks were under $100.00. The Idaho Supreme Court Data Repository website verifies this (not the amount of the checks). He has also had numerous traffic violations, and DUI violations. Patient has a probation officer, Cliff Cummings: 237-9194 ext 236, or 221-4506
MEDICAL HISTORY: No prior history documented in Emergency Room records.
BLOOD ALCOHOL: At 9:00 am, the patient's blood alcohol was 264.
VITAL SIGNS: BP: 144/71, Pulse: 123, Resp: 18, Temp: 98.5, O2 sat: 93 on ra,
SOCIAL HISTORY: Smokes unknown amount. Drinks unknown amount.
MEDICATIONS: Denies
PHARMACY: IHS
PSYCHIATRIC HISTORY: No prior treatment.
****

NARRATIVE: Mason Meeks is a 22 -year-old Native American Male who presented to the Emergency Department via EMS due to two self-inflicted lacerations. One of the two lacerations was on his arm, and was made in an attempt to "cut an artery." The laceration was significant enough to require Dr. Wills, a reconstructive surgeon to complete the repair. Patient continues to report no reason to live, and "wanting to go out with a bang." Patient's probation

PLEASE PLACE IN THE PROGRESS NOTES SECTION OF CHART!

BEHAVIORAL HEALTH ASSESSMENT

officer has indicated that he would like the patient to receive treatment, however he does not want the patient discharged. Upon discharge he is to go back to jail.

RECOMMENDATIONS: Despite the patient's high blood alcohol, the suicide attempt was significant enough to warrant inpatient psychiatric treatment. The MD would need to be aware of the patient's alcohol level so that he could be placed on detox protocol. I have indicated to the Probation Officer that I would attempt to have the patient placed on an involuntary hold.

-Corey L. Richardson, LCSW

Behavioral Health Admission Note
Page 2 of 2

4643260
Mason Meeks

PORTNEUF MEDICAL CENTER HISTORY AND PHYSICAL
NAME: MEEKS, MASON D
D.O.B.: MRN: 000036291 VISIT ID NO: 4643260

AGE: 22Y GENDER: M REVISION #: 1
ADMIT DATE: 08/05/2010 DISCHARGE DATE:
ATTENDING PHYSICIAN: PREDRAG V GLIGOROVIC

DATE AND TIME: 08/05/2010 at 7:34.

CHIEF COMPLAINT
"Not worth living".

HISTORY OF PRESENT COMPLAINT
Brought in bleeding profusely from self-induced laceration in right antecubital fossa. Laceration repaired by plastic surgeon Dr. Wills and the patient is admitted to the Behavioral Health Unit. He states that he is obsessed about his homosexual relationship with his male partner, having been terminated by his partner after his jail sentence. The patient was jailed for a $15 bad check by a judge who looked at his previous two DUIs and felt that he needed to be in jail to get alcohol treatment. Patient was not molested in jail.

PAST MEDICAL HISTORY
Positive for cholecystitis. The patient continues to have gallstones and intermittent cholecystitis when he eats fatty foods, was diagnosed in the Emergency Department by ultrasound, referred to Surgery. He did not follow through. This is an ongoing problem. The patient denies any other medical illnesses.

REVIEW OF SYSTEMS
Systems review, apart from his intermittent abdominal pain, is negative. HIV and hepatitis C risk, the patient practices receptive anal intercourse, usually with a condom. Was last tested for HIV in April. Wishes to have further tests as he believes his partner has been promiscuous. Patient has had six partners.

ALLERGIES
None.

RECREATIONAL DRUGS
None.

ALCOHOL
Abusive use of vodka and beer. Patient is within alcoholic range.

SMOKING
Patient does not smoke.

FAMILY HISTORY
Parents are alive and well. Father is abusive of mother. Sister was a victim of childhood sexual abuse by an unknown stranger at a party.

PHYSICAL EXAMINATION
VITAL SIGNS: Blood pressure 141/73, Accu-Chek 100. These vital signs taken in the ambulance. In the Emergency Department, 144/71, pulse 92, respirations 16, O2 saturations 94% on room air.
GENERAL: Alert, cooperative, remorseful.
HEENT: Normal.

CHEST: Clear.
HEART: Sounds are normal.
ABDOMEN: Soft.
GENITAL/RECTAL: Exam declined.
EXTREMITIES: Right arm is dressed and has been bandaged. Good perfusion in the right hand.
NERVOUS SYSTEM: His ocular movements are normal. Vision is normal. His facial motor and facial sensory are normal. Moves tongue and palette normally. Sternocleidomastoid is strong. Palate, tone, sensation, reflexes, coordination of all four limbs are normal. Romberg is negative. He has not tremor, no asterixis.

IMPRESSION
1. This patient has a laceration in the right arm that has been repaired.
2. Suicidal attempt and depression.
3. Chronic, recurrent cholecystitis, secondary to gallstones.
4. Alcoholism.

PLAN
The patient is to be withdrawn from alcohol. Ativan is to be used, Dr. Gligorovic has prescribed. If he has a gallbladder attack, he will be referred for a laparoscopic cholecystectomy. His depression will be treated by Psychiatry. He will have an HIV and a hepatitis C test because of his preference for receptive anal intercourse.

Job ID: 467436
DOCUMENT ID: 103961
DD: 08/05/2010 19:34:28 / Jonathan Cree
DT: 08/05/2010 20:05:56 / mjc

cc:

Authenticated by Jonathan Cree, MD On 08/23/2010 09:46:04 AM

PORTNEUF MEDICAL CENTER INPATIENT PSYCHIATRIC EVALUATION
NAME: MEEKS, MASON D
D.O.B.: MRN: 000036291 VISIT ID NO: 4643260

AGE: 22Y GENDER: M REVISION: 0

ADMIT DATE: 08/05/2010 DICTATOR: Predrag V Gligorovic
DISCHARGE DATE:

ATTENDING PHYSICIAN: PREDRAG V GLIGOROVIC

This is an inpatient psych evaluation.

The patient was seen yesterday in the Emergency Department at Portneuf Medical Center after trying to kill himself by cutting his right lower arm with a raiser.

The patient is a 22-year-old gentleman from Fort Hall Indian Reservation in Fort Hall, Idaho who is seen after he tried to commit suicide. This is a protective custody involuntary hospitalization.

The patient is a 22-year-old gentleman who stated that his life changed approximately a year and a half ago. The patient stated that at that time he was working in Fort Hall Indian Casino as a banker and after that he wrote a bad personal check which ended up landing him to jail for nine months. During that period of time, his relationship with his living partner, Bradley, and he found out that Bradley was lying to him and his family and made different stories that he is out of town, that he is in cancer treatment, and that he has multiple problems that caused a somewhat strained relationship between the patient and his family and once when the patient was released in prison in June this year, he started drinking on a daily basis. The patient stated that this completely broke his heart, and a guy whom he loved and trusted lied to him and used his good heart and heart of his family.

The patient stated that he was thinking about suicide for the last month or two, but yesterday he was just drinking more and drinking more liquid, felt that life really came to the end and there is nothing to live to.

The patient stated that at this moment, he is not sure if he is sorry that he survived or he should be happy that he has a new chance.

HISTORY OF PRESENT ILLNESS
The patient stated that he never had any psychiatric hospitalizations, that he never saw a psychiatrist, and never been in treatment. The patient never tried any psychiatric medication in the past.

DRUG AND ALCOHOL REHABILITATION
The patient has never been in drug and alcohol rehabilitation. He stated that he was drinking since pretty early age, approximately since age 16. The patient had two DUIs; the first DUI was in 2006 when the patient was 19 and the second one in 2007 when he was 20. The patient is not on any probation for that right now. The patient stated that in the past he tried methamphetamines but does not use them lately.

FAMILY HISTORY
The patient stated that he has an older brother and two older sisters. He is the youngest of four. Both of the patient's parents used to be pretty heavy in alcohol, but he stated that his mom quit a couple of years ago. The patient denied any suicides in his family. The patient denied any mental illnesses in the family.

MEDICAL HISTORY
The patient denied any medical problems. The patient stated that he cut himself wanting to die without any willingness to injure himself or cut his tendons. The patient had repair last night by plastic surgeon due to severity of his cut.

PSYCHOSOCIAL HISTORY
The patient graduated from high school and went for one year to college with general studies. After that, he had worked up to 2009 in Fort Hall Casino, where he was fired after he went through his nine months of prison for a personal check. Patient has his own house. He is currently without any relationship and spending all of his time just drinking. The patient is still on parole for the next three years. Patient had two DUIs in 2006 and 2007 and stated that he has his license and is not on any probation for that. Patient denied any history of previous sexual or physical abuse.

The patient is a 22-year-old Native American guy who has colored top of his head in a lighter color. He has painted nails. He did not have any scars on his face or body other than a completely covered right arm in a Band-Aid.

The patient is alert, oriented to time, place, person, and situation. He knows where he is at and he knows what time of the day it is, understands the social consequences of the situation. The patient denied any thoughts about hurting himself or hurting anyone else at this moment, but he still has lots of concerns if he did the right thing or this was the wrong decisions. The patient is not having any dyskinesia or any facial asymmetries. The patient denied any psychotic features. He denied any hallucinations, illusions, or delusions. He denied any word salad. Denied any fast switching thoughts. Denied any thoughts about hurting anyone else. Insight is limited and judgment is limited. The patient's denied any specific fears. Denied any phobia. The patient denied any paranoid delusions, denied erotomanic or jealous delusions. The patient is very preoccupied with the bad relationship he ended up with.

DIAGNOSIS
AXIS I
1. Mood disorder, not otherwise specified (NOS).
2. Substance abuse mood disorder.
3. Alcohol dependence.

AXIS II
No diagnosis.

AXIS III
Status post self-inflicted laceration of the right arm.

AXIS IV
1. Parole.
2. PC hold.

AXIS V
GAF is 25.

PLAN
The patient will be admitted to Portneuf Medical Center Behavioral Health Unit. We will start with Ativan taper with 2 mg q.6 hours for now and due to high amount of alcohol which the patient used to drink, the patient will also be started on thiamine and folate. At this moment, we will not start any antidepressant until the detoxification process is finished. Due to the negative urine drug screen test that the patient had and normal AST and ALT, I will not expect any complication of his detoxification. In the next couple of days, we will start antidepressant medication and we will definitely contact the Indian Health at Fort Hall Indian Reservation.

The patient will remain on vital signs q. 2 hours because his blood alcohol level was 264 on admission to the Emergency Department.

Job ID: 467575
DOCUMENT ID: 104159
DD: 08/06/2010 12:59:07 / Predrag V Gligorovic
DT: 08/06/2010 14:28:10 / PH03

cc:

Authenticated by Predrag V. Gligorovic, MD On 08/09/2010 07:25:44 AM

PLEASE PLACE IN THE PROGRESS NOTES SECTION OF CHART!

BEHAVIORAL HEALTH ASSESSMENT

4643260
PORTNEUF MEDICAL CENTER
BEHAVIORAL HEALTH ASSESSMENT

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DATE & TIME: 8/5/2010 11:40 AM
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****

LIVING SITUATION: Homeless. "I stay wherever I want to."
CONTACTS: Mother: Michaeline Edmo (840-0437), Sister: Mia Edmo (Contact mom for phone number), ex-boyfriend: Brady.
EMPLOYMENT: Unemployed.
LEGAL STATUS: Recently released from jail 2 months ago for writing bad checks (6/25/2010). Mother reports that the checks were under $100.00. The Idaho Supreme Court Data Repository website verifies this (not the amount of the checks). He has also had numerous traffic violations, and DUI violations. Patient has a probation officer, Cliff Cummings: 237-9194 ext 236, or 221-4506
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BEHAVIORAL HEALTH ASSESSMENT

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-Corey L. Richardson, LCSW

Mason Edmo
G.I.D Group-Mrs. watson
Chapters of my Life

Chapter 1
I walked down the sidewalk and fell into a deep hole. I couldn't get out and I couldn't figure out why. It wasn't my fault. It took a long time to get out.
I was 19 and in a serious relationship with a guy named Casey. He was 20.. We had been together for about 7mos. At this time, I had been fired from my job. My drinking problem was getting worse. All I cared about was partying and having fun. Our relationship was falling apart. I was eventually put on probation for a DUI and couldn't stay sober, so we decided to move to Washington. I absconded from probation so I tried to stay low and out of trouble. We moved to Walla Walla Wasshing Washington, his home town.
Casey had gotten involved with meth very bad and I turned to alsohol more than ever. Our relationship arguing gotten worse and turned physical. Every day we fought but the alcohol and meth brought us back to gether by the end of the night because we knew one of us had one or the other.
Every night going to bed next to him with a black eye, swollen lip or visible bruises was very depressing. I felt unwanted, hurt and ashamed and stupid. I kept asking myself why? Why do I have this life? Why do I have to hurt? I didn't believe I deserved this.
Shortly after, Casey left me for his ex-boyfriend he had before me. I took it hard and attempted suicide after drinking one night.
I moved back to Idaho, cleaned up my probation problems, got my driver's license back and founf a good job again. It took me one year to finally understand that me and Casey were not a very compatible couple. I seen that his meth use was more inportant and felt that was the reason why we had broken up and ended our relationship. I felt I climbed out of a big hole that could of been my grave.

Chapter 2
I walked down the sidewalk and fell into the same hole again. I couldn't understand. It wasn't my fault. I really had to struggle to get out.
I had been working and staying out of trouble for about a year now.
I had barely turned 21 and decided that my drinking would be controlled since I was of age and could drink. I fell back into the intense drinking binges, and of course lost my job again. Shortly after, I had been partying and carrying on I met Brady Summers. We started dating for about 6 mos., and decided to take things to a serious level. I didn't work and he provided for us both. At this time, my drinking was the most worse it has ever been. I would accuse Bradyof cheating and talking to girls on the phone or sleeping with them when we would drink. He would get mad and we'd argue and fight.
One night at the bar a girl came onto him and he was flirting with her. Well from that night on I would notice that he wouldn't want t to go the bar with me but simply drop me and my friend off and wait for me to be picked up. I found her number in cell phone under a guys ame and called her, she told me the talked all the time and that they had kissed one time. I of course gotten mad and confronted Brady about it and accused him of cheating.
I owuldn't let the issue go, it always came up when I was drinking and me and Brady eventually got into a physical fight with him ending up in jail for domestic. While he was in jail, I cheated on him with a guy at a house party I had.
After Brady got out of jail he found out and things turned worse for

IDOC_HH_pg.1

us. I kept telling myself that it wasn't my fault. He cheated first and I had a good reason to do the same. I kept drinking and partying and wouldn't stay sober to patch things up with Brady. I then caught my felony for Fraud in May of 2010 for forging checks. I didn't care and all I wanted was to numb the pain with alcohol. My co-dependency of having a partner was intense. I couldn't understand why all my relationships were falling apart. It wasn't my fault. I finally violated on felony probation and was given a 160 day rider at Cottonwood. During the trial of my case me and Brady decided to stay together. I felt I really needed him there for me. But two weeks before I was released back on probation, he left me. He told me he couldn't do us anymore and had to leave. I accepted it and agreed.
I got out and stayed sober for ab0ut a year and enrolled myself back into college. I knew I had to become positive somehow. I found a part time job and focused on school. It took me two years to overcome the hurt I felt from being left again.

Chapter 3
I walked down the sidewalk and fell into the sa,e holw again. This time I understood why and it was my fault. This time it was easier to get out.
I was doing good on probation and with school and work. I felt I have once again overcome a possible end of my life.
I started dating a guy name Marcus. I had known him for a few years and decided that sinc we were friends it would be easier for a realtio relationship to work. Very sson after we had been dating I found out he was addicted to meth. I thought I was strong enough to hold out on the party life. I knew I couldn't. I relapsed back into alcohol and seen the pronblems it was going to cause for me and Marcus.
I told him,that I couldn't do this anymore and told him we were done. I knew that if I allowed the alcohol and meth back into my life this hole that I kept falling into was gonna get deeper and wider.
But before I could completely turn away I violated pronation with another charge anc came to prison. I knew why my relationships were falling apart. I became this other person when I was drunk. I became this other person when I was drinking or wanting adrink. I became selfish and controlling with no care for others or their feeling. I would do anything to get my way. I knew what I had to do to get out this cycle of realtionships and frustration.

Gender Identity Disorder Group-Clinician Watson,
"How I see myself"

HOW I SEE MYSELF

I see myself in a lot of different ways at different times.
I can only explain what I feel.
There are times I see myself different, unique, and totally separated from the world, which is not necessarily a good thing when all I want to be is part of something.
Other times my uniqueness is great, I feel special and priviledge
So in all, I guess I see myself as a strong independent woman mentally, but a confused male physically.
I see myself as having deep emotions and passion about life.
I try to portray myself as being a caring person with goals and ambitions, but this struggle between sexes is hard.
I see myself not giving up and fighting for what I feel is right to me. I see myself as a very strong independent female.

How I think others see me

I think others see me as a gay male. With no intention of physically switching sexes. But these are the individuals that only see me once in a while.
The people that know me most are my family, friends and significant others. I think they see me as a strong caring person that should be there for them and give them everything they ask. I think they see as a person that is independent and that I can handle everything on my own,when that is most definitely not the case. I think others see me as a smart person who should make more smarter "choices" in life. I think others see me as a lucky person because they see me with the resources that I need but they lack the understanding of the struggles and hard work that I had to go through to get where I am and what I have.
I think others only see the top coat of my personality.

-Mason Edmo

8393 W. Galileo Ct. Boise, Idaho 83709 1-208-559-3608 clarkcounselingservices@gmail.com

Jeremy Clark

Objective

- Seek a position of Deputy Warden for the Idaho Department of Correction to oversee, supervise, and manage the daily functions of a prison facility.

Technical Skills/Proficiencies

- Experience with Word, Excel, Access, and Power Point
- Speak Spanish proficiently

Experience

November, 2012-Current | Idaho Department of Correction | Boise, Idaho

- Clinical Supervisor
- Currently providing mental health auditing services associated with the Federal Balla lawsuit. I have provided direct clinical supervision for IDOC clinicians in several different facilities, to include the facilities that has the male inmate Acute Mental Health Unit and the 235-bed male inmate Behavioral Health Unit. I have directly supervised up to 11 clinicians and 1 psychiatric technician coordinator. Provide consultation for sex offender treatment programming in the state to include four different programs in four different facilities. Provide oversight and consultation for community supervision of sex offenders for Probation and Parole. Member of multidisciplinary team that provides consultation, treatment planning, and security issues for the transgender inmate population. Provide yearly training and development associated with the assessment and treatment of sex offenders as well as the Violent Risk Assessment Guide-Revised (VRAG-R). Participate in the development of policies for the treatment for sex offenders as well as general mental health programming in the state.

January, 2008-May, 2014 | Boise State University | Boise, Idaho

- Adjunct Instructor-Psychology Department
- Instructor for classes of Introduction to Psychology, Abnormal Psychology and Introduction to Counseling Skills. Student instruction, Class development and scheduling, Exam and assignment development, grading, and holding office hours for instruction outside of class.

November, 2009-November, 2012 | Corrections Corporation of America | Kuna, Idaho

- Sex Offender Treatment Program (SOTP) Clinician
- Development of a new program, group and individual therapy, data entry, assessment and diagnosis, staffing clients and associated reports, completing group and individual clinical reports, placed in charge of program when the Program Manager is not present, research, presenting research and concepts of the program to the public, and attending staffing meetings for the facility.
- Program is a cognitive-behavioral focused program with a focus on the understanding and management of the research-based dynamic risk factors that are associated with sexual offending. There is a focus of relapse prevention, victim empathy, accountability, understanding offense cycles, and community safety.

August, 2006-November, | Sequel-Three Springs Inc. | Mountain Home, Idaho

2009

- Sex Offender clinician for adolescents
- Individual and group therapy, Assessment and diagnosis, Monthly family therapy, Monthly staffing of clients, Quarterly reports on clients' progress, Case Management, Presenting research and concepts of the program to the public, and maintaining clinical notes
- The program had a cognitive-behavioral focus with helping the adolescents develop an understanding of accountability, victim empathy, understanding offense and maintenance cycles, relapse prevention, and community safety.

June, 2006-August, 2006 Alta Services Boise, Idaho

- PSR Specialist and Case Manager
- Helping adults and adolescents learn and perform daily functions such as managing money, cooking, and hygiene. Help clients to get to doctor's appointments and medication management.

September, 2005-May, 2006 Merta Services Las Cruces, New Mexico

- Graduate student clinician
- Group and individual therapy, Assessment and diagnosis, Clinical notes, and client staffing.

Education

New Mexico State University *Las Cruces, New Mexico* *Master's Degree*

- *Counseling and Guidance*
- *Counseling Theory, Diagnosis, Family Therapy, Addictions Counseling, Multicultural Counseling, Human Development, Career Counseling, Group Counseling, School Counseling, and Ethics.*

Boise State University *Boise, Idaho* *Bachelor's Degree*

- *Psychology*
- *Physiological Psychology, Advanced Statistics, Human Development, Abnormal Psychology, Statistical Methods, Research Methods, The Psychology of Health, Psychological Measurement, Capstone, Teaching Assistant, and Research Assistant.*

Department of Correction Training

Conflict Resolution Program (CRP), 4 hours, February 4th, 2013
Static-99R, Stable-2007, Acute-2007 Certification Training, 35 hours, May 19-22, 2015
Leadership 100, 2017

Associations

Clinical Member of the Association for the Treatment of Sexual Abusers (ATSA)	*Since 2007*
Past Treasurer/Secretary and current member of the Idaho chapter of The Association for the Treatment of Sexual Abusers (IATSA)	*Since 2007*
Member of the World Professional Association for Transgender Health (WPATH)	*Since 2013*
POST Instructor Certification	*Since 2014*

APA Division 44

Society for the Psychological Study of Lesbian, Gay, Bisexual and Transgender Issues

American Psychological Association Division 44 Continuing Education

Thank you for attending the 2015 World Professional Association for Transgender Health (WPATH) training Transgender Health: Best Practices in Medical and Mental Health Care. As you know, WPATH and the Society for the Psychological Study of Lesbian, Gay, Bisexual and Transgender Issues (APA Division 44) partnered to offer APA Continuing Education Credits for the training. You will find your 2015 APA Division 44 CE Statement below. Please take the time to review this document, and if you find any missing information, contact me as soon as possible to have a corrected statement issued.

Remember that in order to receive credit for each session you participated in, you MUST have fulfilled each of the requirements below:

1) Have signed IN and OUT of each half-day you request credit for.
2) Have submitted an evaluation form for each session.

If your licensing body requires submission of learning objectives or session descriptions, please email me and I will gladly forward you a copy. This will expedite your licensing when it is due.

Sincerely,

Justin W. Martino-Harms, Psy.D.
Licensed Psychologist
Continuing Education Coordinator
Co-Chair, Education and Training Committee
Division 44 - Society for the Psychological Study of Lesbian, Gay, Bisexual and Transgender Issues
American Psychological Association

CONTINUING EDUCATION STATEMENT OF HOURS

Continuing Education Event: World Professional Association for Transgender Health (WPATH) Transgender Health: Best Practices in Medical and Mental Health Care

Date: November 5-7, 2015 **Location:** Chicago, Illinois

Attendee Name: Jeremy Clark

This statement certifies that the above-listed has attended the following continuing education programs co-sponsored by the Society for the Psychological Study of Lesbian, Gay, Bisexual and Transgender Issues (APA Division 44). APA Division 44 is approved by the American Psychological Association to sponsor continuing education for psychologists. APA Division 44 maintains responsibility for this program and its content.

Number Of Hours	Program Title
1.5	Introduction to Trans Health
1	Overview of WPATH Standards of Care Version 7
1.5	Overview of Surgical Treatment Options
1.5	Foundations in Mental Health
1.5	Foundations in Primary Care
1.5	Foundations in Hormonal Treatment
1	Mental Health Care of Youth and Adolescents
1	Mental Health Care for the Transitioning Client
1	Psychotherapy
1	Cultural Considerations: Incorporating Gender Affirming Care
1.5	Legal and Policy Panel Discussion
1.5	The Multi-disciplinary Team: Case Discussions
.75	WPATH Past Present and Future
16.25	**TOTAL HOURS**

Justin W. Martino-Harms, Psy.D.
Licensed Psychologist
Continuing Education Coordinator
American Psychological Association - Division 44

Questions regarding Division 44's CE Program should be directed to Justin Martino-Harms, Psy.D., jmartinoharmspsyd@gmail.com.

JOINTLY ACCREDITED PROVIDER™
INTERPROFESSIONAL CONTINUING EDUCATION

Certificate of Participation

Rush University Medical Center is accredited by the American Nurses Credentialing Center (ANCC), the Accreditation Council for Pharmacy Education (ACPE), and the Accreditation Council for Continuing Medical Education (ACCME), to provide continuing education for the healthcare team.

Rush University Medical Center designates this live activity for a maximum of **19.75** *AMA PRA Category 1 Credits*™.

ANCC Credit Designation – Nurses
The maximum number of hours awarded for this CE activity is **19.75** contact hours.

Rush University designates this live activity for 19.75 Continuing Education credit(s).

Rush University is an approved provider for physical therapy (216.000272), occupational therapy, respiratory therapy, social work (159.001203), nutrition, speech-audiology, and psychology by the Illinois Department of Professional Regulation.

Rush University certifies that **Jeremy Clark**

Has participated in the following activity entitled "Transgender Health: A WPATH Global Education Initiative" On 01/31/2017 - 2/2/2017

At Los Angeles, CA

And is awarded **6.0** *AMA PRA Category 1 Credit(s)*™.

or is awarded **6.0** Continuing Nursing Education contact hours(s).

or is awarded **6.0** Continuing Education credit(s).

Thomas A Deutsch, MD
Thomas A Deutsch, MD
Provost, Rush University

Rush University Interprofessional Continuing Education, 710 S Paulina St, JRB234, Chicago IL 60612

JOINTLY ACCREDITED PROVIDER™
INTERPROFESSIONAL CONTINUING EDUCATION

Certificate of Participation

Rush University Medical Center is accredited by the American Nurses Credentialing Center (ANCC), the Accreditation Council for Pharmacy Education (ACPE), and the Accreditation Council for Continuing Medical Education (ACCME), to provide continuing education for the healthcare team.

Rush University Medical Center designates this live activity for a maximum of **23.00** *AMA PRA Category 1 Credits™*.

ANCC Credit Designation – Nurses
The maximum number of hours awarded for this CE activity is **23.00** contact hours.

Rush University is an approved provider for physical therapy (216.000272), occupational therapy, respiratory therapy, social work (159.001203), nutrition, speech-audiology, and psychology by the Illinois Department of Professional Regulation.

Rush University designates this live activity for **23.00** Continuing Education credit(s).

Rush University certifies that **Jeremy Clark**

Has participated in the following activity entitled **USPATH Inaugural Conference** on 2/2/2017 - 2/5/2017

At Los Angeles, CA

And is awarded **20.0** *AMA PRA Category 1 Credit(s)™*.

or is awarded **20.0** Continuing Nursing Education contact hours(s).

or is awarded **20.0** Continuing Education credit(s).

Thomas A Deutsch, MD
Thomas A Deutsch, MD
Provost, Rush University

Rush University Interprofessional Continuing Education, 710 S Paulina St, JRB234, Chicago IL 60612

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Office of Continuing Medical Education
School Of Medicine
University of California San Francisco
ACCME Provider Number: 0000302
San Francisco, California
(415) 476-5808
www.cme.ucsf.edu

Jeremy Clark, MA
1299 N. Orchard Suite 110
Boise, ID 83706

Certificate of Attendance

This is to certify that

Jeremy Clark, MA

has participated in:

MMC13009: 2013 National Transgender Health Summit

May 17 - 18, 2013

Oakland Marriott City Center

This CME activity is approved for a maximum of
11.5 AMA PRA Category 1 Credit(s) ™.
I have earned 11.5 credits.

This course meets the qualifications on an hour-for-hour basis of continuing education credit for MFT's and/or LCSW's as required by the California Board of Behavioral Sciences. Approval No. PCE 1272.

The University of California, San Francisco School of Medicine (UCSF) is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

UCSF designates this educational activity for a maximum of 11.5 AMA PRA Category 1 Credit(s). Physicians should claim only the credit commensurate with the extent of their participation in the activity.

This CME activity meets the requirements under California Assembly Bill 1195, continuing education and cultural and linguistic competency.

2013 NATIONAL TRANSGENDER HEALTH SUMMIT

MAY 17-18 | OAKLAND MARRIOTT

WPATH WORLD PROFESSIONAL ASSOCIATION for TRANSGENDER HEALTH

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welcome!

On behalf of the Faculty and staff of the Center of Excellence for Transgender Health and the World Professional Association for Transgender Health, please accept our very warm welcome to The 2013 National Transgender Health Summit! We are so excited to embark on this joint effort to convene the summit. We, along with many volunteers, have worked hard to build a program that we are certain will lead to a robust learning experience for you. We hope that you will find the information useful in your practice and that you will share it with your colleagues back home. We also encourage you to take the opportunity to network with transgender health colleagues while at the summit and exchange contact information with each other!

Over the last several years, we have made important steps forward in transgender health. There have been revisions to the WPATH Standards of Care, the DSM V, and we hope soon, to the ICD 11. There is greater inclusion of covered transgender health services in health insurance plans. The expanded recognition of transgender civil rights supports our efforts to take further steps on behalf of our patients and clients towards elimination of past stigma and pathology. We are confidently moving into the future, together and with renewed commitment towards excellence in transgender health, for all who seek it. Your participation in the summit is also a reflection of that commitment, thank you!

As you can imagine, we have had lots of assistance in planning the summit and we want to acknowledge all who helped. They include members of the summit planning committee, the track chairs, the summit host committee, the staff from the Tie Core of the Center for AIDS Prevention Studies and the Pacific AIDS Education and Training Center. Please look for the staff and volunteers, who will be wearing ribbons, to acknowledge their help in making it all come together!

On behalf of our two organizations, please accept our warmest wishes for a successful summit!

JoAnne Keatley, Director
Center of Excellence for Transgender Health

Lin Fraser, President
World Professional Association for Transgender Health

acknowledgements

The Center of Excellence for Transgender Health and the World Professional Association for Transgender Health would like to thank the following for their commitment to making the 2013 National Transgender Health Summit a success:

2013 National Transgender Health Summit Planning Committee:

Co-Chairs: JoAnne Keatley, MSW and Lin Fraser, EdD

Planning Committee: Danielle Castro; Maddie Deutsch, MD; Jamison Green, PhD; Luis Gutierrez-Mock, MA; Dan Karasic, MD; Byron Mason; Enzo Patouhas, MA; Greg Rebchook, PhD; Jae Sevelius, PhD; Yavante Thomas-Guess; Angel Ventura

Track Chairs:

Research: Jae Sevelius, PhD

Clinical: Maddie Deutsch, MD

Mental Health: Lin Fraser, EdD; Dan Karasic, MD

Policy Institute: Kellan Baker, MPH, MA; Masen Davis, MSW; Jamison Green, PhD

2013 National Transgender Health Summit Host Committee:

Co-Chairs: Jenna Rapues, MPH and Sean Arayasirikul

Host Committee: Cecilia Chung; Chav Doherty; Sharyn Grayson; Zander Keig; Yoseñio Lewis; Martin Rawlings-Fein; Tiffany Woods

2013 National Transgender Health Summit Volunteer Committee:

Committee Chair: Byron Mason

Special thanks to all of our volunteers!

2013 National Transgender Health Summit Research Track Abstract Review Committee:

Walter Bockting, PhD; Curtis Crane, MD; Maddie Deutsch, MD; Tri Do, MD, MPH; Diane Ehrensaft, PhD; Laura Erickson-Schroth, MD; Jamie Feldman, MD; Alison Jacoby, MD; Dan Karasic, MD; Johanna Olson, MD; Don Operario, PhD; Seth Pardo, PhD; Enzo Patouhas, MA; Tonia Poteat, PhD, MPH, PA-C; Anita Radix, MD, MPH; Greg Rebchook, PhD; Stephen Rosenthal, MD; Jae Sevelius, PhD; Vin Tangpricha, MD, PhD; Erin Wilson, DrPH; Barry Zevin , MD

Clinical Training Track Planning Group:

Madeline Deutsch, MD (chair); Linda Wesp, NP; Jennifer Hastings, MD; Anita Radix, MD MPH; Tonia Poteat PhD MPH PA-C; Johanna Olson, MD; Steve Rosenthal, MD

Special thanks to UCSF students John Paul Farala, MS-3; Karin Hilton, MPH Karin Hilton, MPH, MEPN student; and Matt Hirschtritt, MS-4 for their assistance with slide and content review.

2013 NTHS sponsors

The Center of Excellence for Transgender Health and the World Professional Association for Transgender Health wish to express our sincere appreciation for all of the support we have received from Summit sponsors!

Principal Sponsors ($5,000 and above)

Major Sponsors ($1,000 up to $4,999)

Calendars provided by the Center for TransYouth Health & Development with Childrens Hospital LA

The Global Forum on MSM & HIV (MSMGF)

UCSF Chancellor's Advisory Committee on Gay, Lesbian, Bisexual and Transgender Issues
George Ayala and Tri Do
Chris Haiss

Supporting Sponsors ($100 up to $999)

Alliance Health Project, UCSF
Dr. Karisa L. Barrow
Chav Doherty
Elizabeth A. McCall, in honor of Tom and Betty McCall
Dr. Toby Meltzer
Mind the Gap: Mental Health Consortium of the Child and Adolescent Gender Center
Louise Monsour
The Pacific Center for Human Growth

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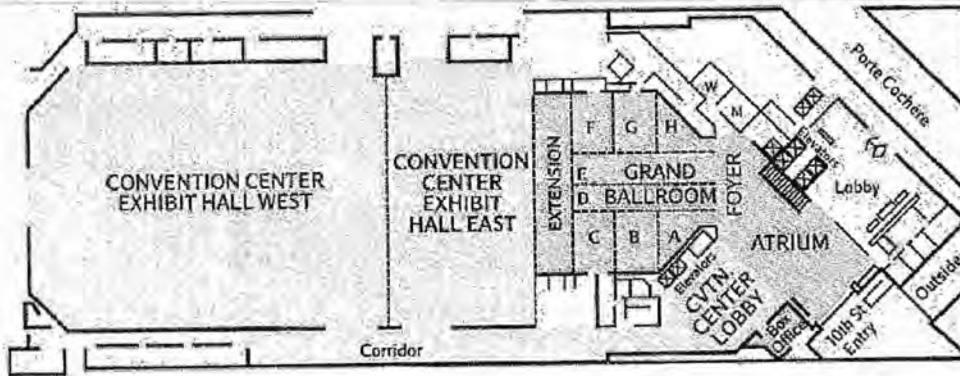
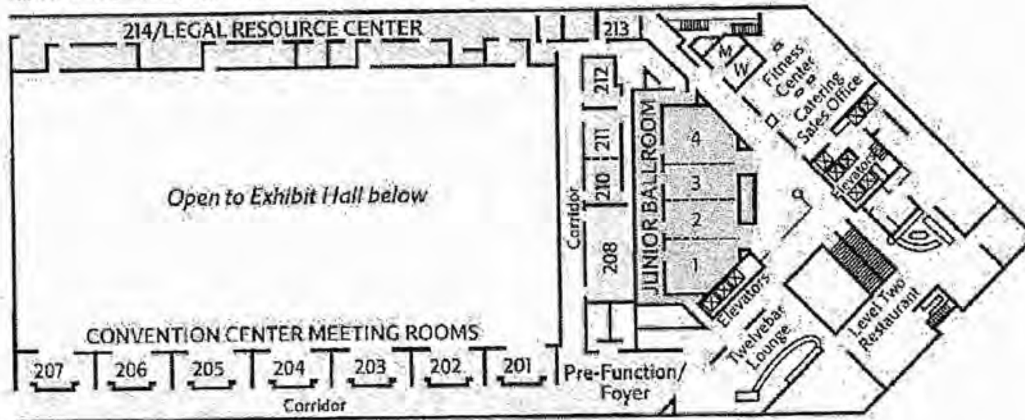
ER 921

venue maps

GROUND FLOOR
Oakland Convention Center: Exhibit Halls
Oakland Marriott City Center: Grand Ballroom



SECOND FLOOR
Oakland Convention Center: Meeting Rooms
Oakland Marriott City Center: Junior Ballroom & Meeting Rooms



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ER 922

continuing ed

Please ensure that you are registered as a recipient of CME or CEU course credit at the Summit registration area.

Continuing Medical Education
This live activity has been reviewed and is acceptable for up to 11.5 hours of CME course credit. The University of California, San Francisco (UCSF) School of Medicine is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians. **The UCSF CME course number is MMC13009.**

All course faculty have indicated that they have no relationships to disclose.

This event is certified for AMA/PRA Category 1 credit. This credit is granted by ACCME-accredited organizations and accepted by the California Board of Psychology for certification and re-certification credits. Psychologists outside of California should check with their state and local board to ensure that ACCME accredited CMEs are accepted by the local board.

Continuing Education Units
This course meets the qualifications for 11.5 contact hours of continuing education credit for nurses as required by the California Board of Registered Nursing, Provider #CPE 13741. This document must be retained by the Participant for a period of four years after the conclusion of this program.

This course meets the qualifications for 11.5 hours of continuing education credit for MFTs and/or LCSWs as required by the California Board of Behavioral Sciences. **Provider # PCE 1856**

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ER 923

NATIONAL TRANSGENDER HEALTH SUMMIT

AGENDA AT-A-GLANCE

May 17

9:00 - 9:10am	**Welcome**
9:10 - 10:10am	**Opening Plenary**
10:10 - 10:30am	**Break**
10:30am - 12pm	**Session 1**

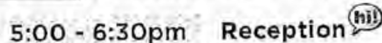
room	Track	Topic
203	RESEARCH 1	Trans Latina Communities
204	RESEARCH 2	Trans Youth
205	RESEARCH 3	Data Collection
JB* 1/2	MEDICAL: BASIC	Transgender Care for the PCP Part 1
JB* 3/4	MEDICAL: ADV	Endocrinology in Transgender Care/ Topics in Transgender Care Part 1
208	MENTAL HEALTH 1	Overview: Mental Health Assessment
210	MENTAL HEALTH 2	Aging and Spirituality
211	MENTAL HEALTH 3	Training Systems: Trans Competency
206	POLICY	Transgender Health Coverage

12pm - 1:30pm	**Lunch Plenary**
1:30 - 3:00pm	**Session 2**

room	Track	Topic
203	RESEARCH 1	Transwomen, HIV and Interventions
204	RESEARCH 2	Transmen, Mental Health and Hormones
205	SPECIAL TOPICS	Surgeon Roundtable
JB* 1/2	MEDICAL: BASIC	Transgender Care for the PCP Part 2
JB* 3/4	MEDICAL: ADV	Topics in Transgender Care Part 2
208	MENTAL HEALTH 1	Children, Adolescents, Puberty Blockers
210	MENTAL HEALTH 2	Research for Clinicians/Sexual Medicine
211	MENTAL HEALTH 3	Special Topics: Forensics, Eunuchs
201	MENTAL HEALTH 4	Co-occurring Conditions
206	POLICY	Transgender health in the Affordable Care Act

3:00 - 3:20pm	**Break**
3:20 - 4:50pm	**Session 3**

room	Track	Topic
203	RESEARCH 1	Violence and STIs
204	RESEARCH 2	Surgery
208	SPECIAL TOPICS	HIV Treatment Cascade and Silicone Use
201	SPECIAL TOPICS	Criminalization
EAST HALL	ALL MEDICAL	Multidisciplinary Case Presentations
EAST HALL	ALL MENTAL HEALTH	Multidiscip. Case Presentations
206	POLICY	Reproductive rights, fertility and family building


5:00 - 6:30pm **Reception**

May 18

9:00 - 9:10am	**Welcome Back**
9:10 - 10:10am	**Morning Plenary**
10:10 - 10:30am	**Break**
10:30am - 12pm	**Session 4**

room	Track	Topic
203	RESEARCH 1	Transwomen and Life
204	RESEARCH 2	Primary Care for Trans People
201	SPECIAL TOPICS	Trans Training Tools
202	SPECIAL TOPICS	Rectal Microbicides
JB* 1/2	MEDICAL: BASIC	Care of Trans Children & Adolescents
JB* 3/4	MEDICAL: ADV	Transgender Surgery for PCPs
208	MENTAL HEALTH 1	In-depth Psychotherapy
210	MENTAL HEALTH 2	Substance Abuse
211	MENTAL HEALTH 3	Family Building and Relationships
205	MENTAL HEALTH 4	Clinical Training Issues
206	POLICY	Transgender-inclusive Insurance Roundtable

12pm - 1:30pm	**Lunch Plenary**
1:30 - 3:00pm	**Session 5**

room	Track	Topic
203	RESEARCH 1	Transwomen and Identity
204	RESEARCH 2	Trans Aging
201	SPECIAL TOPICS	CDC Roundtable
202	SPECIAL TOPICS	Trans Care for Pharmacists
JB* 1/2	MEDICAL: BASIC	Transgender Surgery for PCPs
JB* 3/4	MEDICAL: ADV	Advanced Case-Based Discussion
208	MENTAL HEALTH 1	ICD 11
210	MENTAL HEALTH 2	Culturally Competent Care for TPOC
211	MENTAL HEALTH 3	Complex Cases in Community MH
208	POLICY	ICD 11

GB*	3:00 - 4:00pm	**Poster Reception**
	4:00 - 5:00pm	**Closing Plenary**

***JB = Junior Ballroom GB = Grand Ballroom**

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DEF EX 2019_0015

plenaries

Friday, May 17 | East Hall

▶Opening Plenary 9:00 am – 10:10 am

Welcome from Congresswoman Barbara Lee, represented by Daniela Quintanilla, Senior Congressional Aide

Transitioning together into the future: Where have we been and what lies ahead for transgender health?

JoAnne Keatley, MSW; Lin Fraser, EdD; Jamison Green, PhD; Shane Snowdon, MA

This presentation will reflect on progress made over the last decade and speculate on additional policy areas to consider.

▶Luncheon Address: 1:00 pm – 1:30 pm

Access to substance abuse treatment for transgender populations.

H. Westley Clark, MD, JD, MPH, CAS, FASAM

Saturday, May 18 | East Hall

▶Morning Plenary 9:00 am – 10:10 am

WPATH's Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People: Version 7 - An Overview

Eli Coleman, PhD

This presentation will provide an overview of Version 7 of the WPATH's Standards of Care which was just released in 2011. Version 7 represents a significant shift from previous versions of the Standards of Care. The presentation will describe the process of preparing this historic revision and highlight the significant changes. There will be opportunity for discussion of the Standards and its applicability to clinical care and an opportunity to provide feedback to WPATH officials.

▶Luncheon Address 1:00 pm – 1:30 pm

Local transgender health policy updates

Theresa Sparks, Executive Director San Francisco Human Rights Commission and invited representatives from the San Francisco Board of Supervisors

▶Closing Plenary 4:00 pm – 5:00 pm

Key takeaways from the 2013 National Transgender Health Summit!

Clinician Rapporteur: Anita Radix, MD, MPH   *Community Rapporteur: Mattie Jim*

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DEF EX 2019_0016

host committee reception

Friday, May 17 | 5:00 - 6:30 pm | Skyline room, 21st Floor

5:00 - 5:10 | Welcome

Hosts: Cecilia Chung and Yoseñio Lewis

5:10 - 5:20 | Special Thanks

JoAnne Keatley, Director of the Center of Excellence for Transgender Health

5:20 - 5:30 | Elected Officials

Senator Mark Leno

Other elected officials

5:30 - 6:30 | Live Entertainment

Veronica Klaus, San Francisco jazz and cabaret singer.

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DEF EX 2019_0017

ER 926

breakout sessions

Session 1: Friday May 17, 10:30 am - 12:00 pm

Research 1: Trans Latina Communities **Room: 203**

Caterpillar to butterfly: A metamorphosis concept for identity and health risk among transgender women in the U.S.-Mexico border region

Oralia Loza, PhD; Thenral D. Mangadu, MD, PhD; Oscar Beltran

Transgender women are at disproportionate high risk for HIV, sexually transmitted infections (STIs), substance abuse, and other negative health outcomes. Factors such as immigration status, gender roles, local cultural norms, and health literacy potentially create unique challenges to health care access for this population in the U.S.-Mexico border region. However, a health assessment or health care access needs of transgender women on the U.S.-Mexico region have not been previously documented, particularly outside to context of sex work. This exploratory qualitative study was conducted to assess health needs, examine STI risk behaviors, and identify prevention and harm reduction resources available and utilized by transgender women in El Paso, Texas.

Immigrant transgender Latinas in North Carolina: Exploring the health priorities of an emerging population through photovoice

Jorge Alonzo, JD; Lilli Mann, MPH; Scott D. Rhodes, PhD, MPH, CHES

Background: Latino populations in the Southeastern United States are growing rapidly; however, little is known about the health needs and priorities of immigrant transgender Latinas in this region.

Methods: Photovoice, an action-oriented community-based participatory research method, was used to explore the realities of the transgender Latina community in North Carolina. A group of Mexicanborn, male-to-female transgender Latinas documented their daily experiences through photography and engaged in empowerment-based dialogue to identify health needs and priorities to present at a community forum.

Immigrant transgender Latinas in New York City — resiliencies, vulnerabilities, and health disparities

Sel J. Hwahng, PhD; Bennett Allen; Cathy Zadoretzky, MA; Hannah Barber; Courtney McKnight, MPH; Don Des Jarlais, PhD

Introduction: Research suggests that the largest racial/ethnic group of trans women (male-to-female transgender people) in New York City is Latinas. HIV seroprevalence among trans Latinas have been found to be as high as 49% in New York City, and trans Latinas are at high risk for HIV infection in other parts of the U.S. as well as internationally. Despite their being at unusually high risk for HIV, very little is known about the social determinants of health among trans Latinas.

Methods: These data comes from a mixed-methods study that examined low-income trans/gendervariant people of color who attended transgender support groups at harm reduction programs in New York City. The study was conducted from 2011-12, with a total N=34, in which N=21 were Latinaidentified. The qualitative portion was derived from six focus group interviews that were audio-taped and transcribed. The quantitative portion was derived from a survey that was administered at the focus groups.

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ER 927

Substance abuse in the Peruvian trans women population living with HIV/AIDS (PLWHA)

Jana Villayzan Aguilar, MPH

We conducted a survey on a total of 162 trans women living with HIV from 8 Peruvian cities, on substance use in their daily basis.

Research 2: Trans Youth **Room: 204**

Expanding gender boundaries: Teens talk about their world

Ellen Kahn, MSS; Anne E. Nicoll, PhD

The Human Rights Campaign's report "Growing Up LGBT in America," provides data from more than 10,000 LGBT identified youth ages 13 – 17 who were surveyed between 2011 and 2012. A secondary analysis will be presented, of the 925 youth from this survey, who identified their gender as "transgender" or "Other" (9% of the original sample). This Gender Expansive Youth Report provides the results of an analysis of the opened-ended gender responses, and identified gender transitions. In addition, the results of their experiences in the areas of personal well-being, family support, community connection, extent of being out and accepted, and support in school and among peers, will be presented. These gender expansive youth face greater challenges than other LGB youth – among their families, peers, school, and community. They are more likely to face social exclusion, harassment, and assault than other LGB youth. And while they are optimistic about the future at somewhat similar levels to other LGB youth, that optimism plummets when they think about trying to achieve those goals in the towns and cities where they currently live.

Retrospective research of the transgender experience during adolescence: Implications for school counselors

Graciela L. Orozco, EdD; John A. Blando, PhD; Chav Doherty, MS, MA; Laura C. Strom, MFT

This study reports on a survey of 33 predominantly white transgender adults who responded anonymously to both quantitative and qualitative questions asking them to retrospectively examine their childhood and adolescent experiences. The average age at which participants realized that their gender identity was different than their physical presentation (assigned natal gender) was well before they entered high school, around the age of nine. Over half of the participants reported experiencing depression, anxiety, and suicidal ideation as youths. More than half of the participants encountered family conflict, verbal harassment, and physical assault in their adolescence. Very few of the survey respondents ever talked to a school counselor, teacher, administrator, social worker, or school psychologist about their gender identity issues. Recommendations for school counselors leading to a more accepting school climate for transgender youth emerged from the study.

Baseline characteristics of transgender youth naïve to cross-sex hormone therapy

Johanna Olson, MD; Marvin Belzer, MD; Leslie Clark, PhD MPH; Shree Schrager, MS, PhD; Lisa Simons, MD

OBJECTIVES/SPECIFIC AIMS: This abstract presents baseline data from an ongoing observationalstudy examining the impact of hormone treatment on transgender youth initiating cross sex hormonetherapy.

METHODS/STUDY POPULATION: Seventy transgender youth (aged 12 to 24) completed a computer assisted survey that assessed gender dysphoria, depression, sexual behavior and suicidality. Physiologic data collected prior to starting hormones was abstracted from medical charts.

RESULTS/ANTICIPATED RESULTS: 70 participants were evaluated for baseline physiologic, 66 for psychosocial parameters. 50% were assigned a female gender at birth. 34 (51.5%) were Caucasian, 28.8% Latino/a, 10.6% African American, and 9.1% other. Basic lab values were within normal clinical range for most of the participants. Youth discovered their gender incongruence at ages ranging from 2 to 22 years (mean 7.9 y; SD 4.4). Five youth (8.1%) had Beck Depression scores in the severe or extreme range. 30% had made at least one suicide attempt.

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ER 928

DISCUSSION/SIGNIFICANCE OF IMPACT: Transgender youth are aware of the incongruence between their internal gender identity and their assigned gender at early ages. Levels of depression and suicidality demonstrate that youth need timely and appropriate intervention. Evaluation of these youth over time will help determine the impact of cross sex hormones and mental health therapy.

Research 3: Data Collection Room 205

Gender-related survey measures and transgender health

Jody L. Herman, PhD; JoAnne Keatley, MSW; Emilia Lombardi, PhD; Sari Reisner, ScD, MA; Kellan Baker, MPH, MA

The GenIUSS group (Gender Identity in U.S. Surveillance), is a collaboration of scientists, scholars, and transgender leaders dedicated to increasing knowledge about gender-related measurement and promoting the inclusion of these measures on population-based surveys. This panel features four members of GenIUSS, who will describe their efforts at creating and promoting gender-related survey measures. JoAnne Keatley will discuss the use of the two-step gender measure at the Center of Excellence for Transgender Health. Emilia Lombardi will present findings from testing of the two-step measure and a gender expression measure. Sari Reisner will present findings from testing a single-item gender identity measure and a measure of sex assigned at birth. Kellan Baker will discuss next steps in advocacy to include these measures on federal surveys. Panel moderated by Jody Herman.

Getting trans* people counted—Trans* health research

e. shor, MPH

It is SUPER important for trans* and gender non-conforming people to be counted in research. However, there is a long-standing dissonance between how to categorize gender on surveys and how to make trans* and queer communities feel safe and affirmed in data collection. This workshop will dive into some of those questions and issues, and explore how to bridge the gap between research and identity. Using the experiences of a local community based trans* research initiative in Minnesota, we will explore the methods and results of this research. What does community based research look like and how do we involve community voices in the research process? How do we formulate questions and response options that are both statistically measurable and inclusive to trans* identities? How do we negotiate creating "gender groups for analysis" with the fact that different gender identities mean truly different things to different people and represent a whole host of behaviors!?

Through this workshop we will be presenting some of the problems and best practices and thoughts and discussions that you can bring back to your communities to make sure that trans* and gender nonconforming people are counted in research.

Medical Training: Basic Junior Ballroom 1/2

Transgender care for the primary care provider: Part 1

Linda Wesp, NP; Jennifer Hastings, MD; Ronica Mukerjee, NP; Jamie Feldman, MD, PhD; Barry Zevin, MD; Nathan Levitt, RN

These sessions are a comprehensive primer for medical providers new to caring for transgender and gender non-conforming populations, this session will consist of two consecutive 90 minute sections. Topics to be covered include cultural sensitivity, capacity building, cross-sex hormone management, primary care and screening, models of intake and care, and a didactic case based discussion. This evidence-based curriculum is designed to provide the foundation necessary for the provider who desires to become competent in the clinical care of transgender patients.

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ER 929

Medical Training: Advanced   Junior Ballroom 3/4

Endocrinology in transgender care/Topics in transgender care: Part 1

Josh Safer, MD, FACP / Madeline Deutsch, MD

This endocrinologist-led session will be presented remotely and will review basic hormonal physiology with particular attention to hormone therapy in transgender patients; Dr. Safer will discuss interpretation of existing evidence on various hormone regimens including postoperative implications. Care of transgender patients with co-existing disease will be discussed. Topics in transgender care, Part 1 will include discussion of cancer screening, cardiovascular health, and bone health.

Mental Health 1   Room 208

Overview of mental health assessment and care

Lisette Lahana, LCSW

Clinicians will develop an understanding of terms related to sexuality, gender identity, biological sex and the process of a gender transition. We will discuss diagnosis, treatment planning and how to be a trans affirmative provider. Participants will leave with greater awareness of how to assess their client's stage of identity development and the course of treatment with clients desiring transition. The presentation will include case vignettes, video clips and group discussion.

Mental Health 2: Aging and Spirituality   Room 210

Psychological and social adjustment in older transgender people

Randi Ettner, PhD

Several forces conspire to make the later decades a climacteric for transgender people. This presentation will examine these influences, present case studies and implications for care.

Spirituality and health

Shawn MacDonald, PhD

Spirituality is noted as an important factor for resiliency and a protective factor, yet little attention has been given to the spiritual lives and the spiritual needs of transgender persons. This talk will focus on the importance of spirituality for the health of transgender persons and provide background on understanding religion and spirituality in the context of gender diversity. The talk will additionally discuss the concerns and issues that transgendered persons are likely to face regarding spirituality and the important resource that spirituality can play for transgender individuals and communities.

Medical decisions and directives

Carol Cobb-Nettleton, DSW

All persons are facing the many changes in the health care systems especially with vital information getting to the "right doc in the right time". This is especially true in emergency situations. Trans persons may have complicated medical histories. The talk will focus on creating a useable medical history; creating an advance directive, state appropriate, to support your medical decisions if you cannot speak for yourself; and using medically reliable websites. Research demonstrates that health care treatment improves when patients are proactive with this information. A sample history will be provided.

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Mental Health 3: Training systems on trans competency | Room 211

The panel will present WPATH's international education efforts, a project to train Canadian health workers in trans care, and trainings developed to train the entire staff of the San Francisco Department of Public Health.

Creating trainings for 14,000 health care workers in a public health department: What we've learned so far

julie graham, MFT; Dan Karasic, MD

This presentation will discuss live and online trainings that are now required of every employee of the San Francisco Department of Public Health and contract agencies, to improve competency and cultural humility in the care of trans people.

Creating standardized transgender health training programs across Canada

Gail Knudson, MD

Training programs for health professionals being developed by the Canadian Professional Association for Transgender Health (CPATH) will be discussed.

WPATH global education initiative

Lin Fraser, EdD

This presentation will discuss the development and launch of Global Education Initiative (GEI). This project utilizes the immense experience of WPATH leadership, partnerships with organizations requesting the training and the use of a technology platform (Scivee) for distance learning

Policy | Room 206

Transgender health coverage: Challenges and work-arounds in implementation

André Wilson, MS; Jamison Green, PhD; Cecilia Chung; Susanne Watson, PhD

Many major employers and colleges have negotiated health benefits plans for employees, students, and dependents that cover clinically indicated treatments related to transgender transition. Nonetheless, most health insurance plans in the U.S. still contain "transgender exclusions" denying coverage for medically necessary services, and, where inclusive plans do exist, many people encounter difficulties using these plans.

We will discuss the continuing barriers to access reported by healthcare providers and patients alike both in inclusive plans and those with exclusions: challenges in prior authorization and claims processing, limited provider networks, and outdated insurer medical guidelines. We will provide information on documentation, procedure and diagnosis codes so providers can minimize denials and succeed with billing and appeals, and discuss strategies for direct advocacy with insurers.

We will continue with an overview of progress towards inclusion, best practices and indispensable advocacy tools such as the Human Rights Campaign (HRC) Equality Indexes (MEI, CEI) and professional association interventions. Comparing progress towards trans*-inclusive benefits in the healthcare industry with other professional sectors, we will consider the role healthcare providers can play in eliminating exclusions in their own sector. Outdated medical policies currently used by most insurers remain a central barrier. We will discuss our draft "Model Guideline" and issues posed by utilization management systems. We will also look at the progress made by the Healthy San Francisco program, and by Kaiser Permanente.

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ER 931

Session 2: Friday May 17, 1:30 - 3pm

Research 1: Trans Women, HIV, and Intervention Research **Room: 203**

Perceptions of HIV vaccine trial participation among transgender women

Gail Broder, MHS; Michele Andrasik, PhD

Observed seroincidence and prevalence rates in male to female (MTF) transgender individuals highlight the need for effective targeted HIV prevention strategies for this community. In order to develop an effective vaccine that can be used by transgender women, researchers must understand and address existing structural issues that present barriers to this group's participation in HIV vaccine clinical trials. Overcoming barriers to participation is important for ensuring HIV vaccine acceptability and efficacy for the MTF transgender community. To explore barriers and facilitators to MTF transgender participation in preventive HIV vaccine clinical trials, the HIV Vaccine Trials Network (HVTN) conducted focus groups among transgender women in four urban areas (Atlanta, Boston, Philadelphia and San Francisco). Data highlight the importance of understanding the use of hormones and silicone and addressing structural factors such as substance abuse. Barriers and facilitators to engagement of transgender women in preventive HIV vaccine clinical trials led to the following recommendations: (1) transgender cultural competency training; (2) creating trans-friendly environments; (3) true partnerships with local transfriendly organizations and health care providers; (4) protocols that focus on transgender specific issues; and (5) data collection and tracking of transgender individuals. These results have implications for the conduct of HIV vaccine trials, as well as engagement of transgender women in research programs in general.

HIV risk among transgender and non-transgender sex workers in Washington, DC

Vivian Towe, PhD; Lynsay Ayer, PhD; Clarissa Sellers, MPH; Elizabeth Saracco, MA; Debbie McMillan; Cyndee Clay

Washington D.C. has been documented as a city in which transgender sex workers often receive suboptimal treatment from law enforcement, medical and social service personnel. A DC-based service organization working with transgender and non-transgender sex workers provided recent data on their service population as a preliminary assessment of their health needs. We will compare transgender and non-transgender sex workers on HIV risk behaviors, HIV testing, and social service needs such as housing using intake data.

Challenges and successes in recruiting, retaining, and completing high-risk transgender women for a CDC-funded EBI, TranSafety Counts

Kimberly A. Kisler, MPH; Cathy Reback, PhD; Angelina Alamilla

The CDC EBI, Safety Counts, was adapted specifically for high-risk transgender women (transwomen) by Friends Research Institute in Hollywood, California. The adapted intervention, named TranSafety Counts, has been implemented in the community and has been accompanied by unique challenges in recruiting, retaining, and completing participants. Strategies that have assisted in successful program implementation have included developing rapport with participants, providing services and/or referrals to assist in addressing additional unmet needs, and hiring indigenous transgender staff. Challenges associated with implementation of TranSafety Counts have included retaining and graduating participants who have unstable living situations, as well as competing life issues such as substance abuse and mental health co-morbidities. Many important lessons have been learned for the successful recruitment, retention, and completion of high-risk transgender women for TranSafety Counts, including the need to bridge a relationship with local law enforcement, and building trust with community members and gatekeepers.

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ER 932

Project LifeSkills: Engaging young transgender women in HIV prevention research and public health practice

Emilia Dunham; Jackie White, MPH; Sari L. Reisner, ScD, MA; Matthew Mimiaga, SCD, MPH

Recruitment, retention, and community engagement and trust are common challenges and barriers faced when conducting research with trans communities. LifeSkills study staff from the Boston site will discuss the HIV prevention intervention design, content, and delivery as well as highlight specific recruitment challenges and share innovative approaches to effectively engage young trans women, a traditionally "hard-to-reach" population in public health research and practice. Attendees may benefit from the Boston LifeSkills team experiences and understanding strategies that represent "best practices" for engaging trans community members in the development and delivery of HIV prevention efforts. There will be opportunities to ask questions and provide input on future public health research and community engagement efforts.

Research 2: Trans Men, Mental Health, and Hormones **Room: 204**

Shifts in sexual attractions in transitioning female-to-male trans men: Evidence from recalled crosssectional and prospective longitudinal studies

Colt Meier, PhD; Sari L. Reisner, ScD, MA; Seth Pardo, PhD; Levi Herman

The DSM-IV-TR includes sexual attraction subtypes for its gender identity disorder (GID) diagnosis. Research suggests that sexual attraction is not static over the life course. Therefore, sexual attraction subtyping may not be appropriate for diagnostic discernment among female-to-male trans men (FTMs). Two studies examined the prevalence of and self-reported changes in sexual attractions and sexual identities among FTMs. Study 1: Cross-sectional online sample of 605 FTMs (mean age = 27). Study 2: Longitudinal community sample of 80 FTMs enrolled at baseline (initiation of testosterone treatment) and follow-up (three months later and one year later), matched to non-transgender men and women controls (mean age = 26).

Subcutaneous testosterone: An effective delivery mechanism for masculinizing transgender men

Johanna Olson, MD; Leslie Clark, PhD, MPH; Lisa Simons, MD; Sheree Schrager, MS, PhD; Marvin Belzer, MD

Background: Testosterone therapy has been used for decades in transgender men who desire the development of male secondary sexual characteristics. While intramuscular injection remains the most common means of delivering testosterone, subcutaneous delivery has been used with clinical success.

No data reporting serum levels and feasibility are available.

Objective: This abstract presents baseline and 6 month follow up data from a subpopulation of transgender males enrolled in a large prospective, longitudinal study evaluating the impact of treatment on transgender youth between 12 and 24 years of age. Thirty-three participants received testosterone cypionate via subcutaneous injections to suppress menses and masculinize their bodies. Free and total testosterone levels and menstrual history were assessed at baseline and at 6 months.

Testosterone treatment in female-to-male trans men leads to MMPI-2 improvements

Colt Meier, PhD; Sari L. Reisner, ScD, MA; Seth Pardo, PhD; Levi Herman

The aim of the present study was to investigate the short-term effects of testosterone treatment on psychological functioning in trans men compared to controls. A non-clinical sample of trans men (n=48) completed the MMPI-2

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ER 933

immediately before initiating testosterone (baseline) and again 3-months later (follow-up). Non-transgender matched male and female controls (n=115) controls completed the protocol during the same time period. After adjusting for baseline scores, linear regression models were used to predict both within- and between-group changes in psychological functioning at follow-up.

Effects of testosterone treatment and chest reconstruction surgery on mental health and sexuality in female-to-male transgender people

Sam Davis, MSW; Colt Meier, PhD

This study examined the effects of testosterone treatment with or without chest reconstruction surgery (CRS) on mental health in female-to-male transgender people (FTMs). Qualitative reports of changes in sexuality related to testosterone were also examined. Over two hundred FTMs completed a written survey including quantitative scales to measure symptoms of anxiety and depression, feelings of anger, and body dissatisfaction, as well as qualitative questions assessing shifts in mood and sexuality after the initiation of testosterone. At the time of the study, 57 percent of participants were receiving testosterone and 40 percent had undergone CRS. Results indicate that testosterone either alone or with CRS was related to fewer symptoms of anxiety and depression as well as less anger. Those who had CRS in addition to testosterone reported the least body dissatisfaction of all groups. In qualitative reports, many participants described improved mood, increased sexual attraction to non-transgender males, and shifts in sexual orientation identity after taking testosterone. Overall, this study demonstrated that testosterone treatment was associated with indicators of more positive mental health, and that the combination of testosterone and CRS was related to greater body satisfaction.

Special Topics Room 205

Surgeon Roundtable

Curtis Crane, MD; Marcie Bowers, MD; Toby Meltzer, MD; Peter Davis, MD; Kate O'Hanlan, MD; Maurice Garcia, MD

Moderated roundtable discussion on the various gender affirming surgical procedures available to transgender woman and men presented by surgeons who are active in gender confirmation surgery and have expertise in these procedures. The interactive session is designed to promote dialogue among the conference participants and the surgeons.

Medical Training: Basic Junior Ballroom 1/2

Transgender care for the PCP: Part 2

Linda Wesp, NP; Jennifer Hastings, MD; Ronica Mukerjee, NP; Jamie Feldman, MD, PhD; Barry Zevin, MD

These sessions are a comprehensive primer for medical providers new to caring for transgender and gender non-conforming populations, this session will consist of two consecutive 90 minute sections. Topics to be covered include cultural sensitivity, capacity building, cross-sex hormone management, primary care and screening, models of intake and care, and a didactic case based discussion. This evidence-based curriculum is designed to provide the foundation necessary for the provider who desires to become competent in the clinical care of transgender patients.

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ER 934

Medical Training: Advanced **Junior Ballroom 3/4**

Topics in transgender primary care: Part 2

Anita Radix, MD, MPH; Juno Obedin-Maliver, MD, MPH; Tonia Poteat, PhD, MPH, PA-C

These sessions will cover a range of primary care topics and will be oriented towards those providers who already have some level of comfort and experience in the care of transgender patients. Individual topics will be explored in depth with a focus on current evidence. Subject areas include fertility, HIV and antiretroviral-hormone interactions, FTM gynecology, care of genderqueer patients, use of silicone, and issues of particular concern to transgender persons of color.

Mental Health 1: Children, adolescents, and puberty blockers **Room 208**

Panel moderated by Shawn Giammattei, PhD

A primer for working with trans youth

Michele Angello, PhD

Gender variant youth are discriminated against in multiple areas of their lives. This talk will discuss ways to support gender variant, transgender and gender non-conforming youth in the most prevalent areas: coming out to families, peers, school, physicians, religious/spiritual institutions, dealing with puberty, potential psychiatric issues. Each of these seven variables will be discussed in a way that the health care provider can guide the patient as well as the family in an attempt to allow for the most successful gender exploration possible for the child/adolescent.

Children, adolescents, puberty blockers

Joel Baum, MS

This presentation will discuss children, adolescents, and puberty blockers.

Children, adolescents, puberty blockers: The case for a study of early transitioning in children under 10

Herbert Schreier, MD

This talk will present the rationale for doing a descriptive study of the effects of early transitioning in gender variant children.

Mental Health 2: Research for clinicians/Sexual medicine **Room 210**

Research for clinicians

Walter Bockting, PhD

Depression and suicidal ideation are among the top health concerns of the U.S. transgender population, and recent research has demonstrated that these concerns are related to gender-related stigma and discrimination. This presentation will review the status of the research in this area, and discuss its implications for clinical practice and prevention.

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ER 935

The effects of hormones and surgery on sexual function

Gail Knudson, MD

Both hormone therapy and genital surgery can have effects on sexual function. This lecture will briefly overview the effects of masculinizing and feminizing hormones on sexual function. Secondly, it will overview the cognitive behavioral techniques used to improve sexual function post-operatively.

Sexual functioning in transgender people

Jaime Veale, PhD

This presentation will summarize the research literature on sexual functioning of transgender people. It will discuss sexual function problems and the factors related to these including transition and surgery.

Mental Health 3/Special topics: Forensics, eunuchs **Room 211**

The role of the forensic psychologist

Randi Ettner, PhD

This presentation will be a discussion of how forensic psychology has advanced the field of transgender care and the challenges in doing so.

Male-to-eunuch gender dysphoria

Thomas Johnson, PhD

While most individuals continue to view human sex and gender in terms of binary pairs (i.e., male or female; masculine or feminine), there are other variants. My colleagues and I have been working for several years with a population of genetic males, who wish to be not male, but do not consider themselves to be female. They variously identify as third-gender, eunuch, or continue to identify as male post-castration. We have termed this a Male-to-Eunuch Gender Dysphoria.

Mental Health 4 **Room 201**

Co-occurring conditions

julie graham, MFT; Randall Ehrbar, PsyD

This session will include an overview of the following: 1) Trauma: the importance of assessing abuse and histories of bullying; 2) Overlapping Spectrums: Neurodiversity, Autism Spectrum conditions and Gender; and 3) Anxiety, depression, schizophrenia, and dissociative disorders: When do we say no or not yet?

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ER 936

Policy **Room 206**

Transgender health in the Affordable Care Act

Kellan Baker, MPH, MA; Masen Davis, MSW

The Affordable Care Act is the biggest reform of America's health care system in more than 40 years. The law makes many changes that have the potential to help transgender people stay healthy and to promote the wellbeing of transgender communities. Some of these changes include making health insurance coverage more affordable and comprehensive, expanding access to HIV prevention and treatment services, and building the knowledge base about transgender health. But the full potential of the law won't be realized unless transgender people and our allies are engaged in turning the health reform law into reality for our communities. In this session, health policy experts and health care providers will explain the highlights and key challenges of health reform and engage in a discussion of how transgender advocates can leverage the law's reforms to advance transgender health priorities.

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DEF EX 2019_0028

ER 937

Session 3: Friday May 17, 3:20 - 4:50 pm

Research 1: Violence and STIs **Room: 203**

Multiracial trans people and bullying: Findings from the National Transgender Discrimination Survey

Luis Gutierrez-Mock, MA

School bullying is common among transgender (trans) and gender non-conforming youth and is associated with negative health outcomes. Multiracial youth also report being bullied in school, with evidence for differences in health outcomes when compared to their mono-racial counterparts. Using data from the National Transgender Discrimination Survey, this study examined multiracial ethnic identification disparities in bullying in grades K-12. Logistic regression was used to determine the association between multiracial status and bullying, controlling for gender identity, education, age, income, citizenship and family acceptance in trans adults. Multiracial respondents were significantly more likely to report bullying and harassment from peers and/or teachers than mono-racial White, mono-racial Black and mono-racial Asian respondents.

Sexual violence in transgender communities

Loree Cook-Daniels, MS; Michael Munson

Over the past decade, FORGE and other researchers have begun to document not only the very high rate at which transgender and gender non-conforming people have experienced sexual violence—more than 50%—but also how survivors are coping with their traumas, and how they approach (or not) victim services agencies and allied professionals. Data from three national research studies conducted by FORGE in 2011 and 2004 will be presented. Content will include 1. reported experiences and challenges transgender sexual violence survivors face, including short- and long-term physical and mental health consequences, treatment experiences and preferences (n=265); 2. transgender respondents' knowledge of and willingness to access multiple types of mainstream victim services following sexual assault or domestic violence, barriers experienced in accessing care (n=1005); 3. sexual violence service agencies' strengths and weaknesses in effectively serving transgender sexual violence survivors, common barriers faced, and factors that may inhibit transgender survivors from seeking services at their agency (n=310). FORGE has multiple grants with the Office on Violence Against Women, serving as a national training and technical assistance provider on transgender survivors of sexual assault, domestic violence, stalking, and dating violence. We also provide direct services, nationwide, to transgender sexual violence survivors. Research findings will be present interactively to solidify the retention of data and the implications for transgender survivors and for health care professionals, therapists, other allied service providers, and transgender organizers who serve transgender and gender non-conforming individuals/survivors. (236)

Prevalence of sexually transmitted infections in transgender patients: A quality improvement approach

Luis F. Molano, MD; R. Barucco

Evaluate the effectiveness of the Community Healthcare Network's Transgender Family Program in reducing risk taking activities by collecting data on sexually transmitted infections before and after enrollment. Program staff collected historical data (2008 - June 2012) from patients' charts. Staff divided patients who tested positive for sexually transmitted infections before entering the program from those who tested positive after enrollment. Data was collected from previous existing records and medical history collected by the medical provider. Staff calculated and compared the prevalence of sexually transmitted in the two groups.

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ER 938

Use of dermal-fat grafts for augmentation of labia majora in a transgendered woman

Lydia Fein, BS; Christopher J. Salgado, MD; Christopher E. Estes, MD; Harold M. Reed, MD; Clara AlvarezVillalba, MD

Introduction: Genital reconstruction is an expanding field as patients desire cosmetic and functional improvement. Various procedures exist for female genital reconstruction, including labiaplasty, hymenoplasty, vaginoplasty, perineoplasty, and clitoral hood reduction. Labiaplasty consists of two methods: labia minora reduction or labia majora augmentation. Depending on anatomy, amount of accessible tissue, and patient's aesthetic goals, labia majora augmentation may be the preferred technique.

Methods: In a 47-year-old transgender woman desiring fuller labia majora, augmentation was pursued using dermal fat grafts. The grafts were harvested from tissue of a concomitant mini-abdominoplasty procedure of which the patient also desired. Main outcome measures were patient satisfaction, sustainable tissue augmentation, and improved cosmesis.

Costs and benefits to employers of providing transition-related health care coverage to employees

Jody L. Herman, PhD; Peter J. Cooper

In the 2013 Corporate Equality Index, the Human Rights Campaign (HRC) identified 287 employers who provide transition-related health care benefits to their employers. Though this list of employers has rapidly grown since HRC first began tracking these health benefits in 2009, medically-necessary transition-related health care is most often excluded from employee health benefits policies. Prior research suggests that utilization of transition-related health benefits is very low, as are the costs of providing the coverage. Prior research also suggests that there are health benefits to individuals when they are provided access to medically-necessary care for transition and related care. Yet, little research has been conducted to link the costs and benefits of transition-related health care coverage to the overall net benefits that employers accrue that provide the coverage.

This presentation will outline findings from a recent study that examines the business case for providing transition-related health care coverage. Utilizing an original survey of businesses that provide the coverage and an extensive literature review, this study examines the costs and benefits to employers of providing transition-inclusive health benefits for their employees. Findings from the original survey will provide data on cost, utilization, and perceived benefits as reported by participating employers. Findings from the literature will outline the benefits of transition and how providing transition-related health care to employees who need it may impact employers' overall health benefits costs in the long run.

Genital surgery outcomes of transsexual males

Trystan T. Cotton, PhD

This paper presents the results of transsexual men's satisfaction with sex reassignment surgery. Tens of thousands of transsexual men have undergone genital surgery to align their morphological sex with their gender identity. Yet, very little is known about their surgical journeys, why they choose genital surgery, and its transformative impact on their lives. Academic literature in Gender Studies presents a truncated view of the surgical outcomes and the myriad reasons why transsexual men seek surgery in part because they don't engage the medical literature on SRS or transsexual men who've actually undergone surgery. While surgeons' report successful surgical outcomes in medical journals, their accounts lack the human perspective of patients reporting on how surgery changes their lives socially, sexually, psychologically.

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ER 939

and somatically. This paper presents data that corrects the analytical myopia of academic criticism of FTM genital surgery and broadens medical understanding of the significance of genital surgery for transsexual men. The data comes from three sources: 1) my ethnography of 61 transsexual men in the African diaspora; 2) medical literature statistics on FTM genital surgery; and 3) autobiographical testimonies written by transsexual men who've undergone sex reassignment.

Special Topics 1: HIV treatment cascade and silicone use **Room 208**

HIV treatment cascade among transgender women in a San Francisco respondent driven sampling study

Glenn-Milo Santos, MPH; Erin Wilson, DrPH; Jenna Rapues, MPH; Oscar Macias, MPH; Tracey Packer, MPH; H. Fisher Raymond, DrPH

Background: Male-to-female transgender women (transwomen) have a disproportionate burden of HIV worldwide—transwomen have 48.8 fold greater odds of being HIV-infected compared to the general adult population, according to pooled estimates of available data. In San Francisco, transwomen have the lowest 5-year survival probability of all gender groups and the least ART use. Despite their poor health outcomes compared to other groups, little is known about the treatment outcomes of transwomen with HIV. We sought to estimate population-level HIV-treatment cascade indicators among transwomen in San Francisco.

Methods: We conducted a Respondent-Driven Sampling (RDS) study of 314 transwomen from AugustDecember 2010. Participants were offered an HIV test and the study collected self-reported data on linkage and access to care, most recent CD4 count and viral load, and antiretroviral treatment (ART). We derived population-based estimates and 95% confidence intervals of cascade indicators using sampling weights adjusted for homophily and probability of being recruited into the study (social network size of transwomen) using established RDS methods.

Results: The RDS-weighted population-based estimate of HIV prevalence was 39% (95%CI 32-47) among transwomen tested for HIV. Among HIV-positive transwomen, 77% (70-93) reported being linked to primary care within 3 months of their HIV diagnosis and 87% (76-98) had accessed care in the past 6 months. In addition, 35% (24-55) of HIV-positive transwomen reported a CD4 count below 350, 65% (54-75) were currently on ART, and less than half (44%; 21-58) reported being virologically suppressed (viral load ≤200 copies/mL).

Conclusions: We observed a high prevalence of HIV in our population-based estimates of transwomen in San Francisco, coupled with modest ART use and low virologic suppression rates, indicating high potential for forward transmission. These findings are consistent with San Francisco surveillance data showing that HIV-positive transgender individuals have higher HIV community viral load and higher mortality rates than other HIV-positive populations. Taken together, these data suggest that multi-level efforts are urgently needed to ameliorate disparities in HIV clinical outcomes among transwomen and reduce secondary HIV transmission to their partners.

Dying to be a woman: Morir por ser mujer

Arianna Inurritegui-Lint

The Trans-Latina Coalition presents a documentary short about silicone injection in the trans community that includes interviews with trans women who have been affected by silicone injection and complications. This video demonstrates the urgency for education about this issue, and advocates for access to healthcare that meets the needs of the trans community. Members of the Trans-Latina Coalition will lead a discussion of the film and silicone use in transgender communities.

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ER 940

Special Topics 2: HIV Criminalization **Room 201**

Intersections of disclosure and prosecution: Transgender people respond to criminal laws based on HIV status

Laurel Sprague, Sean Strub, Cecilia Chung, and Robert Suttle

Communities bearing the brunt of the HIV epidemic are also communities with historically fraught relationships with public health and the justice system. As such, laws that criminalize non-disclosure of HIV status raise key issues about community norms, expectations of fair treatment by authorities, privacy and vulnerability. In 2012, the Sero Project, with Eastern Michigan University, conducted survey research with people living with HIV and affected communities (n=3248) about HIV criminalization. Results showed significant differences based on sex and gender. Critically, in a time of concern about the gaps in HIV testing, treatment, and care, transgender respondents were the most likely to say that fears about criminalization made it very reasonable to avoid HIV testing, disclosure to partners, and treatment for HIV infection. The responses from all survey respondents who were living with HIV painted a picture of intense vulnerability to the legal system. This was even more marked in the responses by transgender individuals who were much more likely to worry about false accusations than other respondents and least likely to expect that a person with HIV, particularly a transgender person, could get a fair hearing in their state if accused of HIV non-disclosure. Transwomen, in particular, indicated high levels of fear of facing false accusations. Overall, transgender respondents described emotionally difficult, complex decision-making processes regarding HIV disclosure and criminalization, particularly in terms of ethics of care for others and themselves in the face of unequal sexual relationships and larger societal stigma. The survey responses highlight multiple, overlapping vulnerabilities for transgender people within health and justice systems, revealing a critical need for advocates, researchers, and the medical community to address HIV criminalization and to ensure protective health care and legal environments for the wellbeing of transgender people living with and at risk for HIV.

Medical Basic **Medical Advanced** **Mental Health** **East Hall**

Joint Session: Multidisciplinary case presentation

Description: Typical case vignettes and one complex case of a transitioning patient with mental illness and substance abuse will be presented and discussed by interdisciplinary panels.

Case #1: "Transition is complete, for today"

Dan Karasic, MD; Heather Weisbrod, LCSW; Deborah Brown, MD

Description: Multidisciplinary care of a genderqueer youth with bipolar disorder and alcohol dependence will be presented by three of the youth's providers at the Dimensions Clinic. Dr. Karasic will discuss the care of patients across the gender spectrum and with co-occurring mental health conditions.

Case #2: Case vignettes roundtable

Lin Fraser, EdD; Nathan Sharon, MD; Madeline Deutsch, MD

Case vignettes illustrating principles of care will be presented and discussed by a panel of health providers from different disciplines. Discussions will explore the interface with mental health services from the perspective of primary care for a range of topics including pre-surgical clearance, gender identity exploration, and "coming-out" issues. Emphasis in this section will be on transgender patients without psychiatric co-morbidities.

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ER 941

Policy Institute **Room 206**

Reproductive rights, fertility, and family building

Masen Davis, MSW; Katherine Hsiao, MD; Collin Smikle, MD; Laura Nixon, Esq.

Transgender people are increasingly asserting their right and desire to have families and children, raising new policy and medical questions for providers and advocates. This session will explore a range of options and implications for reproductive rights, fertility, and family structure from both provider and advocate perspectives.

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DEF EX 2019_0033

ER 942

Session 4: Saturday May 18, 10:30am - 12pm

Research 1: Trans women, substance use, and HIV **Room: 203**

The rising cost of living: How housing status affects substance use, sexual partnering, and HIV risk behaviors in a sample of urban transgender women

Kimberly Kisler, MPH; Jesse B. Fletcher, PhD; Cathy J. Reback, PhD

Street outreach encounters were used to collect data of self-reported HIV status, substance use, and sexual risk behavior among transgender women (N=2,181) over a seven-year period, from January 2005 through December 2011. Analyses were conducted to assess demographic data, self-reported HIV status, frequency of substance use, and engagement in sexual risk behaviors and sex work. The mean age was 31.1 years (SD=8.7). Most participants (72.1%) self-reported as Hispanic/Latina or African American/Black (12.4%). Self-reported HIV serostatus also fluctuated, with the percentage of transwomen reporting HIV-positive status ranging from 5.8% (second half of 2006) to 20.7% (first half of 2005); the overall HIV-prevalence rate for the entire sample was 13.3%. The most frequency reported substances were alcohol - ranging from 37.9% (first half of 2005) to 71.0% (second half of 2006) - followed by marijuana - ranging from 12.8% (first half of 2008) to 47.2% (second half of 2009) - and methamphetamine, ranging from 14.4% (second half of 2008) to 36.0% (second half of 2007). Rates of recent engagement in unprotected anal intercourse with a male ranged from 5.0% (first half of 2006) to 17.7% (first half of 2010); recent engagement in unprotected anal intercourse for the sample as a whole was 11.9%. Rates of recent engagement in sex work ranged from 60.0% (first half of 2006) to 85.6% (second half of 2008); the rate of recent engagement in sex work for the sample as a whole was 74.1%. These data indicate the need for ongoing HIV prevention efforts directed to this particular high-risk population.

HIV status, substance use, and sexual risk trends among street-recruited transgender women

Cathy J. Reback, PhD; Jesse B. Fletcher, PhD

Street outreach encounters were used to collect data of self-reported HIV status, substance use, and sexual risk behavior among transgender women (N=2,181) over a seven-year period, from January 2005 through December 2011. Analyses were conducted to assess demographic data, self-reported HIV status, frequency of substance use, and engagement in sexual risk behaviors and sex work. The mean age was 31.1 years (SD=8.7). Most participants (72.1%) self-reported as Hispanic/Latina or African American/Black (12.4%). Self-reported HIV serostatus also fluctuated, with the percentage of transwomen reporting HIV-positive status ranging from 5.8% (second half of 2006) to 20.7% (first half of 2005); the overall HIV-prevalence rate for the entire sample was 13.3%. The most frequency reported substances were alcohol - ranging from 38% (first half of 2005) to 71% (first half of 2006) - followed by marijuana - ranging from 13% (first half of 2008) to 47% (second half of 2009) - and methamphetamine, ranging from 14% (second half of 2008) to 36% (second half of 2007). Rates of recent engagement in unprotected anal intercourse with a male ranged from 5.0% (first half of 2006) to 17.7% (first half of 2010); recent engagement in unprotected anal intercourse for the sample as a whole was 11.9%. Rates of recent engagement in sex work ranged from 60.0% (first half of 2006) to 85.6% (second half of 2008); the rate of recent engagement in sex work for the sample as a whole was 74.1%. These data indicate the need for ongoing HIV prevention efforts directed to this particular high-risk population.

Characteristics and potential needs of transgender individuals entering substance abuse treatment

Annesa Flejtje, PhD; Nicholas C. Heck, MA; James L. Sorenson, PhD

The purpose of this study is to identify characteristics of transgender individuals entering substance abuse treatment by comparing the psychosocial, mental heath, and substance use histories of maleto-female (MTF) and female-to-

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male (FTM) transgender persons using data from the San Francisco County Database, which contains treatment admission data for persons (N=14,015) entering treatment programs in San Francisco between July 2007 and June 2009. A total of 146 MTF and 53 FTM persons were identified in the database

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Thick trust, thin trust, and HIV among trans women of color in New York City

Sel J. Hwahng, PhD; Bennett Allen; Cathy Zadoretzky, MA; Hannah Barber; Courtney McKnight, MPH; Don Des Jarlais, PhD

Introduction: African American and Latina trans women (male-to-female transgender people) have been measured to have very high HIV seroprevalence nationally, and in New York City almost half are HIV positive. Trans women of color are in the midst of an HIV epidemic, and greater knowledge and understanding about trans women of color social networks may provide relevant information towards more effective interventions and policies.

Methods: These data comes from a mixed-methods study that examined low-income trans/gendervariant people of color who attended transgender support groups at harm reduction programs in New York City. The study was conducted from 2011-12, with a total N=34. The qualitative portion was derived from six focus group interviews that were audio-taped and transcribed. The quantitative portion was derived from a survey that was administered at the focus groups.

Research 2: Primary Care for Trans People **Room: 204**

Harm reduction model for treatment of MTF transsexuals below the poverty line

Jennifer Burnett, MS, MD, FAAFP

Many Transsexuals are highly motivated by their extreme gender dysphoria to seek cross-gender hormones by any means possible. There is a significant subset of TS who subsist below the poverty level and, due to lack of a stable job, societal restraints (e.g. unable to qualify for any type of welfaresponsored medical care), or other factors, are unable to obtain any medical care for their condition. Many of these will seek out hormones through the "black market" and use them with little or understanding at what type(s) or dosages they are giving themselves. Most of these illicit preparations are highly unsuitable, even dangerous for those using them, and are administered with the only directions being by "word of mouth", passed on by peers or other non-medical personnel..This presentation is a summary of 4+ years of demographic and outcomes data on the treatment of M2F transsexuals utilizing a Dual Hormone Protocol of injectable Estradiol Valerate and Depo-Provera. Through this project M2F TS were able to significantly reduce their risk for complications, receive needed patient education and be evaluated for their other medical needs as well.

We have a hard time treating your kind here: Negative health experiences of transgender women in San Francisco

Leah B. Rorvig, MS4, MSc

Transgender women are subjected to numerous forms of mistreatment in the health care setting and describe a high degree of emotional distress related to these experiences. This is particularly important in light of the high prevalence of major depression in this population. Transgender women actively prioritize gender-affirming health care and employ varied avoidant and proactive strategies to ensure knowledgeable and respectful care.

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Socio-economic barriers to accessing gender-confirming care

Janelle Downing

Transgender people experience significant barriers to receiving counseling and top surgery as a result of not having health insurance. Gender confirming surgeries are not accessible for transgender people who are poor or near poor. These barriers to accessing health services may continue to perpetuate and even exacerbate disparities in health of transgender people.

Heading the call: An OBGYN's role in female-to-male transgender (FTM) patient care

Juno Obedin-Maliver, MD, MPH; Alexis Light, MS4, MPH

According to the 2011 Institute of Medicine Report and emphasized by the American Congress of Obstetricians and Gynecologists (ACOG) committee opinion, transgender individuals encounter significant barriers to healthcare. ACOG charges obstetrician-gynecologists (OB/GYNs) to help eliminate these barriers to care by creating non-discriminatory practices and assisting with transitions. But what does this mean in practice?

By drawing on preliminary research from two current studies, this presentation will discuss the care of female-to-male (FTM) transgender patients within OB/GYNs practice. One study "Gynecological Surgery for Female-to Male Transgender Men: Total vaginal hysterectomy as an approach for gender confirming surgery" is a chart review analyzing the feasibility of total vaginal hysterectomies, without the additional morbidity and cost of laparoscopy, thereby expanding options for these patients. The other, "Pregnancy After Transitioning Study (PATS) - Feasibility and pilot study of FTM transgender men who have experienced pregnancy," is a retrospective analysis to better understand the pregnancy and birth experience of FTM individuals as well as possible birth outcomes.

Special Topics 1: Trans training tools   Room 201

Affirmative care for transgender and gender non-conforming people: Best practices for front-line health care staff

Emilia Dunham, BA; Harvey Makadon, MD

In collaboration with trans health care providers, researchers and front-line staff, the National LGBT Health Education Center at The Fenway Institute created a helpful tool of best practices for front-line health care staff to provide affirmative care for transgender and gender non-conforming individuals. Our needs assessments and review of available research reveal a great need for front-line staff to learn how to appropriately and sensitively communicate with transgender patients. With increased need for health centers and other health care organizations to become more culturally competent in providing affirmative services for transgender clients, this tool addresses the often overlooked best practices for training front-line staff.

Special Topics 2: Rectal microbicides   Room 202

HIV prevention that Gels: Rectal microbicides for transgender communities

Ian McGowan, MD, PhD; David Nalos

As one of the most at-risk groups for HIV in the United States who are often left out of biomedical HIV research, transgender women can benefit greatly from playing an active role in rectal microbicide research and advocacy.

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These voices are vital to shape a rectal microbicide research agenda that is inclusive and responsive to the needs of transgender communities. During this session, experts will provide an in-depth and up-to-date discussion of the science, community challenges, and advocacy related to rectal microbicides as an alternative HIV prevention strategy for transgender people who practice anal sex. Attendees will have an opportunity to view a newly launched educational video on rectal microbicides, and leave with new knowledge about the status of HIV prevention research and how to overcome the barriers that may be preventing transgender communities from becoming involved in this promising research area.

Medical Training: Basic — Junior Ballroom 1/2

Care of transgender children and adolescents

Johanna Olson, MD; Steve Rosenthal, MD; Jennifer Hastings, MD; Michele Angello, PhD

This session is an introduction for the medical provider who is new to caring for trans and gender nonconforming children and adolescents. Topics to be covered include care and social transition for children, puberty blocking and peri-pubertal clinical decision making, early through late adolescent care including cross-sex hormones, as well as a discussion of the biology of gender. Special emphasis will be made on the multi-disciplinary approach as well as important mental health considerations for youth.

Medical Training: Advanced — Junior Ballroom 3/4

Transgender surgery: What primary care providers need to know

Christine McGinn, DO

This session will cover a range of surgical topics of interest and concern to the primary care provider. Topics to be discussed include preoperative medical evaluations and clearances, common postoperative problems, medical implications of surgery, as well as an update on current surgical treatment paradigms and options.

Mental Health 1: In-depth psychotherapy — Room 208

Moderator: Lin Fraser, EdD

Clinical explorations in the renegotiating of erotic matter for transgender clients

Elise Turen, PhD, ACS

TS/TG people can achieve a heightened sense of Sexual Selfhood far more nuanced and inspiring then the average population, due to the monumental task of re-ascribing and redefining sexual/erotic orientation(s) and identities potentially leading to a more profound and intimate attunement to Self and Others. This workshop will address the Clinical Issues related to the integration of a Sexual Self-hood along with a Gender Congruent Identity.

Finding the way home: The challenge of embodiment for transgender/transsexual clients

Kim Hraca, LMFT

When someone undergoes a gender transition, how do we find ways to address what is experienced in the body? In this talk, we will pay particular attention to the visceral impact of social transition, hormones and/or surgery and the challenge of navigating those changes within a relationship.

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Mental Health 2: Substance abuse — Room 210

Substance abuse
Jay Williams, MSW, ASW

This presentation utilizes Harm Reduction as a holistic model to support safety, well-being, and personal empowerment in transgender, genderqueer, and questioning youth with substance concerns.

Substance abuse
Jeanna Eichenbaum, LCSW

This presentation will explore the ways that healthy and unhealthy relationships to substances have impacted and informed the trans and gender-variant communities.

Mental Health 3: Family building and relationships — Room 211

Trans parents: When trans people have kids before coming out
Randall Ehrbar, PsyD

This presentation will provide a review of the literature and discussion about trans people who are parents and the impact of transition on their children.

Reproductive options for prospective trans parents
Gail Knudson, MD

This session will briefly overview the reproductive options available to trans people as an introduction to a larger discussion on family building and parenting in the latter part of the workshop.

Issues in working with cis-trans couples: Transition and beyond
Maureen Osborne, PhD

In committed relationships where one member identifies as transgender, there are unique challenges. Whether the context be one of early or later discovery/disclosure, part-time or full-time, public or private expression, straight or queer-identified, there are many difficult issues that may arise. Among these are damage to mutual trust, loss of intimacy, unrealized hopes and expectations, competition for attention, finances, and more. This talk will identify issues and suggest therapeutic strategies for working with couples with a gender variant partner.

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Mental Health 4: Clinical training issues **Room 205**

Transition in training

Nathan Sharon, MD

Dr. Sharon will be discussing his personal experiences of medical transition during medical school as well as ongoing needs of teaching transgender healthcare competency within residency training.

Transgender psychiatry: Training modern clinicians

Jack Pula, MD

Dr. Pula will discuss his efforts training psychiatric residents and other mental health professionals on caring for transgender people in psychiatric settings, making use of his own personal and professional experience, and collaboration with psychiatric colleagues in clinical and advocacy settings. Participants will learn about the state of training standards and fundamental aspects of competency in transgender psychiatric care.

Clinical training issues

Becca Keo

Becca Keo will share experiences with encountering a professor who made a trans-negative comment in class and how the situation was navigated in a professional manner. Additional topics will include receiving support and affirmation from a mentor regarding transgender and gender diverse issues, and engaging in collaborative learning with colleagues in the social work department regarding training on trans issues.

Clinical training issues

Colt Meier, PhD

Dr. Meier will discuss his experiences transitioning in grad school in Texas, navigating multiple relationships with community members in an ethical manner, and dealing with resistance in training graduate students and professionals in conservative environments.

Policy Institute **Room 206**

Transgender-inclusive insurance roundtable

Kellan Baker, MPH, MA; Jamison Green, PhD; Masen Davis, MSW

An expert roundtable on trans insurance issues will serve as the capstone of the Policy Institute. During this session, invited experts will discuss recent developments around comprehensive and accessible private and public insurance coverage for a range of transgender health needs. In particular, we will focus on harnessing and expanding the potential of recent engagements with insurance commissioners in California, DC, Colorado, and Oregon that have resulted in groundbreaking new protections for trans people with private insurance coverage. The roundtable will include short presentations about how the work in these jurisdictions was done, what pitfalls arose, and what future needs are for continuing to make advances with regard to both private and public coverage.

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Session 5: Friday May 18, 1:30 - 3 pm

Research 1: Transgender Identities **Room: 203**

Constructing a multidimensional model of gender identity and expression sensitive to the diversity of experiences within the transgender and gender non-conforming spectrum

Laura Kuper, MA; Laurel Wright; Brian Mustanksi, PhD

Based on assessment of the existing gaps in the literature on transgender and gender nonconforming developmental trajectories, the present study aimed to: (1) identify gender-related dimensions of personal experience and (2) develop a model of their development from Childhood through Emerging Adulthood that (a) is applicable to both gender nonconforming and transgender individuals (b) reflects the influence of ecological factors (c) is sensitive to issues of diversity, and (d) is informed by the sociopolitical and historical knowledge. In order address these aims we conducted qualitative interviews with twenty racially diverse young adults who reported high levels of childhood gender nonconformity. At the time of interview, roughly half of these participants identified as transgender. Remaining participants identified as lesbian or gay but not transgender, although some had identified as transgender in the past. Interviews explored the ways participants reflected on their childhood experiences, conceptualized their current identities, and narrated their process of identity development. Participants' experiences were first sorted into Intrapersonal, Interpersonal (e.g., family, peers, strangers), and Structural (e.g., school, workplace, society) domains. Within the Intrapersonal domain, four main dimensions of gender related self-understanding were identified: Gender Identity, Gender Presentation, Gender Role/Expression, and Physical Self Image. These variations in Gender were also relevant to participants' descriptions of their Sexuality. A model was developed to reflect how these Gender and Sexuality related self-understandings develop over time, as influenced by Intrapersonal and Structural factors. This model will be displayed at the poster session along with an additional three figures that provide more detail on (1) Gender and (2) Sexuality related domains of self-understanding, and (3) propose a theoretical overview of how these variations in Gender and Sexuality come to influence mental health. The model is currently being developed into a quantitative measure intended for both clinical and research applications and feedback will be welcomed from all attendees.

This is my life today: A portrait of transgender women of color in New York City

Luis F. Molano, MD; R. Barucco

The workshop will present the findings of a descriptive, exploratory analysis based on records' review and case studies. We collected and synthesized the information from psychosocial assessments provided to 100 transgender female of colors in non-LGBT, community-based healthcare setting located in underserved areas throughout New York City. The study summarizes the information collected in the psychosocial assessments in the following areas: serostatus information and patient's adjustment to HIV status, medical concerns, family and collateral support, education, financial and legal situation, substance use assessment, mental health assessment, and risk assessment. Findings provided significant insight into the real lives of transgender women of color. The presentation provides qualitative insights into the difficulties that transgender women of color experience and ultimately into the implications on the way they live their live. The analysis will conclude with data-driven hypothesis in terms of service recommendations for transgender women of color.

Mental health among transgender women of color: A view on combined discrimination and transgender identity

Kevin Jefferson, BS; Torsten B. Neilands, PhD; Jae Sevelius, PhD

Little is known about the experiences of transgender women of color and their mental health needs. Given the relationship between discrimination and depression, we hypothesized race and transgender discrimination would

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be associated with increased odds of depression among transgender women of color (Diaz, Ayala & Bein, 2004; Nemoto et al, 2004). Cross sectional data were analyzed from 98 participants in Sheroes, an ongoing transgender women's health study. Using logistic regression, we examined the relationship between depression and exposure to transphobic and racist events, respectively, subsequently accounting for coping self-efficacy and regard about one's transgender identity. Experiences of transphobic events (OR = 1.043; $p < .05$) and racist events (OR = 1.035; $p < .05$) increased the odds of depression, respectively; whereas regard about women's transgender identity decreased the odds of depression (OR = 0.494; $p < .05$). When we explored the combined effects of racist and transphobic events in a logistic model, we found higher levels of non-additive discrimination were associated with increased odds of depression. Our findings underscore the need to address transphobic events in transgender health campaigns, identity-based psychosocial interventions, and policy. Based on the joint influence of transphobic and racist events on depression, these strategies must also acknowledge the unique experiences of transgender women of color. Furthermore, the protective association ascribed to higher regard of a transgender identity underscores the importance of developing empowerment opportunities for transgender women. We discuss opportunities to address the health needs of transgender women of color in research, psychosocial interventions, and policy.

Research 2: Transgender Health Risks, Resiliencies, and Aging **Room: 204**

Morbidity and mortality in a transgender hormone treated patient population: Preliminary data

Jamie Feldman, MD, PhD; Katherine Spencer, PhD

Background: The Institute of Medicine has called for clinical research in hormone-treated transgender persons to understand the effects of treatment. Current studies suffer low numbers of patients and short exposure time, and absence of systematic data analysis from the United States.

Methods: Retrospective chart review from 15 gender dysphoria centers (10 Europe, 5 USA), Eligibility criteria: 18 or older, received hormones prior 2010, and follow up for ≥ 1 year. Analysis of entire data set is ongoing for cause-specific side effects with age, type/dose of hormones, duration, pre-existent comorbidity, and cardiovascular risk factors. Data from one US clinic (Minnesota) has been analysed for proportion of patients receiving hormones, demographics, co-morbid status and adverse events.

Results: 357 charts were reviewed. 72 (23 FtM, 49 MtF, 20.1%) met criteria for study inclusion. 201 (56. 3%) charts showed assessment for gender dysphoria, but never received hormones at the clinic. Average age at hormone start, 33.9 years, 69% nonsmokers. Common co-morbidities: depression, hypercholesterolemia, hypertension and diabetes. 18% transfeminine and 17% of transmasculine patients were obese or morbidly obese prior to hormone therapy. Patients followed average of 4.22 years (range 1-28 years). Adverse events during feminizing hormone therapy included: 1 deep venous thrombosis, 1 myocardial infarction, and death from splenic artery rupture in a patient with underlying liver disease. Adverse events during masculinizing hormone therapy included: hypercholesterolemia, ACL tear, and subfascial hematoma related to IM injection.:

Transgender older adulthood and end of life concerns

A. Evan Eyler, MD, MPH; Tarynn M. Witten, PhD, LCSW

Transgender and gender variant persons in the older adult age groups are becoming more visible, and often present for medical services related to both gender transition and age appropriate physical and mental health needs. Research evidence is currently lacking for this population, although some extrapolations can be made from clinically relevant populations and from the non-transgender medical literature. This workshop will address the concerns of transgender older adulthood from an Ericksonian and practical perspective. Recommendations regarding preventive medical care pertinent to this population will be presented, and some of the implications of estrogen and testosterone use among older adults will be considered. Palliative care, end of life concerns, and the creation of legacy will be discussed. Results from a recent year-long survey on end of life preparation and perception will

be presented. A case based format will be used. This workshop is intended for medical and nursing clinicians who work with gender variant persons in the middle and older adult years, though others are welcome to attend.

Health and aging among LGBT older adults: Risks and resiliencies

Jill Gover, PhD

This PowerPoint presentation will review the research data from the Caring and Aging with Pride 2012 study, a collaboration with eleven community based agencies throughout the nation serving LGBT older adults, and the first national federally funded project to examine LGBT aging and health. The project accessed data from 11 community based agencies across the nation serving LGBT older adults. This presentation will highlight the key findings and the recommendations stemming from this groundbreaking research project on LGBT older adults, with a focus on transgender health disparities.

Special Topics 1: CDC roundtable **Room 201**

Strengths and challenges from PS 11-1113 grantees adapting HIV prevention interventions for trans women of color

Mac McKleroy, MPH; Gladys Gonzalez; Sabrina Bennett; Sharyn Grayson; Shaun Che; Trey Gantt; Victor Harrell

This session will highlight the successes of six grantee organizations funded by CDC to implement evidence-based behavioral HIV prevention interventions and public health strategies with transgender women in Baltimore, Detroit, New York, Oakland, and Washington DC. Challenges will also be identified; and subject matter experts and peers will discuss strategies for overcoming barriers to successful implementation.

Special Topics 2 **Room 202**

Transgender care issues for pharmacists

Kirsten Balano, PharmD

This session will tackle the pharmacologic issues related to effective use of hormonal therapy for transgender clients. Evidence-based issues regarding formulation, dosing and cost will be reviewed. In addition, time will be spent reviewing HIV and Antiretroviral Pharmacology, describing current classes of agents used to treat HIV infection and identifying preferred HIV treatment strategies in 2013.

Medical Training: Basic **Junior Ballroom 1/2**

Transgender surgery: What primary care providers need to know

Christine McGinn, DO

This session will cover a range of surgical topics of interest and concern to the primary care provider. Topics to be discussed include preoperative medical evaluations and clearances, common postoperative problems, medical implications of surgery, as well as an update on current surgical treatment paradigms and options.

Medical Training: Advanced — Junior Ballroom 3/4

Advanced case-based discussion

Madeline Deutsch, MD; Anita Radix, MD, MPH; Johanna Olson, MD; Steve Rosenthal, MD; Jennifer Hastings, MD; Linda Wesp, NP; Ronica Mukerjee, NP; Curtis Crane, MD

This session will serve as a capstone to the two day clinical training track and will involve an in-depth discussion of a range of complex cases in both pediatric and adult patients. A panel comprised of course faculty will take turns reviewing and moderating case discussions.

Mental Health 1: ICD 11 — Room 208

ICD 11 promises dramatic changes in diagnosis, including removal of Transsexualism from the mental disorders section, and a narrowing of the paraphilic disorders. Some controversies persist, in particular the inclusion of Gender Incongruence of Children. Proposals for ICD 11 will be presented by WHO staff and committee members responsible for the proposals, and discussed by others involved in diagnostic change.

ICD-11: Introduction

Dan Karasic, MD

This presentation is a brief overview of issues leading to the diagnostic changes in ICD 11.

ICD-11: The World Health Organization's process for revising diagnoses affecting transgender people

Geoffrey Reed, PhD

Geoffrey Reed, PhD is Senior Project Officer, Revision of ICD-10 Mental Health and Behavioural Disorders, World Health Organization. He will describe the process and timeline for revising ICD.

ICD-11: Proposals for gender incongruence diagnoses

Peggy T. Cohen-Kettenis, PhD

Dr. Cohen-Kettenis will review ICD-11 proposals on Gender Incongruence of Adults and Adolescents, and Gender Incongruence of Children

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ICD-11: Paraphilic disorders

Richard Krueger, MD

This presentation will review proposed paraphilic disorders in ICD-11.

ICD-11: WPATH's recommendations

Gail Knudson, MD

WPATH has been an active participant in providing feedback to the WHO with respect to the ICD 11 gender diagnoses. This presentation will overview the three phases of the project and summarize the proposals thus far.

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From gender madness to gender wellness in the ICD-11

Kelley Winters, PhD

This presentation will discuss strategies for transition health care coding in the ICD-11, addressing issues of social stigma and transition care access for children, adults and adolescents. Includes recommendations from the Global Action for Trans* Equality (GATE) Expert Working Group.

Mental Health 2 Room 201

Culturally competent care for trans people of color

Willy Wilkinson, MPH

In this interactive workshop, participants will explore the varied complexities of gender identity and expression, develop tools for providing culturally competent care for diverse client populations, and identify trans-inclusive policies and procedures to ensure equal access on an organizational level.

Mental Health 3 Room 211

Complex cases in community mental health

Heather Weisbrod, MSW; Maria Porch, LCSW; Robyn Stukalin, LCSW; Michelanne Baker, PsyD

This session will include presentation of cases from community mental health/public health settings. These cases will highlight strategies for engaging and supporting people through the process of transition while simultaneously addressing multiple psychosocial challenges.

Policy Institute: ICD 11 Room 208

Policy Institute participants will join the Mental Health 1 participants for this informative session.

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Poster Reception: Saturday May 18, 3:00 pm – 4:00 pm

Transitioning transgender

Lydia Fein, BS; Christopher E. Estes, MD; Marlene Velasquez-Sedito, RN; Christopher J. Salgado, MD

Better understanding the transitioning process allows doctors to be more sensitive to their transgender patients' needs. This study sought to identify the most significant aspects of transitioning that allow transgender patients to best pass as and feel like their true gender.

Objectified body consciousness in gender diverse populations

Dulcinea Pitagora, MA; Jessica A. Joseph, MA

The Objectified Body Consciousness Scale (OBCS) has predominantly been used to measure Objectified Body Consciousness (OBC) in women. Though attempts have been made to extend the utility of the OBCS by including men in samples, there has been no research to date incorporating gender diverse individuals. The current study administered an online survey to a sample (N = 185) of individualswho self-identified as androgynous, cross-dresser/MTF, gender fluid, gender non-conforming, gender queer, man, transgender/MTF, and woman. Measures included the OBCS, Body Esteem Scale (BES), and 6 original items related to gender expression and passing. Three hypotheses were tested: (1) OBC Body Surveillance and Body Shame subscale scores for gender diverse groups should be significantly higher than cisgender groups, and will have a negative correlation to the BES; (2) scores on the OBC Control Beliefs subscale should vary significantly depending on gender identification; and (3) gender groups that identify most with culturally stereotyped genders should score higher in OBC Control Beliefs subscale correlating to higher scores on items related to salience of gender difference and importance of passing. Reliability, correlational, and Kruskal-Wallis (non-parametric ANOVA) analyses were conducted. Findings suggested that the OBCS is generalizable to gender diverse populations; passing may be a more appropriate correlate to the OBC subscales than thinness or muscularity; and a positive association with one's gender identification, regardless of compliance with cultural norms, can contribute to higher body esteem, and could mitigate the negative effects of OBC.

Transgender health: Fulton and DeKalb counties transgender mobilization project

Benjamin Moore, MS, PhD

This poster explores a method to reduce the lack of HIV specific prevention programs, medical clinics, case management, and social support services available for the AA Transgender communities in Metro Atlanta - DeKalb and Fulton Counties.

Laser hair removal services for transwomen: An effective connection to care

Cecily Cosby, PhD, FNP-C/PA-C; Tamera Valenta, MSN, FNP; Tev Monnin, RN, FNP

Maintaining continuity with primary and/or specialty care services is often challenging for many transwomen. Strategies intended to facilitate the connection to care can have a positive impact on both quality of life and patient outcomes. A needs assessment conducted with a California Bay Area group of transwomen in 2011 identified feminizing services, specifically the management of facial hair, as a high priority. Few things are as masculinizing as dark, coarse facial hair. Beyond the anxiety and distress this causes are the associated safety concerns related to being 'clocked' by those who would do harm. Feminizing services, such as laser hair removal (LHR) and electrolysis are increasingly being seen as medically necessary rather than simply cosmetic. The permanent reduction of facial

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and body hair can have a significant impact on personal and professional credibility as well as safety. Beginning in August 2011 LHR services were offered in space donated by a local CBO. Notices of the affordable services were sent to several local transgender affiliated organizations. Treatments were offered 3-5 days per month. Since optimal hair reduction typically can require between 5 and 10 treatments, each 4-6 weeks apart, these services offer the opportunity for regular, ongoing client contact. Over the course of LHR treatments, screening related to risk behaviors, health education, HIV testing, queries related to medical and psychiatric needs, medication adherence support and referrals can be offered. To date there have been no treatment-related adverse events, and over 125 unique patient participants have resulted in over 600 patient encounters.

Older transgender experiences in psychotherapy

Amanda Beth Elder, MA

The purpose of this study is to enrich the understanding of transgender individuals' subjective experiences in psychotherapy throughout their lifespan, both to offer perspectives that are often overlooked due to transgender marginalization, and to improve the quality of psychotherapeutic care for gender variant people. The researcher will conduct one-hour interviews with a diverse sample of 8 to 10 transgender-identified people. Participants will be 60 years of age or older, with at least one significant psychotherapeutic experience, regardless of their gender identity at the time of treatment. A qualitative research method using thematic analysis will identify and analyze themes embedded in the data (Braun & Clark, 2006). The study intends to be trans-affirmative, and will refrain from asking personal questions regarding participants' health. In respect of participants' privacy, no questions will be asked about their health history regarding surgical, hormonal or other gender realignment procedures they may have had. They will be able to disclose anything regarding their health history solely at their discretion. Participants will ideally be recruited with the purpose of maximizing diversity related to gender, race, ethnicity, age, and ability status to offer different perspectives on the topic. Respondents will be screened by email to determine their eligibility for the study.

MTF transgender Christians: An exploratory study with milestone events

Trista L. Carr, PsyD; Mark A. Yarhouse, PsyD; Rebecca Thomas, BS

This poster will expound on the descriptive and qualitative data of an exploratory study of 32 MTF transgender Christians. It will also address the clinical, ethical, and theological considerations for clinicians in their work with transgender Christian persons.

Exploring the experiences of transgender college students

Robert Enoch, MS

The purpose of this research study was to achieve a better understanding of the experiences of students attending the University of Montana who identify as transgender. While relatively few studies have examined the experiences of transgender college students, those looking at this community have determined that these students typically lack support in various domains, including not having adequate access to physical and mental health services, not having appropriate campus facilities (e.g., restrooms and locker rooms), and needing more allies among both faculty and students (Beemyn, 2003; McKinney, 2005). The intent of this study was to discover whether these issues are still identified, determine how challenges for transgender students have changed over time, and hear about any positive aspects of their experiences.

Using a phenomenological approach to qualitative analysis, semi-structured interviews were conducted with 15 students recruited from various LGBT-oriented community and campus organizations. Interviews were coded by a

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team of researchers, allowing for a number of themes to emerge that embody the experiences of these students. Results indicated that some of the findings from earlier studies, such as concerns about access to physical and mental health services, are still relevant; however, there was also evidence that transgender students' inclusion in campus organizations has increased. Implications from the study focus on ways in which campus administrators can strive to help make their universities more inclusive places for transgender students.

Navigating Jewish and transgender identities

Nicole Thalheimer, MA

Holding both a transgender and a Jewish identity can come with a plethora of challenges and stigma. The invalidation of an already marginalized group is exacerbated by clinical invisibility and lack of empirical research. The current review of literature yielded no empirical studies that examine the experiences of individuals who identify as transgender women and Jewish. Some narratives have been compiled in recent popular memoirs looking at individuals with these intersecting identities. Holding multiple minority statuses can compound minority stress in a multitude of ways, often times affecting the mental health of the individual. Transgender individuals are often marginalized for identifying outside the gender binary, which complicates and compounds the lived experience of individuals who find themselves at the intersection of other marginalized statuses as well. Without research to guide their practice, many clinicians may feel at a loss when trying to work with a client who identifies as transgender and Jewish. The presentation will discuss the existing information on individuals who identify as transgender and Jewish, the need for further research, and the importance of an intersectional approach when working clinically with transgender individuals.

Exploring social and behavioral contexts for HIV risk behaviors in the San Francisco transgender community: Preliminary findings from a community based drop-in center

Erin Armstrong; Judy Tan, PhD; Cynthia Dela Cruz

Using the "Behavioral Health Survey", a data collection tool created by A&PIWC and input from the SFDPF, over 50 unique data points from participants every 6 months, and covers topics as diverse as employment, immigration, condom usage, sexual behavior/history, alcohol and drug use, Hormone Replacement Therapy, and more.

Asian transgender clients APICHA Community Health Center

Jun Matsuyoshi, LCSW

APICHA Community Health Center's Trans Health Clinic is 20 months old. Services include: trans-focused primary care, mental health services, case management, and psychoeducation groups.

Malama mahuwahine

Lyndall Ellingson, PhD; Ashliana Hawelu-Fulgoni

This presentation will provide understandings of the health and well-being of mahuwahine (Native Hawaiian Transgender women). The data are from three separate studies conducted by the presenters from 2004-2011 among mahuwahine living on O`ahu. The studies varied significantly and provide a wide range of data that capture the lived experience, perceptions, challenges and resiliencies of mahuwahine around substance use, intrapersonal violence,

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access to health care, experience with medical and social service providers, sex industry work, homelessness, and poverty. Quantitative survey results highlight increased risk for sexually transmitted infections, substance abuse, homelessness, and violence. Qualitative results, garnered from interviews and focus groups, explore ethnic and gender identity, ethnic and culture pride, familial and social support networks, as well as historical, geographical and cultural threats to well-being and sources of resilience. Impact data on the effectiveness of culturally-focused HIV and Hepatitis C prevention program designed for mahuwahine will also be discussed including pre- and post-test data on sexual risk and harm reduction behaviors, perceived agency, perceived risk, and substance use.

Adaptation is the key: successfully conducting mass HIV testing among Transgender Women

Pocahontas Crowe; Tamara Stephney; Kimberley A. Parker, PhD, MPH, CHES

Abounding Prosperity (AP) in Dallas, Texas has the reputation as the "go to" agency for Black Men Who Have Sex with Men (MSM); and, this reputation has led to some encouraging inroads in serving Black Transgender male-to-female (MTF) individuals. However, the national tendency to collapse MSM issues with the needs of Transgender individuals has also caused missed opportunities. However, over the past year, the mass testing of MTF at AP has seen significant increases that have naturally developed from a research-based practice. The focus of the proposed forum will be a discussion of this research-based practice that has led to significant recruitment of Transgender women for mass HIV testing.

About a year ago, AP instituted a discussion group known as "Chat & Chew," a monthly meeting for MTF centered around good food and great conversations. Creating questions that would generate dialog about sex, sex work, other forms of employment, friendship/support networks, and self-esteem/life style, the "Chat & Chew" became a repository of personal testimonies, struggles, and triumphs. Processing this raw data and hiring a Transgender woman to help us translate their experiences into practice, AP was able to boost its mass HIV testing numbers.

Archival footage of MTF who will not be able to attend the Summit will be a part of the presentation. The actual speakers will be a round table including MTF who have been a part of AP's mass HIV testing program.

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about the Center of Excellence for Transgender Health

The mission of the Center of Excellence for Transgender Health (CoE) is to increase access to comprehensive, effective, and affirming healthcare services for trans and gender-variant communities in the United States. The Center of Excellence for Transgender Health combines the unique strengths and resources of a nationally renowned training and capacity building institution, the Pacific AIDS Education and Training Center (PAETC), and an internationally recognized leader in HIV prevention research, the Center for AIDS Prevention Studies (CAPS), both of which are housed at the University of California, San Francisco.

Our ultimate goal is to improve the overall health and well-being of transgender individuals by developing and implementing programs in response to community identified needs. We include critical community perspectives by actively engaging with a National Advisory Board (NAB) of 14 trans identified leaders from throughout the country: Jordan Blaza; Dee Dee Chamblee; Ashliana Hawelu-Fulgoni; Sel J. Hwahng, PhD; Mattee Jim; Earline Budd; Yoseñio V. Lewis; Terra Moore; Raquel Sapien; Bali White; Tiffany Woods and Cecilia Chung. The collective experience of our diverse and talented NAB assures that all of our programs address issues that are timely and relevant to the trans community.

Our faculty and staff reflect diverse backgrounds in academia, public health research and social justice work. With many combined years of experience in transgender health, the CoE strives for excellence in all that we do. Faculty and staff are listed below:

E. Michael Reyes, MD, *MPH Professor*
JoAnne Keatley, MSW, *Director*
Gregory M. Rebchook, PhD, *Assistant Professor*
Jae Sevelius, PhD, *Assistant Professor*
Madeline Deutsch, MD, *Clinical Lead*
Jamison Green, PhD, *Health Policy Analyst*
Luis Gutierrez-Mock, MA, *Senior Technology Exchange Specialist*
Danielle Castro, *Community Mobilization Specialist*
Angel Ventura, *Program/Research Assistant*
Enzo Patouhas, MA, *Research Assistant*
Yavanté M. Thomas-Guess, *Technology Exchange Specialist*
Charlie DeVries, *Summit Coordinator*

To learn more about The Center of Excellence for Transgender Health, please visit our website at **www.transhealth.ucsf.edu.**

about the World Professional Association for Transgender Health

The World Professional Association for TransgenderHealth(WPATH)isaninternational association devoted to the understanding and care of transgender, transsexual and gender nonconforming individuals. Founded in 1979, and currently with over 650 physician, psychologist, social scientist, and legal professional members, all of whom are engaged in research and/or clinical practice that affect the lives of transgender and transsexual people, WPATH is the oldest interdisciplinary professional association in the world concerned with this specialty.

WPATH Mission Statement
As an international multidisciplinary professional Association the mission of WPATH is to promote evidence based care, education, research, advocacy, public policy and respect in transgender health.

WPATH Vision Statement
We envision a world wherein transsexual, transgender and gender non-conforming people benefit from access to evidence-based health care, social services, justice and equality.

Standards of Care
WPATH promotes the highest standards of health care for individuals through the articulation of Standards of Care (SOC) for the Health of Transsexual, Transgender, and Gender Nonconforming People. The SOC are based on the best available science and expert professional consensus.The overall goal of the SOC is to provide clinical guidance for health professionals to assist transsexual, transgender, and gender nonconforming people with safe and effective pathways to achieving lasting personal comfort with their gendered selves, in order to maximize their overall health, psychological well being, and self-fulfillment.

Executive Committee
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Jamison Green, PhD
Walter Bockting, LP, PhD
Gail Knudson, FRCPC,MD
Bean E. Robinson, LP, LMFT, PhD

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Marsha Botzer

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Randi C Ettner, PhD
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Sam Winter
Kevan R Wylie, MB, MD, FRCP, FRCPsych, FRCOG

Staff
Bean E Robinson, LP, LMFT, PhD, *Executive Director*
Jeffrey Whitman, BS, *Office Manager*
Andrea Martin, *Executive Administrator*

International advisory Committee
Co-Chairs
Walter Bockting, LP, PhD
Marsha Botzer

Members
Tamara Adrian, LGBT Rights Venezuela (Venezuela)
Craig Andrews, FTM Australia (Australia)
Christine Burns, MBE, Plain Sense Ltd (UK)
Naomi Fontanos, Society for Transsexual Women's Rights in the Phillipines (Phillipines)
Rupert Raj, Shelburne Health Center (Canada)
Masae Torai, FTM Japan (Japan)
Kelley Winters, GID Reform Advocates (USA)
Anne Tamar-Mattis, Executive Director at Advocates for Informed Choice (USA)

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Assessment and Clinical Work with Transgender, Transsexual, Intersex and Gender Nonconforming Clients

May 17, 2013

Lisette Lahana, MSW, LCSW
Private Practice, Oakland California

The Genderbread Person v2.0

Identity

Attraction

Expression

Sex

Biological Sex

Attracted to

Transgender

Gender identity or
Gender expression differs from the conventional gender expectations for males and females.

Additional uses of the Term Transgender

- A person who lives full or part time as another gender, but *does not* wish to undergo sex reassignment surgery
- A transsexual person who has **not** had SRS

Cisgender

- A cisgender person is someone who identifies as they gender/sex they were assigned at birth.
- Congruence between body and mind.
- Referring to cisgender people as non trans implies that being trans is abnormal.

MTF and FTM

- FTM: born female, has an internal sense of self as a man. MTF: born male, has an internal sense of self as woman
- Full range of expression
- Many do not feel surgery is necessary or cannot afford

Non-normative gender, either as an umbrella term or a stand-alone identity

1. Both man and woman (androgyne)
2. Neither man nor woman (*agender, neutrois, non-gendered*)
3. Moving between two or more genders (*gender fluid*)
4. Third gendered or other-gendered
5. Overlap or blur of gender and orientation and/or sex (*girlfags* and *guydykes*)
6. "Queer" gender, may include those political or radical in their understanding of being genderqueer

Genderqueerid.com

Genderqueer Voices

The Experience Project

•Now I still feel more like a boy most of the time, but I do like being a girl. Fashion and girly things are still a part of my life, but being a total tomboy is too. I really feel split down the middle. Half of me is a girl, the other half a boy. I just have to see which side is winning for the day.

- **I have always been a gender bender... I don't feel like I am a man in a woman's body I feel like I am exactly as I should be. I am not found of the labels put on to people like me. I have been asked by several people what are you? I always answer "I'm human..for the most part"**

Crossdresser

- **Cross-dressing** is the act of wearing clothing commonly associated with the opposite sex *within a particular society.*
- Through out history
- Private or public

Intersexuality

Almost 2 percent of the population intersex

1 in every 2000 births

Fausto-Sterling (2000); Preves (2005)

"...sex anatomy that is not considered standard for a male or a female. Like disorders of sex development, it is an umbrella term that covers many different conditions that appear in humans as well as other animals. The term is often used by adults with DSDs to talk about their bodies and their experiences...."

From Accordalliance.org

Eunuchs in Contemporary Society

Prostate cancer patients distressed by side effects of androgen deprivation and strive to hide the effects of castration. In contrast, most voluntary eunuchs are pleased with the results.

MtE is a valid gender identity

Johnson, Brett, Roberts and Wassurburg 2007 J Sex Med 4:930-945

Suicidality

16 % attempted suicide

35 % Ideation

64 % among those who had ideation <u>because of gender issues</u>

Xavier2000 Washington, DC (N=252)

41% of respondents reported attempting suicide, compared to 1.6% of the general pop

NTDS 2011 (N=6,450)

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2011 National Transgender Discrimination Survey (NTDS) N=6,450

19% Housing

11% Evicted

50% reported experiencing harassment in workplace

1 in 4 fired

78% reported feeling more comfortable at work and performance improving after transitioning, same levels of harassment.

Creating An Environment of Acceptance

- Personal religious or moral beliefs of providers *should be separate from dynamics of their relationship with LGBT patients.*
- Use patient's language to describe their relationships, sexual behaviors and health concerns.
- Respect patient's wishes to disclose or not disclose identity to others.

A Provider's Handbook on Culturally Competent Care: Lesbian, Gay, Bisexual and Transgender Population, 2nd Edition, Kaiser Permanente national Diversity, (2004) pg. 23

Beginning Clinical Work

- Many clients will present just as any other therapy client, wanting to work on relationships, stress, trauma, managing mood.
- While a person's gender experience informs your work, **do not** assume trans identity will be part of treatment.

Creating a Space for Disclosure

Intake forms:

Gender:________ rather than Gender M or W

Or How do you identify your gender?__________

Gender Identity Project:

Gender Basics

NY (Callen Lorde)

Engaging Transgender Clients

Beginning Clinical Work

- Determining what stage of identity development client is in helps you shape your treatment planning

Identity Development Models

Vivienne Cass, 1979

Aaron H. Devor, 2004

Witnessing and Mirroring: A 14 Stage Model of Transsexual Identity Development-Aaron Devor (1997)

"Each of us has a deep need to be witnessed by others for whom we are. Each of us wants to see ourselves mirrored in others' eyes as we see ourselves. These interactive processes...When they work well, we feel validated and confirmed—our sense of self is reinforced" (Poland, 2000). When the messages which one receives back from others do not match how one feels inside, various kinds of psychological distress and maladaptive behaviors result.

Transgender Emergence: A Developmental Model Arlene Istar Lev (2004)

- Interaction of developmental and interpersonal transactions.
- Normative process that everyone experiences
- Complicated by cultural expectations that are at dissonance with core sense of self.
- Move from experience of denial and self-hatred to one of self-respect and gender congruence.
- Stages not linear nor do they define maturity.

Transgender Emergence: A Developmental Model Therapeutic Tasks (Arlene Istar Lev, 2004)

- **Awareness:** May be in distress, seek to normalize their experience.
- **Seeking Information/Reaching out:** Facilitate linkages, provide education and outreach.
- **Disclosure to significant others:** Support integration in the family system.
- **Exploration -- Identity and Self-Labeling:** support the articulation and comfort with gender identity.
- **Exploration – Transition issues/possible body modification:** Resolution of the decisions, and advocacy towards manifestation.
- **Integration -- Acceptance and post-transition issues:** integrate and synthesize trans identity; adaptation to transition related issues.

Trans Affirmative Care

- Respect client's right for self-determination related to gender expression and medical decisions.
- Believe gender nonconformity and transgender/transsexual identities are not pathological or mental disorders
- Take into account extensive cultural or personal histories of discrimination & hostility.
- Default to trusting client's self-report rather than having clients feel they must convince their therapist of who they are.

Trans Affirmative Care

- Use gender diagnoses as a tool toward helping clients access care.
- Prioritize your client's goals for treatment whenever possible.
- Inform clients about what to expect during their work together as well as what they may expect from other healthcare systems and providers.
- Advocate for client's needs in healthcare systems, both large and small.

"Therapy is seen as a means of allowing the transsexual person to become aware of his or her options (many aren't aware), and to help to work through difficulties which can arise in the coming out process and during transition"

-Dallas Denny

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Countertransference Considerations

- How do you feel about the client?
- When might you bring the countertransference response into the room?
- Are there certain clients with whom countertransference is so strong that you must refer out?
- Do you feel positive transference such as being eager to help or identify with client?

Know Your Own Stuff

- Uncomfortable working with people who are expressing an alternative gender identity or appearance?
- Have unexplored issues being triggered by the client's story?
- Feel like you "should" be OK working with a certain trans client?

The Purpose of Assessment

- To understand client's history
- Learn about other mental health issues
- Get on the "same page" as client
- Treatment planning and creating interventions
- Understand client's goals for gender expression
- Collaboration of care

DSM V Revisions (adapted)

APA Sexual and Gender Identity Disorders Work Group

Gender Dysphoria (in Adolescents or Adults)

Marked incongruence between experienced or expressed gender and assigned gender, at least 6 mos, manifested by 2 or more:

1. Marked incongruence between experienced/expressed gender and primary and/or secondary sex characteristics (or anticipated)
2. Strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with gender.
3. Strong desire for the primary and/or secondary sex characteristics of other gender

DSM V Revisions (adapted)

APA Sexual and Gender Identity Disorders Work Group

4. strong desire to be of the other gender or some alternative gender
5. strong desire to be treated as the other gender or some alternative gender
6. a strong conviction that one has the typical feelings and reactions of the other gender or some alternative gender

B. Clinically significant distress/impairment or increased risk of suffering, such as distress or disability

DSM V Revisions (adapted)

APA Sexual and Gender Identity Disorders Work Group

Subtypes Disorder of sex development

Specifier Post-transition

- full-time living in desired gender (with or without legalization)
- undergone (or is undergoing) at least one cross-sex medical procedure such as surgery or treatment regimen such as hormones.

On the DSM V Revisions
Kelley Winters GIDReform.org

While this specifier is intended to aid continued access to hormonal care for post-transition people whose medical records do not yet reflect their affirmed gender, it is so broadly worded that it **blocks exit from the diagnosis.**

On the DSM V Revisions
Kelley Winters, GIDReform.org

Gender Dysphoria in Children

"Five of the proposed sub criteria for children are strictly based on gender role nonconformity, with no relevance to the definition of mental disorder. As a consequence of similar criteria in the current DSM-IV-TR, children are punished and shamed for nonconformity to assigned birth roles."

GIDReform.org Concerned Professional Group Recommendations

- Direct Distress and Deprivation Distress

Anatomic dysphoria: painful distress with current physical sex characteristics and hormone status
Social role dysphoria: distress with ascribed or enforced social gender roles that are incongruent with one's inner experienced gender identity

- Distress may be described as deprivation of physical characteristics or social gender expression that are congruent with inner experienced gender identity. (Anne Vitale 2010)

Gender diagnosis

•Clients should learn their insurance's policies around gender related treatment.

•Do not give insurance company (state/federal agency) or other providers info about client's gender issues unless the client gives permission to disclose.

Gender Therapy
A Social Work Perspective
Using an Ecomap (1975, Ann Hartman)

Assessment and History

- Psychosocial History
- Mental Health Issues and Treatment
- Gender History
- Sexual/Romantic History
- Vision for Gender and Future Plans
- Family/Relationship Issues
- Workplace and School
- Community, Friendships and Support Groups

Taking a Gender History

Across client's lifespan how did they experience:

1. Gender Identity
2. Gender Role
3. Body and Secondary Sex Characteristics
4. Gender Expression

In Working With Gender Dysphoria Clinicians Can Recommend **Fully Reversible to Irreversible Changes**

Early Interventions With Gender Dysphoric Individuals Education and Socializing

- Education about transgender issues
- Recommend and support client in attending trans groups locally
- Encourage exploration of activities relevant to desired gender identity or cross-living

Early Interventions With Gender Dysphoric Individuals Fully Reversible

- Cross-dressing in private
- Changing hair style
- Binding breasts or Breast Forms
- Using a unisex nickname

Gatekeeper Issues

Collaboration and Sharing Information with Health Care Providers

Complexity of Having a Dual Role of Therapist and Evaluator

Gatekeeping

That I am a gatekeeper in undeniable - I have the power to write referral letters to endocrinologists, or not. I have the power to diagnosis people with mental illnesses, and who among us is not afraid that of some outside authority's power to decree us "mad."

Arlene Istar Lev, LCSW in Transgender Tapestry, Issue #90, Summer 2000.

Collaboration vs. Gatekeeping

- Discussion about the power relationship.
- Education around the assessment and why you are asking certain questions.
- Inform client as soon as possible if you have concerns about how they will be impacted by transition or other gender changes including surgery or hormones.
- Clients can refuse or decline to share aspects of their history or experience at any time.

Collaboration and "The Letter"

- Let clients know **there is no one right type of trans identity history and experience**
- The purpose of the eval process is for the therapist to fully understand a client's history in order to communicate it to others
- Gather info about obstacles as well as resources clients can access during transition
- Have client read and edit and ask questions about the letter for doctors

Collaboration vs. Gatekeeping

- Let client know where they are in your process throughout assessment period
- Check in each session about how they want to use their time and if needs have changed.
- Discussion about choices that impact client financially including choice to see you. Openness about other options.

Collaboration vs. Gatekeeping Group Question:

How can you develop an understanding of client's history while not reaffirming idea that there is a right way to share it?

How would you discuss a gender evaluation process that can engage clients as collaborators versus lab rats?

Coming Out: Interventions

1. Explore gender identity and gender history
2. Clarify gender identity and initial short-term goals and long-term goals
3. Develop friendships or online friendships with people who see them as client sees self
4. Identify one person who might respond positively to disclosure to obtain experience coming out.
5. Plan how to talk about gender identity, role play, help construct or edit letters to friends or loved ones.

Coming Out: Interventions

5. Process the impact of coming out and any negative fall out or positive results.
6. Discuss readiness to come out to important people, such as extended family or workplace.
7. Create safety plans and support before, during or after each disclosure.
8. Be available to client during key disclosure periods by phone or additional schedule sessions.

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Coming Out

- It is not necessary to come out in order to cultivate a positive sense of identity.
- The end point of the coming out process will vary based on cultural and religious identities.
- "Forming a positive identity without coming out to family or at work is possible and may be especially common among particular ethnic, regional, or religious groups."

Liddle, Becky J. in Handbook of Counseling and Psychotherapy with Lesbian, Gay, Bisexual and Transgender Clients. (2007) pg. 56

Tips on Coming Out

- Don't Rush It
- Assess Risks to Patient
  - Safety
  - Loss of Relationships
  - Financial/Housing Situation
  - Job Loss
  - Church/Spiritual Community
  - Mental Health: suicidality or substance abuse
- Access to positive friends/family, community resources, such as coming out groups

Reading Recommendations

Transgender Emergence by Arlene Istar Lev

Casebook for Counseling Lesbian, Gay, Bisexual, and Transgender Persons and Their Families(editors S. Dworkin and Mark Pope) 2012 in process of publication

Counseling and Mental Health Care of Transgender Adults and Loved Ones by Bockting (free article online)

The Transgender Child by Brill and Pepper

Gender Born, Gender Made by Diane Ehrensaft

Helping Your Transgender Teen by Irwin Krieger

Reading Recommendations

Transgender Care by Gianna Israel, Gender Loving Care by Randi Etner and True Selves by Mildred Brown(older but much still relevant)

Not therapy oriented:

Whipping Girl by Julia Serrano

Transliberation by Leslie Feinberg

The Invisible Man by Jamison Green

National Resources

International Foundation for Gender Education
FTM International
Accord Alliance (intersex/DSD)
Transgender Law Center
Children of Gays and Lesbians Everywhere
(Kids of Trans Resource Guide)
Parents and Friends of Lesbians and Gays
Trans People of Color Coalition
National Center for Transgender Equality

Provide professional education at their yearly conferences

World Professional Association for Transgender Health Thailand 2014
Gender Spectrum.org Berkeley 2013 - families, schools and children
Philadelphia Transgender Health Conference
Seattle Gender Odyssey Conference

Lisette Lahana, LCSW
Oakland, CA
(510) 915-4796
www.LisetteLahana.com
Therapy@LisetteLahana.com

•Monthly Video Conference Consult and Training Group on Fridays

•Phone Consultation and Supervision

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Scott Anders Eliason M.D.
Forensic Psychiatrist
Boise Forensic Psychiatry
2976 E State St, 120-432
Eagle, ID 83616
Phone: (208) 275-9202
Fax: (208) 493-4209

Education

July 2007 – July 2008 Forensic Psychiatry Fellowship
Specialized training in civil and criminal forensic psychiatry cases including evaluations, report writing, forensic consultations, and expert testimony

UCSF Psychiatry and the Law Program
San Francisco, CA 94143

San Quentin Prison
San Quentin, CA 94964

Maguire Correctional Facility
300 Bradford St.
Redwood City, CA 94063

2006-2007 Chief Resident
University of Washington Psychiatry Residency, Spokane Track
Sacred Heart Medical Center, Spokane Mental Health Clinic
Spokane, WA 99202

2005-2007 Residency Training – Graduated June 2007
University of Washington Psychiatry Residency, Spokane Track
Sacred Heart Medical Center, Spokane Mental Health Clinic, Eastern State Hospital
Spokane, WA 99202

Eastern Washington State Hospital Forensic Unit
Medical Lake, WA 99022

2003-2005 Residency Training
University of Washington Psychiatry Residency, Spokane Track
University of Washington Hospital, Harborview Hospital, VA Hospital
Seattle, WA 98125

1999-2003 Doctor of Medicine
Medical College of Wisconsin
Milwaukee, WI 53216

1996-1999 Bachelor of Science, Microbiology
Brigham Young University
Provo, UT 84604

1993-1994 College Courses
Ricks College (now Brigham Young University – Idaho)
Rexburg, ID 83440

Teaching Experience

2009-Present	Supervising and Training Nurse Practitioners and Nurse Practitioner Students, Physician Assistants and Physician Assistant Students
2008-Present	Clinical Instructor, University of Washington Psychiatry Residency- Boise Tract. Supervise and train psychiatry residents from the University of Washington.
2007-2008	Forensic Fellow, taught medical students, law students, psychiatric residents, and community mental health providers through lectures, classes, and work supervision.
2006-2007	Chief Resident, University of Washington, Spokane Tract, collaborated with faculty to modify teaching curriculum for both medical students and psychiatry residents.
2003-2006	Resident, Outpatient Clinics and Inpatient Rotations, taught medical students in both continuity clinic and clerkship rotations.

Recent CME

NCCHC Mental Health Conference July 2014
NCCHC Spring Meeting April 2015

Professional Associations

Member of American Psychiatric Association
Member of American Academy of Psychiatry and the Law
Member of the American Medical Association
Member of the Suicidology Committee of the American Academy of Psychiatry and the Law

Licensure & Certification

2013 Certified Correctional Healthcare Professional- Mental Health
2010 Certified Correctional Healthcare Professional
2009 Board Certified Forensic Psychiatrist
2008 Certified Diplomate of the American Board of Psychiatry and Neurology
2008 Qualified Medical Examiner State of California
2007 American Board of Psychiatry and Neurology Board Eligible
Step 1 of ABPN Board- passed
2007 Advanced Clinical Trainer for Suicide Risk Assessment at QPR Institute

2006 Idaho State License #: M-9576
2005 Buprenophrine Certified
2004 USMLE Step 3 Passed

Employment

August 2016- Present	Developmental Disability Committee evaluations for Department of Health and Welfare
May 2011- Present	Psychiatric Director at Ada County Jail
April 2010- Present	Full Time Regional Psychiatric Director for Corizon in the State of Idaho
March 2009- Feb 2013	Inpatient Psychiatrist at Eastern Idaho Regional Medical Center, Behavioral Health Center one weekend per month
January 2009-Present	Part Time Private Practice and Medical Director of Boise Forensic Psychiatry
August 2008-April 2010	Full Time Community Mental Health Psychiatrist at Region IV Adult Mental Health Clinic
	Medical Director State of Idaho Health and Welfare, Behavioral Health Division
July 2008- December 2008	Clinical Director at the Idaho State School and Hospital- managing treatment of both inpatient and outpatient clients with developmental disability and mental illness.
	Idaho State Forensic Psychiatry Director- Helping design, plan, and then direct the first locked forensic psychiatry unit in Idaho.
	Forensic psychiatry private practice – Performing independent medical-legal-psychiatric evaluation and expert testimony.
August 2005- April 2007	Managed locked inpatient psychiatric unit at Sacred Heart Hospital in Spokane Washington two weekends a month.
Sept. 2005- Feb. 2007	Conducted nine disability evaluations a month for the Washington State Department of Social Services.

Awards

June 2018 Outstanding Faculty Award from the Idaho/University of Washington Psychiatry Residency Training Program

Child and Adolescent Psychiatry Experience

May 2008- Present Inpatient Psychiatrist at Eastern Idaho Regional Medical Center. Evaluating and Treating children and adolescents one weekend per month.
January 2009- Present Outpatient Psychiatrist at Eagle River Psychiatry, treating and evaluating adolescents
August 2008- December 2008 Psychiatrist at Region III mental health clinic evaluating and treating children and adolescents
July 2008- December 2008 Psychiatrist for the Support and Outreach Team at the Idaho State School and Hospital. Performed Consultations for patients with mental illness and developmental disabilities throughout the State of Idaho.
September 2005-June 2007 Managed the Child and Adolescent Psychiatry Unit at Sacred Heart in Spokane 1-2 weekends a month.
January-October 2006 Spokane Mental Health Clinic Outpatient Child Psychiatry
January-April 2006 Inpatient Child and Adolescent Unit

Presentations

NCCHC Conference Presentation: Gender Dysphoria: A Comprehensive Approach to Treatment and Policy Management
NCCHC Conference Presentation: Vicarious Traumatization in Correctional Healthcare Workers
NCCHC Conference Presentation: Managing Cultural Competence: Diagnostic and Treatment Implications
NCCHC Conference Presentation: Nonsuicidal Self-Injurious Behaviors in Inmates Without a Mental Illness
NCCHC Conference Presentation: Toxic Masculinity as a Barrier to Behavioral Health Treatment
NCCHC Conference Presentation: The Social Determinants of Health Among African-American Men: Diagnostic and Treatment Implications
NCCHC Conference Presentation: Genetic Testing in Psychiatry: Practical for Corrections?
NCCHC Conference Presentation: Psychogenic Polydipsia
NCCHC Conference Presentation: Suicide Risk Factors
NCCHC Conference Presentation: DSM 5 in corrections
Presentation at the American Academy of Psychiatry and the Law conference in October 2011: Management of Deliberate Self Harming Inmates: Novel Uses of DBT
Idaho Department of Corrections Trainings- Differential Diagnosis, Traumatic Brain Injury, and Post-Traumatic Stress Disorder
Grand Round: Correctional Psychiatry
Grand Round: When Patients Lie
Grand Round: Pregnancy and Psychiatry
Presentation at the American Academy of Psychiatry and the Law conference in October 2008: Murder-Suicide: A review of the recent literature.
Grand Rounds: Violence Risk Assessment
Forensic Lectures at University of California San Francisco: Murder-Suicide
Guest Lecturer at University of San Francisco: Forensic Psychiatry
Grand Rounds: Drugs for Drugs: Using Medication to Treat Chemical Dependency
Grand Rounds: The Truth about Benzos
Grand Rounds: Insomnia
Resident Didactics: Complementary and Alternative Treatment in Mental Health

Forensic Experience

Competency to stand trial evaluations

Insanity defense evaluations
Pre-sentencing evaluations
Board of Parole evaluations
Three-strike law mitigation evaluations
Psychiatric Malpractice evaluations
Fitness for duty evaluations
Violence Risk Assessment
Psychological Damages
Child custody evaluations
Worker's Compensation evaluations
Disability evaluations for Department of Social Security
Civil Commitment evaluations of Sex offenders
Psychosexual Evaluations
Death Penalty Mitigation evaluations

Publications

1. Scott Eliason. **Murder-Suicide: A Review of the Recent Literature.** J Am Acad Psychiatry Law, Sep 2009; 37: 371 - 376
2. Scott Eliason and John Chamberlain. **Competence to Stand Trial.** J Am Acad Psychiatry Law, Jun 2008; 36: 255 – 257
3. Scott Eliason and John Chamberlain. **Immunity for Professional Review Committees.** J Am Acad Psychiatry Law, Jun 2008; 36: 257 - 258.

Research Experience

September 1997 - December 1998
Brigham Young University, Animal Science Department
Bench researcher
Dr. David Kooyman

February 2006 – 2007
Washington State University Spokane Campus
Literature Review
The Addictive Potential of Benzodiazepines
Dr. Clarke St. Dennis

September 2006-March 2007
Washington State University Spokane Campus
Literature Review and Data Analysis
Epidemiology of Major Mental Disorders in Methamphetamine Users
Dr. John Roll

EVIDENTIARY HEARING - Motion for Preliminary Injunction (Day 1)

UNITED STATES DISTRICT COURT FOR THE DISTRICT OF IDAHO

Judge: B. Lynn Winmill
Case No: 1:17-cv-151
Date: October 10, 2018
Place: Boise

Deputy Clerk: Jamie Bracke
Reporter: Tammy Hohenleitner
Time: 4 hours and 59 minutes

ADREE EDMO v. CORIZON INCORPORATED, et al

Counsel for Plaintiffs: Amy Whelan, Shaleen Shanbhag, Lori Rifkin, Deborah Ferguson, and Craig Durham

Counsel for Corizon Defendants: Dylan Eaton and Kevin West

Counsel for IDOC Defendants: Brady Hall and Marisa Crecelius

Opening Statements.

WITNESSES

Plaintiff:

1) Randi Ettner, PhD

EXHIBITS

Joint: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, and 19

Plaintiff: 1003 and 1001

2:35 p.m. - Afternoon recess. The hearing shall resume on October 11, 2018 at 8:30 a.m. before Judge B. Lynn Winmill.

Case Nos. 19-35017 and 19-35019

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

ADREE EDMO,
Plaintiff-Appellee,
v.
IDAHO DEPARTMENT OF CORRECTIONS, ET AL.,
Defendants-Appellants.

On Appeal from Orders of the United States District Court
For the District of Idaho
(No. 1:17-cv-00151-BLW)

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Lawrence G. Wasden,
Attorney General State of Idaho
Brady J. Hall,
Special Deputy Attorney General
Marisa S. Crecelius
Moore Elia Kraft & Hall, LLP
P.O. Box 6756
Boise, ID 83707
(208) 336-6900
brady@melawfirm.net
marisa@melawfirm.net
Attorneys for Defendants-Appellants Idaho Department of Corrections, Henry Atencio, Jeff Zmuda, Howard Keith Yordy, Richard Craig, and Rona Siegert

Dylan Eaton
J. Kevin West
Parsons Behle & Latimer
800 West Main Street
Suite 1300
Boise, ID 83702
(208) 562-4900
Deaton@parsonsbehle.com
KWest@parsonsbehle.com
Attorney for Defendants-Appellants Corizon, Inc., Scott Eliason, Murray Young, and Catherine Whinnery

Dated: March 6, 2019

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1 **UNITED STATES DISTRICT COURT**

2 **DISTRICT OF IDAHO**

3

4 ADREE EDMO (a/k/a MASON EDMO),) CASE NO. 1:17-cv-00151-BLW
)
5 Plaintiff,) **EVIDENTIARY HEARING DAY 1**
)
6 vs.)
)
7 IDAHO DEPARTMENT OF)
CORRECTION; HENRY ATENCIO, in)
8 his official capacity; JEFF)
ZMUDA, in his official)
9 capacity; HOWARD KEITH YORDY,)
in his official and individual)
10 capacities; CORIZON, INC.;)
SCOTT ELIASON; MURRAY YOUNG;)
11 RICHARD CRAIG; RONA SIEGERT;)
CATHERINE WHINNERY; and DOES)
12 1-15,)
)
13 Defendants.)
_________________________________)
14

15

16 **TRANSCRIPT OF PROCEEDINGS - VOLUME 1**
BEFORE THE HONORABLE B. LYNN WINMILL
17 **WEDNESDAY, OCTOBER 10, 2018, 8:53 A.M.**
BOISE, IDAHO
18

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20

21

Proceedings recorded by mechanical stenography, transcript
22 produced by computer.

23

24 **TAMARA I. HOHENLEITNER, CSR 619, CRR**
FEDERAL OFFICIAL COURT REPORTER
25 550 WEST FORT STREET, BOISE, IDAHO 83724

1 **FOR PLAINTIFF**

2 Lori Rifkin
HADSELL STORMER & RENICK LLP
3 4300 Horton Street, #15
Emeryville, CA 94608
4
Amy Whelan
5 NATIONAL CENTER FOR LESBIAN RIGHTS
870 Market Street, Suite 370
6 San Francisco, CA 94102

7 Shaleen Shanbhag
HADSELL STORMER & RENICK LLP
8 128 N. Fair Oaks Avenue
Pasadena, California 91103
9
Craig Durham
10 Deborah Ferguson
FERGUSON DURHAM, PLLC
11 223 N. 6th Street, Suite 325
Boise, ID 83702
12
FOR DEFENDANTS IDAHO DEPARTMENT OF CORRECTIONS, HENRY ATENCIO,
13 **JEFF ZMUDA, HOWARD KEITH YORDY, RICHARD CRAIG, AND RONA SIEGERT**

14 Brady J. Hall, Special Deputy Attorney General
Marisa S. Crecelius
15 MOORE ELIA KRAFT & HALL, LLP
Post Office Box 6756
16 Boise, Idaho 83707

17 **FOR DEFENDANTS CORIZON, INC., SCOTT ELIASON, MURRAY YOUNG, AND**
CATHERINE WHINNERY
18
Dylan A. Eaton
19 J. Kevin West
PARSONS, BEHLE & LATIMER
20 800 W. Main Street, Suite 1300
Boise, Idaho 83702
21

22

23

24

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4 Management", by Mark Fleming, Ph.D., Scott Eliason, M.D., Mariann Atwell, Psy.D., Laura
5 McKinnon, MA, and Jessica Lee, MSN (PBL0399-0474)................................... 85
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1 P R O C E E D I N G S

2 October 10, 2018

3 THE CLERK: The court will now hear Civil Case 17-151,

4 Adree Edmo vs. Corizon, Incorporated, regarding a motion for

5 preliminary injunction.

6 THE COURT: Good morning, Counsel.

7 Before we start, first, I will be taking a moment to log

8 in. But while I'm doing that, I wanted to let you know a couple

9 things.

10 One is Ms. Hohenleitner had agreed that she should be able

11 to prepare the transcript within a week, I think, after the

12 trial is completed. The challenge is that we had not

13 anticipated a case set for trial next week which we thought had

14 been resolved but was not. So we will be in trial next week.

15 And I'm in trial the two weeks after that as well. So I have

16 got back-to-back trials going from now through the next four

17 weeks.

18 And Ms. Hohenleitner, that puts quite a burden on her. And

19 I think she was anticipating that she would be able to take care

20 of the transcript next week when we were not in trial. And, of

21 course, that has now changed.

22 So I can't put undue pressure on her, and so this may

23 affect her ability to get the briefing -- the transcript to you

24 in preparation for the final briefing and submission of findings

25 of fact and conclusions of law.

1 The second issue has to do with the nature of the
2 proceeding. We're here on a hearing for a temporary injunction,
3 but the request -- or the relief requested is in the form of a
4 mandatory injunction in terms of requiring IDOC and Corizon to
5 take certain affirmative steps, some of which are not
6 reversible.
7 So it's a -- it's hard for me to envision this hearing
8 being anything but a hearing on a final injunction at least as
9 to that part of the relief requested.
10 Does that make a difference? I don't know. But I think
11 it's something I will want to at least hear from counsel at some
12 point between now and Friday as to whether a different standard
13 applies, whether this should be treated as a hearing on a final
14 injunction for a final hearing on the request for injunctive
15 relief, realizing there may be other claims that will not be
16 resolved as part of this proceeding. But I think we're just in
17 kind of an awkward procedural posture, and I will want counsel's
18 input on that.
19 Finally, we're starting late, unavoidable. These things
20 happen, but we still need to keep the same amount of time
21 because counsel has been put on the clock. I can't make up the
22 time today because I teach a class this afternoon, and I have to
23 be done at 2:30, as we originally planned.
24 But tomorrow and, if need be, Friday, we can find
25 additional time. So we probably will go until 3:00, would be my

1 best guess; we'll go until 3:00 on Thursday. At least I think
2 that's correct.
3 Ms. Bracke, is that correct, we don't have anything
4 scheduled in the afternoon?
5 THE CLERK: Correct, Your Honor.
6 THE COURT: All right. So there we are.
7 All right. With that, I think counsel requested the right
8 to present very brief opening statements or arguments. So, with
9 that, I think from the plaintiffs, maybe we will just hear first
10 from you.
11 MR. EATON: Your Honor, if I may, real fast.
12 THE COURT: Yes.
13 MR. EATON: Dr. Eliason is a party to this case. I
14 was planning to have him sit in with us today. He is ill today.
15 So I was hoping that if he can be excused, I anticipate he would
16 probably testify tomorrow.
17 THE COURT: No, he doesn't need to be here. That's
18 fine if you are not feeling well.
19 I should also point out, if you haven't noticed in the
20 courthouse, we had a major flood at the bottom of the building
21 on Thursday. The heating system has still not been restored.
22 Fortunately, this courtroom maintains a fairly stable
23 temperature anyway, but it's going to be quite cool probably in
24 the public areas.
25 It's the best we can do. The only alternative is to recess

1 the trial until they fix the system. They promised to have it
2 done Friday, Monday, Tuesday, and they are still working on it.
3 So we don't know when it will be done.
4 All right. And that's, in part -- if he is not feeling
5 well, that's an additional reason to have him find someplace
6 where he can be comfortable.
7 With that, then, we'll hear first from the plaintiffs in
8 terms of arguments of counsel.
9 MS. RIFKIN: Thank you, Your Honor. Lori Rifkin for
10 plaintiff, Adree Edmo.
11 Before I start with opening, just on the issue of delay,
12 Your Honor, we're informed that the IDOC transport with Ms. Edmo
13 was actually almost in the city with Ms. Edmo to be on time and
14 turned around and went back to the prison to pick somebody else
15 up.
16 And so I think that in terms of making sure that we start
17 on time in the next couple of days, it seems like there was a
18 communication problem and not a lag with the preparation of
19 Ms. Edmo.
20 We appreciate the chance to present a short opening simply
21 for framing the issues, because there will be a lot of facts and
22 opinions packed into the course of the next three days. But
23 this is a straightforward constitutional case.
24 It is not disputed that gender dysphoria is a serious
25 medical condition within the ambit of the Eighth Amendment's

1 mandate that prisoners receive adequate treatment for their
2 serious medical needs.
3 Plaintiff's experts will explain that there is a medical
4 treatment for gender dysphoria that is routinely provided for
5 patients with Ms. Edmo's symptoms. And this treatment does not
6 depend on where someone lives or whether they are thought to be
7 deserving or not.
8 While gender dysphoria is highly treatable, untrained and
9 inexperienced providers making treatment decisions place
10 patients at risk. And the results of not adequately treating
11 gender dysphoria are predictable and dire.
12 The set of facts relevant for plaintiff's motion for
13 preliminary injunction are fairly narrow. Ms. Edmo has been in
14 IDOC custody since 2012. She was diagnosed with gender
15 dysphoria in the summer of 2012 and started cross-sex hormone
16 treatment in the fall of 2012. She has been receiving
17 feminizing hormones for six years.
18 Our experts will explain that hormones essentially reach a
19 point where they have had the maximum feminizing impact they are
20 going to have and that Ms. Edmo is past that point. While the
21 hormones alleviated some of her severe gender dysphoria, they
22 are only a partial treatment.
23 She continues to experience ongoing and acute distress from
24 gender dysphoria, twice culminating in attempts to perform
25 self-surgery by cutting off her testicles.

1 She has repeatedly and consistently requested gender
2 confirmation surgery since 2014 and filed this lawsuit pro se in
3 2017.
4 There is an internationally accepted standard of care for
5 gender dysphoria treatment. It includes criteria for
6 determining when gender confirmation surgery is medically
7 necessary to treat severe and persistent gender dysphoria.
8 Gender confirmation surgery is not new, and it is not
9 experimental; it is the medical treatment for this medical
10 condition. And whether surgery is appropriate is determined by
11 medical standards, not by someone's incarceration status.
12 The gender dysphoria treatment standards mirror the Eighth
13 Amendment's requirement that people in prison receive medically
14 necessary treatment, and the standard of care for what is
15 medically necessary does not change between the community and
16 prison.
17 THE COURT: Well, but to be clear, the standard of
18 care, at least in Idaho, is a negligence-based standard. And
19 the Eighth Amendment does not say that we treat this as a
20 medical malpractice claim. There has to be a deliberate
21 indifference to the medical needs of the inmate.
22 So standard of care means something different in
23 imprisonment. It means outside -- if we're talking about Eighth
24 Amendment, does it not?
25 MS. RIFKIN: Well, the standard of care as referenced

1 to determining what is medically necessary is the same in the
2 community and in prison.
3 The standard for the Eighth Amendment for evaluating
4 liability requires the additional showing that refusal or
5 failure to provide medically necessary treatment was
6 deliberately indifferent rather than negligent. But for
7 evaluating what is medically necessary treatment, that's the
8 same standard that's applied in the community and in prison.
9 THE COURT: All right. But medically necessary does
10 not mean -- in the Eighth Amendment context does not mean that
11 it is -- that a failure to act in a particular way gives rise to
12 liability unless it arises to a potential for either death or
13 wanton pain. So the standard is different on that level.
14 Do you agree with that?
15 MS. RIFKIN: I don't exactly agree with that,
16 Your Honor. I think that the idea, deliberate indifference to a
17 serious medical need, the standard is a substantial risk of
18 serious harm. And so the idea that it has to be -- I mean, it
19 has to be serious medical harm.
20 Everyone here, including defendants' experts, is going to
21 agree that gender dysphoria constitutes a serious medical need,
22 and failure to provide treatment results in serious medical harm
23 cognizable by the Eighth Amendment. So that issue isn't really
24 in dispute.
25 The issue is whether surgery, gender confirmation surgery,

1 is the treatment that the medical standards of care require.
2 And I think the deliberate indifference analysis comes in in the
3 question of: Do defendants know -- are they on notice that
4 Ms. Edmo has a serious medical need? Are they on notice that
5 without the treatment at issue, which --
6 THE COURT: You just said that they agree that this is
7 a serious medical need. So regardless of what's happened in the
8 past, you are saying if they agree on that, then they are not
9 only on notice, but they are, in fact, accepting as true the
10 fact that Ms. Edmo has a serious medical need.
11 MS. RIFKIN: That is correct, Your Honor. That is
12 what defendants have stated in their briefing in opposition to
13 this motion for preliminary injunction.
14 And their experts will tell you that they, themselves, have
15 evaluated Ms. Edmo, and they, themselves, have agreed that she
16 has a diagnosis of gender dysphoria.
17 And their experts will also tell you that they agree that
18 she continues to experience ongoing clinically significant
19 distress or impairment of functioning, which is the definition
20 of the medical condition.
21 So this is not in dispute in this case that she has this
22 serious condition and she continues to experience clinically
23 significant and cognizable distress.
24 THE COURT: Okay. One of the things that we wrestle
25 with, you know, in Eighth Amendment cases all the time is when

1 an individual has a medical need and then there are, you know,
2 three or four different alternative possible treatments. One
3 might be very conservative; the other might be quite radical;
4 and there might be a number of options in between. As long as
5 all four -- all of these options are recognized as appropriate
6 responses to a medical need, the choice of one over another does
7 not constitute deliberate indifference.
8 Do you agree?
9 MS. RIFKIN: I do agree with that when there are
10 options and one is not preferable over the other in terms of
11 from a reasonable medical provider's point of view.
12 THE COURT: So that's kind of maybe the key issue in
13 the case. Do you agree?
14 I mean, assuming that everyone is in agreement that there
15 is a serious medical need, there is a medical condition which
16 would satisfy the Eighth Amendment standard, the question is --
17 in terms of whether you're deliberately indifferent, is whether
18 the care provider has chosen a reasonable option or whether they
19 have closed their eyes to the most viable option in favor of one
20 that just simply saves them money.
21 MS. RIFKIN: Well, Your Honor, that's why I think that
22 this case is actually a simple case because those issues that
23 you just said are not in dispute.
24 The defendants' experts are not going to say that gender
25 confirmation will not treat Ms. Edmo's gender dysphoria. And

1 they are not even going to say that the hormone treatment she is
2 currently receiving is sufficient treatment to alleviate her
3 ongoing distress.
4 Instead, they are going to present you with a host of
5 rationales about why she is not ready for treatment or why she
6 doesn't deserve treatment that aren't part of the medical
7 considerations in this case.
8 Nobody is going to testify, except potentially defendants'
9 actual clinical providers, that the course of treatment Ms. Edmo
10 is currently receiving is sufficient for her gender dysphoria.
11 Their experts and her providers are going to tell you that she
12 is required to do other things to address other medical
13 conditions that they contend that she has or that she needs to
14 be better behaved in prison in order to get these treatments.
15 They are not going to present evidence that surgery that
16 she is requesting will not alleviate her gender dysphoria. That
17 is uncontested in this case.
18 THE COURT: Well, again, I want to ensure that my
19 layman's understanding or layperson's understanding doesn't get
20 in the way of the facts.
21 If you would have asked me whether or not there are some
22 potentially serious psychiatric consequences to this surgery,
23 some of which need to be prepared for, need to be encountered,
24 need to be wrestled with, and it's quite a long process because
25 of the change it will bring about in a person's personality --

1 that all of that takes time, and typically it is not just a snap
2 decision that is made, but, in fact, it requires consideration
3 of a lot of factors, including the defendant -- a patient's
4 mental health, underlying sources of problems in their life,
5 things of that sort, before you resort to reassignment surgery,
6 which is essentially irreversible.
7 Am I wrong about that? And I'm not throwing that out as
8 that's my opinion. I'm just saying that's kind of what I have
9 been led to believe by reading the things that people read in
10 our society. And I want to make sure that doesn't get in the
11 way of the facts in this case.
12 So -- and that sounds a little bit like what the defendants
13 are arguing here, at least in part, certainly not -- that
14 doesn't reflect an argument that Ms. Edmo needs to behave better
15 in prison. That's -- I agree. Frankly, I would be shocked if
16 the defendants were going to argue that, at least not in that
17 fashion.
18 But this other concern I have is this is a very complex
19 decision with a lot of pieces that need to be considered and put
20 together before a final irreversible decision is made to engage
21 in the reassignment surgery.
22 MS. RIFKIN: Your Honor, there are two responses to
23 that.
24 The first is: This is a complex decision. Surgeries, in
25 general, for medical conditions are complex. And that's why we

1 look to governing standards of care that are developed by the
2 experts with medical authority. And generally, when surgeons,
3 when doctors, when psychiatrists practice, they go to medical
4 school, and they are trained, and they follow the practices set
5 forth by their profession and the specialty in which they
6 practice.
7 And the treatment for gender dysphoria, the expert
8 association -- just like the American Medical Association, the
9 American Psychiatric Association -- is the World Professional
10 Association for Transgender Healthcare, or WPATH. They have
11 been in existence since 1979.
12 And they look at and review all of the evidence, all of the
13 data, and they put forward the best practices. And not just the
14 best practices, but they create the criteria for considering
15 whether surgery is appropriate and whether it's medically
16 necessary.
17 And so they have -- they create criteria that our experts
18 will talk about that does what you're talking about; that
19 consider all of the complex issues that need to be considered to
20 determine whether this is the right treatment for somebody.
21 And so those criteria are what enable us to make the
22 decision. And you will hear that for those criteria, the answer
23 for Ms. Edmo is actually very clear.
24 And related to that is the idea that there needs to be a
25 certain amount of time to make sure this isn't a snap decision.

1 This isn't a snap decision. Ms. Edmo has been on hormones for
2 six years. And the criteria that you will hear about from our
3 experts require that somebody has had severe, persistent
4 dysphoria for at least six months and that they have been on
5 hormones for, I think, a year and that they have consistently
6 presented in their gender identity that they are transitioning
7 to for at least 12 months.
8 And so you're right, Your Honor, that it's not a snap
9 decision. But in the community, the standards look at six
10 months and a year as time periods here, and we have extensive
11 documentation since at least 2012, when Ms. Edmo came into the
12 prison system, that she has consistently and persistently
13 presented as female and been on hormones for that long.
14 THE COURT: Now, there was a suggestion I think in
15 your brief that Ms. Edmo had actually presented as a female even
16 before she came to prison. But the defense disputed that. And
17 at least from the statement you just made, I'm assuming that
18 you're not going to argue -- or if you are -- that perhaps it's
19 not necessary for the court to decide whether or not Ms. Edmo
20 had presented prior to being incarcerated.
21 MS. RIFKIN: Your Honor, that is a disputed fact in
22 this case. You will hear from Ms. Edmo, herself. But what is
23 more important for the consideration in this case is the second
24 part of what you just said, which is you will hear from our
25 experts that the issue is not what happened more than six years

1 ago. The issue is: What is Ms. Edmo's medical condition now;
2 what is the harm she is experiencing; and what is the necessary
3 medical treatment now to make sure that her condition is
4 sufficiently addressed in medical terms.
5 THE COURT: All right. Just if I could -- again, I'm
6 taking up more of your time, but I think the purpose of the
7 opening statement is to make sure I understand the issues. I
8 have read the briefs, so I pretty much know, I think, how the
9 evidence is going to play out.
10 So what it really comes down to is that the parties, in
11 your view, really don't dispute that Ms. Edmo has a serious
12 medical condition, the response to which is necessary to avoid
13 violating her rights under the Eighth Amendment.
14 So the question is: What is the appropriate response? And
15 your view is that if Ms. Edmo satisfies all of the criteria for
16 sex reassignment surgery, which is set forth by the body which
17 establishes the standard of care, then that is the choice that
18 is necessary to avoid an Eighth Amendment violation.
19 Is that roughly the argument?
20 MS. RIFKIN: That's correct, Your Honor, with the
21 additional information that she has had all of the other
22 possible treatments. Those other options --
23 THE COURT: That's part of what's necessary to put her
24 in a position where she is -- the appropriate course of
25 treatment at this point -- and critical term is "at this point"

1 because she has been through these other processes -- is sex
2 reassignment surgery?
3 MS. RIFKIN: That's precisely the case, Your Honor.
4 So I won't take up too much of your time but just try and
5 make points that we haven't already covered.
6 THE COURT: Okay.
7 MS. RIFKIN: I think, as Your Honor recognized,
8 bringing up behavior in prison is not necessarily relevant.
9 Defendants' experts and their witnesses are going to try to make
10 it relevant by suggesting that these behaviors or Ms. Edmo's
11 conviction offense or her experience of childhood sexual abuse
12 or whether she presented as feminine enough prior to her
13 incarceration, somehow affect and must be considered in terms of
14 what the medical treatment is for her now.
15 And our experts will explain that none of these factors are
16 relevant for determining what's medically necessary and whether
17 surgery is appropriate at this point and whether Ms. Edmo is
18 capable of making informed consent, of participating in medical
19 treatment, and of participating in the necessary follow-up to
20 medical treatment and surgery, as is often required with
21 surgery.
22 Defendants' experts will also claim that the symptoms and
23 manifestations of Ms. Edmo's gender dysphoria, that her attempts
24 at self-castration, now cutting on her arm to distract herself
25 from the distress somehow disqualify her from getting treatment,

1 from getting surgery for gender dysphoria.
2 They are going to argue that, despite her eligibility under
3 these criteria, that this makes her not ready, that this makes
4 it inappropriate for her. And their answer is that she has to
5 engage in talk therapy to improve her coping mechanisms.
6 This is like telling a cancer patient they should be in
7 psychotherapy to stop anxiety about their tumor growing while at
8 the same time denying them chemotherapy and radiation to
9 actually treat the tumor.
10 Defendants will call their current -- her current clinical
11 providers to testify that she should not have the surgery -- not
12 that the surgery won't treat gender dysphoria, but they will say
13 that her current treatment is sufficient right now. They will
14 acknowledge that surgery may be appropriate for her at some time
15 in the future, but they will suggest that before she can have
16 surgery, if she would only try harder and cooperate more with
17 them, she would do better, as if she could simply think away the
18 serious medical condition by focusing on other things rather
19 than it being the other way around, that this condition needs to
20 be treated so that she can move on with her life and focus on
21 the rest of what she needs to improve.
22 And the problem is that defendants' clinical providers are
23 not trained in the medical specialty of gender dysphoria. Just
24 like defendants' experts, they have very little experience
25 treating people with gender dysphoria. And critically, they

1 have absolutely no experience with gender confirmation surgery.
2 Not one of the witnesses that defendants will call in this
3 case has experience with gender confirmation surgery. They have
4 never referred someone for gender confirmation surgery. They
5 have never treated someone who has had gender confirmation
6 surgery.
7 So they characterize surgery as something unknown,
8 speculative, scary. But that is simply reflective of a
9 philosophy that denies this treatment to people in prison and
10 suggests that different science and different medicine applies
11 to them.
12 The evidence and the legal arguments will show that
13 philosophy is not based in medicine, it's not based in science,
14 and it's not based in law.
15 Plaintiff's experts will tell you that the issue of whether
16 gender confirmation surgery for Ms. Edmo is medically necessary
17 is not even a close call. The ongoing distress she experiences
18 is the predictable result of inadequately treated gender
19 dysphoria. It is a medical condition with a medical treatment,
20 and this treatment has been established for decades.
21 We will also hear from Ms. Edmo, herself, who is with us in
22 the courtroom, who will get a chance to tell the court directly
23 why she has gone to such lengths to ask for treatment, why she
24 has persisted in presenting herself as who she is even in what
25 is perhaps the most challenging context to do so, being a woman

1 in a men's prison -- facing harassment, threats, discipline, and
2 abuse.
3 She knows that by bringing this lawsuit, by bringing this
4 motion, she is subjecting herself to even more scrutiny, to the
5 most personal of questions and challenges about her body, her
6 identity, her character, her shortcomings.
7 But as she will tell you, she is doing what she knows she
8 has to in order to be able to survive and keep moving forward in
9 prison and out.
10 And unless Your Honor has any additional questions --
11 THE COURT: No. That's fine. Thank you.
12 MS. RIFKIN: -- I'll sit down.
13 THE COURT: Do either of the defendants wish to make
14 an opening statement? Mr. Hall?
15 MR. HALL: Yes, Your Honor. In the interest of time,
16 the defendants have agreed to do a joint opening statement.
17 THE COURT: Very good.
18 MR. HALL: Your Honor, we have prepared a brief
19 PowerPoint presentation just to provide some context to what the
20 issues really are in this case.
21 Your Honor, as a preliminary matter, I would like to thank
22 the court for the opportunity to have the summer to perform some
23 discovery so that we could prepare a defense and that we could
24 tell the court the entire story here.
25 I also want to apologize on behalf of my clients, the Idaho

1 Department of Correction. I do not know yet why Ms. Edmo was
2 not here prepared at 8:30, but I have talked to my clients, who
3 will make sure it does not happen again tomorrow. But I
4 appreciate the court's understanding, and we will address that.
5 Your Honor, I think it's important to begin this proceeding
6 by understanding exactly what this case is about. This is not
7 about defendants refusing to recognize that gender dysphoria is
8 a serious mental health disorder.
9 When Ms. Edmo came into the Idaho Department of Corrections
10 custody in 2012, she requested an evaluation for gender
11 dysphoria, which was known as "GID" at that time. She was
12 provided one. Within a month, she was diagnosed.
13 This is not a case about defendants' refusal to recognize
14 the accepted treatment options for gender dysphoria. There are
15 four primary treatment options for gender dysphoria that are set
16 out by the WPATH, all of which the IDOC has recognized in policy
17 as appropriate on an individual case-by-case analysis.
18 Since 2012, Ms. Edmo has been placed on hormone therapy,
19 which has been followed closely and monitored. There may be
20 some disagreement throughout this case as to whether or not this
21 lab showed a proper response, but that is not the limited
22 difference.
23 Ms. Edmo has been offered psychotherapy, group therapy, to
24 which she has denied or refused a lot of that, Your Honor.
25 Ms. Edmo has been allowed to feminize to the greatest extent

1 possible within the IDOC's prison policies.

2 There is striking difference -- we will see photographs of

3 Ms. Edmo in 2010, when she was initially in IDOC custody, again

4 in 2012 and then, of course, today. And the progress is

5 astonishing.

6 THE COURT: Mr. Hall, is the microphone -- would you

7 pull it -- yeah.

8 MR. HALL: Can you hear me now?

9 THE COURT: Much better. It's much easier for the

10 court reporter as well. Thank you.

11 MR. HALL: I didn't want to bump into it.

12 So there is no -- there's no dispute there that IDOC, by

13 policy itself and by application, recognized the appropriate

14 treatment options for gender dysphoria. And this is not a case

15 about the failure to provide those treatment options.

16 What this case is about is a difference in professional

17 opinion as to whether one treatment option, which is surgery, is

18 or has ever been appropriate for Ms. Edmo.

19 Now, we need to understand when surgery is appropriate.

20 There are no universal standards out there. The area here is

21 rapidly evolving.

22 One of plaintiff's experts will testify -- excuse

23 me -- that this area has seen an explosion over the last several

24 years. There has been a rapid change in the surgical

25 treatments, the techniques, the medicine involved, as well as

1 the terminology.

2 When we started this case, surgery was referred to as

3 "sexual reassignment surgery." I learned recently that has now

4 changed. It is now "gender confirmation surgery." As we know,

5 "GID" is no longer; it is referred to as "GD." A lot is

6 changing in this field.

7 Now, the defendants recognize the WPATH standards of care

8 in the seventh edition do provide the best guidance, but they

9 are also flexible clinical guidance that are subject to

10 modification based on individual case-by-case basis.

11 There is articles out there, few and far between, but one

12 which is one of the few that actually interprets those WPATH

13 policies and criteria within the prison system. And that's the

14 article you will hear about this in case, Your Honor, from

15 Osborne and Lawrence, which is "Male Prison Inmates with Gender

16 Dysphoria: When is Sex Reassignment Surgery Appropriate?"

17 And to deny or to ignore that there are key differences

18 in -- between a prison population and in the community is not

19 only ignorant but is dangerous for the population.

20 And that's not to say that the Department or the defendants

21 are saying, well, a certain treatment option is not available in

22 prison. They have never said that. They do not believe that.

23 You will not hear that from the defendants.

24 But one thing remains, Your Honor, is that there is a

25 critical need for more evidence-based research, especially how

1 these WPATH standards will apply or do apply or should apply in
2 a prison context. The WPATH is aware of that, and they have
3 been working on it.
4 Ultimately, Your Honor --
5 THE COURT: So you are saying that this association is
6 actually specifically considering whether the standard is
7 different in a prison setting than in a nonprison setting?
8 MR. HALL: No, Your Honor. They have -- they have two
9 pages of their standards that apply that reference how to apply
10 these in prisons, not a lot of data out there. They relied on
11 maybe two articles.
12 So they do say they should be applied with reasonable
13 accommodations in a prison context. However, what they are
14 looking at is, as a community wide -- whether it's out of prison
15 or in prison -- these standards lack a sufficient amount of
16 evidence-based research. And that is needed. That is critical.
17 And it goes towards the clinicians who are applying these
18 need to understand: Is this based on sound science? Is this
19 based on advocacy? And there is a dispute out there.
20 Now, at the same time, Your Honor, the defendants have
21 recognized the WPATH. The IDOC has had a member since 2014,
22 2015 of the WPATH. And you will hear testimony from Mr. Clark.
23 And they look at it, they consider it, they find it
24 appropriate at times; but it must be applied on a case-by-case
25 analysis. And all they are going to say --

1 THE COURT: Let me just back up, though.
2 MR. HALL: Yes.
3 THE COURT: I want to make sure we are understanding
4 each other.
5 If -- there are a lot of areas in which our understanding
6 is expanding rapidly. I have a daughter-in-law who is involved
7 in oncology. And she is involved in immunotherapy, which is the
8 cutting edge, changing. Probably every six months, there is
9 massive changes.
10 It doesn't mean, though, that in the course of treatment,
11 they stand still, waiting for that silver bullet to be
12 developed. And I'm just a little concerned to say that we
13 should not be taking any action because this is an evolving
14 area.
15 And I'm not saying how this all cuts. I just want to
16 be -- it kind of reminds me -- or it's the reason we don't use
17 what's called the *Fry* standard in terms of evaluating expert
18 witnesses. Now we use *Daubert*, which allows us not to wait for
19 something to be generally accepted in the scientific community.
20 Instead, we look at, on a more dynamic basis, whether or not the
21 principles are sound, whether or not they are applicable and
22 relevant to the issue before the court.
23 And it seems to me -- I just -- you need to understand, I'm
24 much more of a *Daubert* guy than I am a *Fry*e guy, no pun
25 intended, I guess. But I just don't think generally, in this

1 day and age, we can wait for things -- to wait until they are
2 very stable and fixed, because they never are.
3 MR. HALL: Right.
4 THE COURT: And I assume you are not arguing that
5 that's the reason why we shouldn't order it here.
6 You are saying, as I suggested in my discussion with
7 Ms. Rifkin, that there is a variety of treatments that are
8 appropriate, medically indicated, and medically endorsed. You
9 have chosen one, not the one plaintiffs want. And that choice
10 should be ratified as long as it is a reasonable choice.
11 MR. HALL: Right.
12 Well, Your Honor, a couple points. First, defendants are
13 not saying that the court should overlook these standards. That
14 is not it. Defendants recognize these standards. They apply
15 these standards. They are the best standards out there. And
16 they are relying on these standards in Ms. Edmo's case. That
17 needs to be very clear.
18 No one is saying we need to wait for better evidence. What
19 we're saying is that the evidence that we have, the concerns we
20 have do weigh against providing SRS gender confirmation surgery
21 at this time.
22 Now, ultimately, it's whether or not it's appropriate for
23 Ms. Edmo. IDOC has provided and the defendants have provided
24 three of the four available treatment options. And no one is
25 saying Ms. Edmo is never going to be appropriate or it's never

1 going to be appropriate for her to have surgery. What they have
2 been saying is not at this time.
3 And that brings us to, really, understanding what the
4 criteria for surgery is. And I want to look at the WPATH,
5 because that's what defendants are looking at, that's what
6 plaintiffs are looking at.
7 The plaintiff recognizes and has advanced the WPATH's
8 criteria, many of which it's undisputed that Ms. Edmo meets and
9 exceeds. However, there are a couple that defendants have
10 concerns.
11 The primary one is highlighted and bolded there. If
12 significant medical or mental health concerns are present, they
13 must be well controlled. That is not language that the
14 defendants created. That is the WPATH language. That is the
15 standard, the criteria that is advanced by the plaintiffs in
16 this case. And that is what the defendants are focused on in
17 making sure that they are doing and making the right decision
18 here before a permanent, irreversible, potentially harmful
19 procedure is provided.
20 Not saying never. Not saying other GD offenders in the
21 prison system do not meet these criteria or may meet these
22 criteria at some point. It's a case-by-case analysis.
23 The WPATH -- and we will see testimony on this -- requires
24 that clinicians and mental health providers look for these
25 coexisting mental health concerns, which include -- and the ones

1 highlighted in red there, the second bullet, are key. Because
2 as we will see, Ms. Edmo has suffered from these, continues to
3 suffer from many of these -- anxiety, depression, self-harm, a
4 history of abuse and neglect, substance abuse, sexual concerns,
5 and personality disorders.
6 Again, these are not defendants' words or standards. These
7 are the WPATH standards. It's critical that we understand if
8 there are coexisting mental health concerns and how they are
9 affecting this individual.
10 And the WPATH recognizes that because these coexisting
11 mental health concerns can be, as captured in the third bullet,
12 a significant source of distress and, left untreated, can
13 actually complicate the process of gender identity exploration,
14 resolution of gender dysphoria.
15 The WPATH mandates that these must be well controlled --
16 not reasonably well controlled -- for surgery, well controlled.
17 And in that final bullet, they must be optimally managed. And
18 that's ultimately the issue in this case, Your Honor.
19 Ms. Edmo has a number of coexisting mental health concerns.
20 Your Honor, it's important that the IDOC -- it is understood
21 that we are not bringing up all this prior history and behavior
22 in the prison to embarrass Ms. Edmo. It is the job of the
23 mental health clinicians and the medical providers to understand
24 her entire clinical picture, what is she facing from a mental
25 health standpoint. Because you can't treat gender dysphoria or

1 any one condition alone. You can't treat it in a vacuum. It's
2 not what the providers were trained to do, and it certainly
3 isn't what the WPATH, the standards advanced by plaintiffs,
4 actually require.
5 And what the testimony will show -- we believe the evidence
6 already on the record by way of declarations really establishes
7 this already -- Ms. Edmo has a number of coexisting mental
8 health concerns that are not well controlled. And in part, no
9 fault to Ms. Edmo. She has been a victim.
10 But also, Ms. Edmo has not participated in her treatment.
11 She has refused a number of treatment and therapy groups that
12 are aimed to identify the problems and address these coexisting
13 issues so that it will make her stable. And if stable, gender
14 dysphoria can be potentially treated with surgery.
15 Your Honor, gender dysphoria, again, the defendants do not
16 dispute that it's a serious medical need. They have provided
17 treatment. They are hesitant and do not believe at this point
18 that it is appropriate, even under the WPATH standards, to
19 provide it in light of the mental health concerns that are
20 coexisting.
21 You will hear testimony that Ms. Edmo claims that she lived
22 full time as a woman prior to incarceration. We dispute that.
23 It's relevant not only to her credibility but to her
24 understanding of what it means to identify as a woman and what
25 were her stressors at the time that she had a lot of prior

1 mental health issues preincarceration.
2 Depression, Your Honor, is one that has plagued Ms. Edmo
3 for her entire life. We have records that go back to 2006 time
4 frame showing that Ms. Edmo has been depressed. She identified
5 in 2012 that it runs in the family. It's a component of her
6 genes, and she was diagnosed as early as 2009.
7 It continued through her incarceration, and she's --
8 preincarceration she has described her depression as extreme.
9 And in March of this year, plaintiff's own expert performed some
10 testing. And one of those testing results was that Ms. Edmo
11 currently has severe depressive symptoms. So, again, depression
12 is a significant factor that is not well controlled at this
13 time.
14 Anxiety is very much the same. And that goes, really, part
15 and parcel with the depression. Ms. Edmo identified
16 preincarceration as having high anxiety. In March of this year,
17 plaintiff's expert also identified that Ms. Edmo had severe
18 anxiety symptoms.
19 THE COURT: Mr. Hall, if, indeed, these
20 issues -- well, her mental health I don't think is --
21 concerns -- what's the terminology in the WPATH standard?
22 MR. HALL: Coexisting mental health concerns.
23 THE COURT: Is that the language used?
24 MR. HALL: Yes.
25 THE COURT: The mental health concerns?

1 MR. HALL: Mental health concerns.
2 THE COURT: Need to be well controlled --
3 MR. HALL: Yes.
4 THE COURT: -- or must be well controlled.
5 MR. HALL: Must be well controlled.
6 THE COURT: If the mental health concerns -- if a
7 mental health concern stems directly from gender dysphoria, is
8 that -- does the WPATH standard make clear that that also needs
9 to be well controlled before gender confirmation surgery is
10 ordered?
11 MR. HALL: Your Honor, it --
12 THE COURT: It's kind of the chicken and egg.
13 MR. HALL: It can be. And it's often left to
14 providers to sort that out, those who know the individual best.
15 What you will hear -- and I think it's no surprise to the
16 court -- is that mental health is complex. You can have
17 anxiety, you can have depression, but you can't identify exactly
18 what's causing that; you can try. And one of the best ways to
19 do it is to have talk therapy, to work through issues, to have
20 mood management therapy to address to see if it's a certain
21 component that is causing it.
22 And this is not a case that is -- that all of Ms. Edmo's
23 problems are related to gender dysphoria that can be cured with
24 this surgery. No one is saying that.
25 Your Honor, Ms. Edmo has also been a victim of abuse. I

1 don't want to get into that too much, but she has been the
2 victim of preincarceration sexual abuse from family members as
3 well as multiple relationships with significant others in the
4 years prior to, which is a contributing factor to a lot of her
5 other mental health concerns.
6 Her substance abuse is extreme prior to incarceration. The
7 years before 2012, Ms. Edmo was engaged in a lot of drug use --
8 methamphetamines, heroin, but primarily alcohol -- to the point
9 of severe intoxication on a daily basis and a number of trips to
10 the hospital for that, which is also a contributing factor to
11 her significant history of self-harm.
12 We don't know the full extent. We learn more -- we have
13 learned more as this case goes on. Prior to incarceration,
14 Ms. Edmo attempted suicide anywhere from three to five times.
15 We are aware of a potential other one in Washington that we do
16 not have medical records for.
17 There was an event when she was 16 where she attempted to
18 overdose on medication or alcohol. And more recently, in 2010
19 and 2011, Ms. Edmo attempted suicide after having some fights
20 with her significant other which were abusive and also due to
21 ongoing depression, anxiety, feelings of worthlessness,
22 unemployment, substance abuse. A lot going on there,
23 Your Honor.
24 And she continues to have the urge to self-harm. In
25 prison, she has attempted self-castration -- purported

1 self-castration attempts twice. She has also been cutting
2 herself, Your Honor, in the last year, which is extremely
3 alarming. It's not a good coping mechanism, but it shows
4 continued self-harm activities.
5 And in March of 2018, again, plaintiff's expert tested
6 Ms. Edmo, and she scored 100 out of 100, the highest score
7 possible on this test, that denotes the propensity for
8 suicidality. So that is a very real and present concern,
9 Your Honor.
10 Sexual concerns are another one that may not seem relevant
11 at the forefront, but it goes towards a number of the other
12 issues. Ms. Edmo has a long history of engaging in dangerous
13 sexual behavior, multiple partners preincarceration. And then
14 after -- during -- during incarceration, Your Honor, there has
15 been a number of inappropriate sexual contacts that resulted in
16 disciplinary attention.
17 And Ms. Edmo identifies with sex as a coping mechanism. It
18 provides for her attention from male offenders, which is a
19 significant component of this case. And as you will see
20 testimony, may be -- until that's sorted out, that may be
21 influencing Ms. Edmo's desire to have this surgery.
22 And to date, Ms. Edmo has not focused on a lot of these
23 issues, Your Honor. She has not completed the sex offender
24 treatment program that was mandated by the Department of
25 Corrections, and it is one reason why she has not been eligible

1 for parole.

2 Wrapped up in all of these is this concept of Ms. Edmo
3 having personality disorder traits. There has been no formal
4 diagnosis, but none is needed in that the clinicians have been
5 attempting to treat all of the symptoms. Personality disorder
6 traits -- many of them are listed on that in that bubble right
7 there -- pattern of unstable and intense personal relationships;
8 impulsivity, whether by sexual relationships or substance abuse;
9 recurring self-harm behavior, which is very present; unstable
10 mood and aggression.

11 Ms. Edmo has been the perpetrator of several assaults while
12 in incarceration, some over the last couple years, is defensive
13 to her treatment plan, is defensive and aggressive towards staff
14 as well as other offenders.

15 And, Your Honor, to the extent that her disciplinary
16 history is relevant, it is in some regards that it shows an
17 ongoing -- ongoing mental health concerns that do not excuse the
18 conduct. But the clinicians look at it, and they determined
19 that, look, that is a sign or symptom of ongoing mental health
20 concerns.

21 So ultimately, Your Honor, in closing, it is not deliberate
22 indifference here for the defendants to have recognized the
23 gender dysphoria as a serious medical condition. It is not
24 deliberate indifferent for the defendants to have recognized the
25 appropriate treatment, the treatment which has been provided.

1 To date, the only treatment that has not been provided as
2 contemplated by the WPATH for gender dysphoria is surgery. And
3 the defendants have long maintained and continue to maintain
4 that Ms. Edmo does not meet the criteria. And this is perhaps,
5 at most, a dispute by professionals, some of which who from the
6 Department of Corrections have known Ms. Edmo for a long time,
7 have had multiple conversations with her.
8 Plaintiff's experts have met with Ms. Edmo for two hours,
9 maybe three hours apiece. And they certainly have not been
10 provided a complete history, and they weren't when they provided
11 their opinions.
12 Now, the defendants are not saying that surgery is not
13 appropriate in prison. They are not saying that surgery is
14 never appropriate for a GD offender. What they have been saying
15 and continue to maintain now is that surgery for Ms. Edmo is not
16 appropriate. She does not meet -- even if we apply just the
17 WPATH standards, she does not meet those. She has coexisting
18 mental health concerns which are complicating the situation.
19 IDOC has attempted to have Ms. Edmo address through mood
20 management training, social skills, healthy relationships
21 therapy, the sex offender treatment program, and the gender
22 dysphoria group. They have attempted to have her engage to
23 address these other issues, these other coexisting mental health
24 concerns.
25 But Ms. Edmo's focus has primarily been on gender

1 dysphoria; I need the surgery. And it's a difference of medical
2 opinion and professional opinion as to whether or not that's
3 appropriate.
4 And until these are well controlled, until her depression
5 is under control, until her anxiety, her sexual concerns, her
6 self-harm issues, and these personality traits can be managed,
7 it would not be appropriate or safe to provide this surgery.
8 A lot of this is speculative. We don't have a lot of data.
9 And that's not why there would be any denial of that, but mental
10 health professionals need the discretion to be able to consider
11 the whole person and to consider whether or not she is mentally
12 stable at this time or was in 2016 when an evaluation for
13 surgery was performed.
14 Your Honor, unless there are any questions, I have nothing
15 further.
16 THE COURT: No. Thank you.
17 All right. Plaintiffs may call their first witness.
18 MS. RIFKIN: Thank you, Your Honor.
19 We would like to call Dr. Randi Ettner.
20 THE COURT: Dr. Ettner, if you would step before the
21 clerk and be sworn.
22 RANDI ETTNER, PH.D., PLAINTIFF'S WITNESS, SWORN
23 THE CLERK: Please take a seat in the witness stand.
24 Please state your complete name and spell your name for the
25 record.

1 THE WITNESS: Dr. Randi, with an "I," Ettner,
2 E-T-T-N-E-R.
3 THE COURT: You may inquire, Ms. Rifkin.
4 DIRECT EXAMINATION
5 BY MS. RIFKIN:
6 Q. Good morning, Dr. Ettner.
7 A. Good morning.
8 Q. Can you tell us your current positions, Doctor.
9 A. I'm a clinical and forensic psychologist. I'm the
10 secretary of the World Professional Association for Transgender
11 Health. I am the president of the New Health Foundation
12 Worldwide. I'm the psychologist at the Chicago Gender
13 Confirmation Surgery.
14 I perform research and write -- writing on gender-related
15 topics. I supervise other psychologists, and I train people
16 about the care and the condition of gender dysphoria.
17 Q. And you have a doctorate in psychology?
18 A. Yes; correct.
19 Q. How long have you been in practice as a psychologist?
20 A. Since 1980.
21 Q. And we have got a copy of your CV here. It's marked as
22 Plaintiff's Exhibit 1003. We can get that up on the screen.
23 Does the cover of this CV look accurate to you, Dr. Ettner?
24 A. Yes, it does.
25 MS. RIFKIN: Your Honor, I would like to move

1 Plaintiff's Exhibit 1003 into evidence as Dr. Ettner's CV.
2 THE COURT: Any objection?
3 MR. HALL: No objection, Your Honor.
4 THE COURT: Exhibit 1003 will be admitted.
5 (Plaintiff's Exhibit 1003 admitted.)
6 Q. BY MS. RIFKIN: Dr. Ettner, do you currently see patients?
7 A. Yes.
8 Q. And you listed a number of positions in addition to your
9 private practice.
10 Can you describe your other responsibilities besides being
11 a direct treater for patients?
12 A. Well, as I mentioned, I supervise other psychologists. I
13 train physicians, mental health professionals, and other people
14 who are interested in learning how to treat gender dysphoria
15 through the global education initiative of the World
16 Professional Association for Transgender Health.
17 I'm a member of the University of Minnesota's medical
18 foundation, the leadership council. And I consult to
19 organizations, such as Walgreens, Tawani, and others as needed.
20 Q. You have mentioned a couple times and we heard about in
21 opening statements the World Professional Association of
22 Transgender Healthcare, or WPATH.
23 What is this organization?
24 A. Well, you stated that it started in 1979. It actually
25 started in 1976. In 1979, it promulgated the first version of

1 the standards of care.

2 It is now an organization consisting of 2,000 members,

3 professionals in various areas -- such as surgery,

4 endocrinology, primary care, mental health -- who work with

5 gender-variant individuals.

6 Q. And you mentioned that the standards of care first

7 promulgated in 1979 -- thank you -- and we have heard about the

8 most recent version.

9 Can you explain what those standards of care are.

10 A. The standards of care inform treatment for gender dysphoria

11 throughout the world. They have been translated into, I

12 believe, 15 languages and are endorsed by almost all of the

13 scientific and professional organizations, including but not

14 limited to the World Health Organization, the American Medical

15 Association, the American Psychiatric Association, the American

16 Psychological Association, the American Family Practice

17 Association, the National Commission on Correctional Health, the

18 National Association of Social Workers, the American Academy of

19 Plastic Surgeons, the American College of Surgeons, and the

20 surgeons generals themselves.

21 Q. Have you played any role with respect to promulgating the

22 standards of care?

23 A. I am one of the authors of the seventh version of the

24 standards of care.

25 Q. When was that seventh version promulgated?

1 A. It was produced in 2011 and widely circulated by 2012.
2 Q. And you also chair the WPATH Committee for
3 Institutionalization Persons; is that right?
4 A. Yes.
5 Q. What does this committee do?
6 A. This committee actually looks at the care and the
7 assessment of individuals who are incarcerated and develops
8 standards for treatment for the standards of care for future
9 iterations and for the past iterations.
10 It looks at case law and different policies, how different
11 federal and state prisons handle the treatment, the placement,
12 and other policies regarding institutionalized people -- not
13 just in prisons but in other long-care facilities where people
14 really don't have agency to access care on their own.
15 Q. How long have you been a member of WPATH?
16 A. Since 1993.
17 Q. And what is your experience treating patients with gender
18 dysphoria?
19 A. I have personally treated 3,000 individuals with gender
20 dysphoria.
21 Q. Have you, as part of that treatment, evaluated whether
22 gender confirmation surgery is necessary for patients?
23 A. Yes. For certain patients, it's medically indicated.
24 Q. And have you referred any patients for gender confirmation
25 surgery?

1 A. I have referred approximately 300 patients for surgery.
2 Q. Do you have any experience interacting with or treating
3 patients after they have undergone gender confirmation surgery?
4 A. Extensive experience. Many of the patients that I have
5 treated will come back years after surgery not about gender
6 dysphoria, because that's been eliminated, but to discuss the
7 kinds of issues that other people have -- problems at work or
8 concerns with their children or other issues.
9 Q. And what is your experience assessing incarcerated patients
10 with gender dysphoria?
11 A. I have assessed approximately 30 individuals in 30
12 different prisons, federal and state, not just for surgery
13 necessarily but for care in general, medical care in general.
14 Q. And you've also authored a number of books on the treatment
15 of gender dysphoria and transgender healthcare?
16 A. That's correct.
17 Q. And on your resume, it includes the "Principles of
18 Transgender Medicine and Surgery."
19 How would you describe this publication?
20 A. That's a textbook that I edited for medical and surgical
21 care. It's used in medical schools and for surgeons. It was
22 revised in 2017.
23 Q. And you have also authored a number of peer-reviewed
24 articles on treatment of gender dysphoria and transgender
25 healthcare?

1 A. That's correct.
2 Q. What does "peer-reviewed" mean when we talk about
3 scientific publications?
4 A. A peer-reviewed article is when a manuscript is submitted
5 to a journal. The editor will send it to typically three
6 experts in that area to review and to determine whether it is
7 rejected, accepted for publication, or accepted with revisions.
8 Q. And why is peer review important from a scientific
9 perspective?
10 A. Well, anyone can just write an article expressing their
11 opinion, but that may not be in concert with the standards of
12 the profession or the prevailing scientific knowledge.
13 So data, methodology, references, all of those are
14 rigorously checked by the editorial board in order to make sure
15 that the article that's submitted actually advances the body of
16 knowledge.
17 Q. You mentioned earlier one of your responsibilities is that
18 you provide training on treating gender dysphoria.
19 Do you provide training specifically as to assessing
20 whether patients with gender dysphoria require surgery or
21 whether it's appropriate?
22 A. I have in the past. I do that at surgical presentations.
23 I present to the American College of Surgeons, the American
24 College of Plastic Surgeons, determining and explaining at these
25 conferences what the standard of care is and the importance of

1 the mental health professional in collaborating in
2 multidisciplinary teams that provide surgery.
3 Q. Have you served as an expert consultant regarding policies
4 for treatment of gender dysphoria in prisons or jails?
5 A. Yes.
6 Q. Have you been invited by any federal or state agencies to
7 provide training about gender dysphoria?
8 A. Yes. I was an invited guest to the National Institutes of
9 Health to help develop a strategy for research on gender
10 dysphoria and sexual minorities.
11 I was invited to speak to the director of Health and Human
12 Services about the evidence-based care of gender dysphoria. And
13 I was an invited guest of the World Health Organization as -- in
14 2013 as they contemplated where and how to place what was called
15 gender dysphoria, whether to change that name and where to place
16 and conceptualize that in ICD-11, the International
17 Classification of Diseases, which they have just completed in
18 June of this year.
19 Q. And have you ever been appointed by a federal court as an
20 independent expert related to the treatment of gender dysphoria?
21 A. Yes, I have, in relation to evaluation of an inmate for
22 surgery.
23 Q. What did you do to form your opinions in this case,
24 Dr. Ettner?
25 A. I reviewed all of the medical and mental health information

1 that was provided and all of the other documents that were
2 provided to me. I met with Ms. Edmo at the prison where she
3 resides here in Idaho, and I conducted psychodiagnostic testing.
4 Q. Have you -- as part of the records that you received and
5 reviewed, did you review plaintiff's -- Ms. Edmo's medical
6 records prior to her incarceration?
7 A. Whatever was available, yes.
8 MS. RIFKIN: At this point, Your Honor, I would like
9 to proffer Dr. Ettner as an expert psychology witness and an
10 expert witness regarding assessment and treatment of gender
11 dysphoria.
12 THE COURT: I normally don't make a specific
13 determination at the request of counsel designating someone as
14 an expert. You can go ahead and inquire. If counsel feels that
15 your questions exceed her scope of expertise, they can object,
16 but typically they won't.
17 So let's just go ahead and proceed.
18 Q. BY MS. RIFKIN: All right. Can you explain, Dr. Ettner,
19 what the "Diagnostic and Statistical Manual of Mental Disorders"
20 is?
21 A. Yes. It's a book used by mental health professionals that
22 identifies mental health issues and disorders, codes them, and
23 lists the diagnostic criteria and specifiers.
24 Q. Is the diagnosis of gender dysphoria included in the DSM-5?
25 A. Yes.

1 Q. All right. I would like to show you Plaintiff's Exhibit
2 1001.
3 All right. If we can turn to the next page of the exhibit.
4 All right. Is this the DSM-5 entry for gender dysphoria?
5 A. Yes.
6 MS. RIFKIN: Okay. I would like to move Plaintiff's
7 Exhibit 1001 into evidence.
8 THE COURT: Any objection?
9 MR. HALL: No objection, Your Honor.
10 THE COURT: All right. 1001 will be admitted.
11 MS. RIFKIN: And can we put up the demonstrative for
12 this since this is a little hard to read.
13 (Plaintiff's Exhibit 1001 admitted.)
14 Q. BY MS. RIFKIN: Dr. Ettner, can you explain what a
15 diagnosis of gender dysphoria means?
16 A. It means that an individual meets the criteria that are
17 listed here and, additionally, that the condition creates
18 significant distress that impairs some level of functioning.
19 Gender dysphoria is a serious but, fortunately, very treatable
20 medical condition.
21 Q. The first part of this entry talks about a marked
22 incongruence between one's experienced and expressed gender and
23 assigned gender.
24 Can you explain in layperson terms what that means.
25 A. It means that the person's body, their morphology does not

1 align with their sense of who they are, their gender identity.
2 So every individual has a gender identity, a sense of being
3 either male or female.
4 Q. And how is that different from sex or assigned gender?
5 A. I'm sorry. Would you repeat that question.
6 Q. Sure. How is the gender identity different from sex?
7 A. From sexual orientation, for example, or --
8 Q. First, I would like you to talk about how it differs from
9 sex or the assigned gender.
10 A. So the sex assigned at birth is based usually on a cursory
11 examination of the baby's genitals. But as the child grows
12 older and has the ability to verbalize, they may, in rare cases,
13 say that they don't identify with the sex they were assigned at
14 birth.
15 So a little child who is assigned male at birth may say,
16 "They call me son, but I feel more like daughter."
17 Q. And how is that different from sexual orientation?
18 A. Completely different. Sexual orientation is the gender,
19 the sex of someone who you're attracted to. And gender identity
20 is your own sense of whether you're male or female. So they are
21 unrelated.
22 Q. And how does a -- how does gender identity relate to gender
23 presentation, or can you explain what gender presentation means?
24 A. Gender presentation is merely the way one presents their
25 gender. So a person can present the gender that matches their

1 identity by appearing, to the extent possible, with what is
2 traditionally the social signifiers of that gender. So for a
3 female, it would be wearing makeup, hair length, feminine
4 clothing, and the accoutrements of womanhood.
5 Q. Is every person who identifies as transgender also
6 diagnosed with gender dysphoria?
7 A. No.
8 Q. And can you explain what the difference is.
9 A. "Transgender" is really an umbrella term for a person who
10 feels some sense that their assigned gender is not always in
11 concert with their gender identity.
12 But for the gender-dysphoric individual, that incongruity
13 is so severe, that it actually impairs their ability to
14 function.
15 Q. What are typical symptoms that someone with gender
16 dysphoria may experience?
17 A. Well, they would experience a desire to be rid of the
18 primary and secondary sex characteristics of the assigned
19 gender. They would experience a desire to be -- to appear and
20 to be seen as the gender that is their affirmed gender.
21 They would most frequently have some degree of depression
22 or anxiety as a symptom of the gender dysphoria. And depending
23 upon the severity of it, they may have some other psychological
24 attendant symptoms.
25 Q. We can turn to the second -- the next.

1 You mentioned earlier this part of the DSM-5 entry for
2 gender dysphoria.
3 Can you explain what "clinically significant distress"
4 means.
5 A. Yes. So clinically significant distress is where the
6 distress reaches a threshold that the person will either require
7 medical or surgical or both interventions, and the distress will
8 impair or severely limit their ability to function in some way.
9 So when you talk about the distinction between transgender
10 and gender dysphoria, for instance, a child who is a tomboy,
11 assigned female at birth, may be displaying some
12 gender-nonconforming behaviors. But that's not the same as
13 gender dysphoria.
14 Q. Is gender dysphoria related to sexual abuse?
15 A. No.
16 Q. Is sexual abuse a contributing factor to gender dysphoria?
17 A. No.
18 Q. And does the condition of gender dysphoria require medical
19 treatment?
20 A. Typically, gender dysphoria does require medical treatment,
21 yes.
22 Q. Why?
23 A. Because it's a medical condition. And like other medical
24 conditions, it can intensify over time, and does.
25 So, for instance, if we compare it to the condition of

1 diabetes, some people may be prediabetic. Perhaps they can
2 control their diabetes with nutrition and exercise; but in time,
3 they may actually require insulin.
4 So the same is true of gender dysphoria. Some people may
5 initially be able to attenuate the gender dysphoria with a
6 social role transition. But if the gender dysphoria is
7 persistent, they will require other treatments, medical and
8 surgical.
9 Q. And what are the risks of not providing treatment to
10 someone with gender dysphoria?
11 A. If the gender dysphoria is severe, the risks are serious.
12 Prison is actually a place where we see the long-term effects of
13 untreated gender dysphoria. We see the natural progression of
14 the condition. And typically the sequelae are either surgical
15 self-treatment where an individual attempts to remove their own
16 genitals, suicide, or severe emotional decompensation.
17 Q. So I would like to talk about the WPATH standards of care
18 that we discussed a little earlier and we have heard some about
19 today.
20 Can we show the witness Joint Exhibit 15.
21 What version of the standards of care are in effect now?
22 A. Version 7.
23 Q. And I think you told us earlier that that came out in 2011.
24 A. Correct.
25 Q. How do the standards of care get decided?

1 A. How are they produced?

2 Q. Yeah. How is it decided what goes into them and what

3 treatment is going to be recommended or put forward?

4 A. So they begin with the previous iteration, and we

5 look -- and by "we," I mean not only the community of

6 professionals but sometimes stakeholders also will weigh in and

7 will determine what needs to be altered.

8 And if there have been new scientific research that needs

9 to be incorporated or if there have been changes in models of

10 care that need to be incorporated, individuals who have known

11 expertise, who have published or done research, are asked to

12 review the literature and do an evidence-based review of the

13 existing standards.

14 Those papers are then sent for review, just like in a

15 peer-reviewed journal. And then the -- all of the authors

16 review the entire standards of care, and then they are published

17 with an evidence-based and expert consensus with the best

18 possible scientific information available at the time.

19 Q. In opening statements, defendants' counsel stated that

20 WPATH is working on updated standards because there had been

21 insufficient evidence for the treatment of gender dysphoria for

22 the prior standards of care.

23 Is that accurate?

24 A. No.

25 Q. What are the treatment options for someone with a diagnosis

1 of gender dysphoria, under the standards of care?
2 A. So the treatment options would include psychotherapy to
3 promote, for instance, resilience, work with families and
4 schools, help reduce stigma; social role transition, which was
5 previously called the real-life experience, where a person lives
6 in their affirmed gender, and that doesn't involve any medical
7 treatment, although it is considered medically necessary for the
8 treatment of gender dysphoria; cross-sex hormones is the medical
9 intervention; and then gender confirmation surgery to alter
10 secondary and/or primary sex characteristics.
11 Q. Are those treatment options that you just described, are
12 those also the treatment options under the standards of care for
13 someone who is in prison?
14 A. Yes. The standards of care have been discussing treatments
15 for inmates since 1998. And the seventh iteration, the one that
16 you have here, this platform, specifically state that the
17 treatments and assessment of inmates with gender dysphoria
18 should mirror that of the community.
19 So the condition whether or where a person is housed should
20 not determine what the protocol is. The protocol is the same
21 regardless of where a person resides.
22 Q. Are you involved at all, Dr. Ettner, with the update to the
23 standard of care that is currently being undertaken by WPATH?
24 A. Yes.
25 Q. In the next version, based on your involvement in that

1 process, do you know if the standards of care will be revised to
2 make distinctions between what treatment should be available for
3 incarcerated persons and what treatment should be available for
4 people in the community?
5 A. There will be no distinction between treatment options.
6 The treatment will remain the same, regardless, as I said
7 previously, of where a person is housed, similar to other
8 medical conditions.
9 So, for instance, if a person has diabetes, whether they
10 reside in a nursing facility, in a prison, in an orphanage --
11 wherever they are housed, the standard of care, the treatments
12 remain the same.
13 Q. All right. And I would like to show you the portion of
14 this exhibit that describes what have been referred to as the
15 criteria for gender confirmation surgery, already discussed a
16 little here today.
17 Can we blow up the bottom half of that exhibit.
18 So are these the criteria set forth by WPATH for the gender
19 confirmation surgery that involves vaginoplasty?
20 A. Yes.
21 Q. So I would like to go through each of these criteria and
22 have you explain to us what they mean again, in layperson terms,
23 beginning with the first criterion, "persistent, well-documented
24 gender dysphoria."
25 What is meant by "persistent" and "well-documented"?

1 A. What is meant is that the person has a well-established
2 diagnosis of gender dysphoria that has been persistent for
3 beyond six months.
4 Q. And why is that important?
5 A. To rule out any other potential diagnosis.
6 Q. And typically when you, in your practice, are assessing a
7 patient with gender dysphoria or assessing a patient for gender
8 dysphoria, how far back in that person's history do you feel you
9 have to look in order to determine whether their gender
10 dysphoria is persistent?
11 A. Some of the people that I see will tell me that they had
12 feelings of being different or unlike other boys as a child.
13 For some individuals, the condition has emerged around puberty.
14 And other people tell me that it's only been in recent years
15 that they have experienced gender dysphoria.
16 So I'm not on a fact-finding hunt for specific details
17 about their history. The symptoms that they are presently
18 displaying, we know that gender dysphoria intensifies with age.
19 So it's not uncommon to see people who in midlife will come in
20 the community and say, "I didn't experience this as a child, but
21 now I'm experiencing severe gender dysphoria, and I think I need
22 to address it."
23 Q. And are treatment options that we just discussed assessed
24 the same way for those people who present to you in midlife, for
25 example, as for people who come and tell you that they have

1 identified that way since they were a child?
2 A. Treatment options are based on the severity of the
3 condition.
4 Q. And what time period -- over what time period do you look
5 to assess the patient in order to determine the severity of the
6 condition?
7 A. The patient's present clinical situation. So just like
8 with any other medical condition, what is the patient's present
9 status? What are their symptoms? How severe are they? How
10 much are they suffering? What other options have been used and
11 exhausted? What other options remain? But mostly what their
12 present concerns and presentation is.
13 Q. Looking to the second criterion, "capacity to make a fully
14 informed decision and to consent for treatment," what does that
15 mean from the medical point of view here?
16 A. It means that the patient must be able to understand
17 informed decision and to be able to participate in decisions
18 about their healthcare.
19 So in the past, we have seen individuals who are retarded
20 or who are mentally -- have some level of developmental delays.
21 There are some people who may have autism. And we want to make
22 sure that people who have conditions that may impact their
23 decision-making are able to understand and to participate in
24 decisions about treatment options.
25 Q. All right. We can skip No. 3 for the explanation.

1 For No. 4: "If significant medical or mental health
2 concerns are present, they must be well controlled."
3 Can you explain what this criterion means in layperson
4 terms.
5 A. Yes. So significant medical conditions. A recent example
6 from my practice would be an individual who has anal cancer and
7 is medically -- medically, it's indicated that they need gender
8 confirmation surgery. So we would want to make sure that the
9 chemotherapy and radiation are over, that the cancer is
10 resolved, and that some modified vaginoplasty can be performed.
11 So it would involve consultation with the oncologist and
12 the surgeon to make sure that the person's medical condition was
13 well controlled before proceeding with surgery.
14 In terms of mental health concerns, we want to make sure
15 that the individual is not actively psychotic, that their
16 symptoms don't impair their ability to provide informed consent,
17 and that the benefits of surgery outweigh the risks.
18 So even individuals who have serious mental illnesses, like
19 schizophrenia or what we used to call multiple personality
20 disorder, have undergone successfully gender confirmation
21 surgery. But we want to make sure that, at the time of surgery,
22 those conditions are controlled.
23 Q. What does the phrase "well controlled" mean as applied to
24 the mental health concerns?
25 A. Again, it means that these concerns don't impair reality

1 testing, that the person isn't, for instance, in a manic phase
2 where they're not fully understanding the postoperative care
3 involved or that they are unable to provide informed consent;
4 and that the benefit of doing the surgery outweighs the risk.
5 So in some instances, if a person is, for instance, having
6 a manic episode, that would have to be controlled medically, and
7 we would be in consultation with the surgeon, and we would
8 reevaluate the person just prior to surgery.
9 Q. When you use the phrase "the benefit outweighs the risk,"
10 what kind of risk are you referring to?
11 A. Well, the risk of untreated severe gender dysphoria, as
12 I've mentioned, is serious, severe risk. And so many mental
13 health issues -- 50 percent of all Americans will have a mental
14 health diagnosis at some point in their lifetime. So the
15 presence of mental health conditions does not negate or obviate
16 the ability to undergo surgery.
17 If a person has depression and they are taking
18 antidepressants, that may be considered well controlled.
19 Certain mental health concerns, such as personality disorders,
20 are lifelong and characterological, and they are not going to
21 change prior to surgery.
22 So we don't use those as reasons to deny surgery to people
23 for whom surgery is medically indicated.
24 Q. Are there risks for surgery for persons with serious
25 uncontrolled mental health concerns?

1 A. There can be, yes.
2 Q. And what kinds of risks are those?
3 A. Well, for instance, people who have schizophrenia, if they
4 don't understand the need to dilate after surgery or if they
5 don't have adequate housing or the ability to get food in their
6 homes after surgery, those people could be at risk for
7 complications.
8 Q. Moving to the next criterion, No. 5, "12 continuous months
9 of hormone therapy as appropriate to the patient's gender
10 goals."
11 Why is this one of the criteria on for the surgery?
12 A. Sex steroid hormones estrogen work primarily on the brain,
13 so -- and initially on the brain. So when you provide cross-sex
14 hormone therapy to a gender dysphoric person, you will have not
15 only the development of secondary sex characteristics -- breast
16 growth, reduction of male pattern balding, redistribution of
17 body fat, et cetera -- but the person will experience an
18 improvement in their overall level of wellbeing.
19 So it's important to have those hormonal sex steroids
20 circulating, if there are no medical contraindications prior to
21 surgery, so the person will have had a good deal of feminization
22 prior to undergoing other surgical procedures.
23 Q. And how long on average or is typical for the cross-sex
24 hormones to have the kind of feminization effect that you just
25 described?

1 A. Well, after two years, people will typically get the
2 maximum amount of breast growth, for instance, that they are
3 going to attain with hormones, and they will have attained the
4 maximum amount of feminization usually at about the 24-month
5 mark.
6 Q. Moving to the last criterion, criterion No. 6, "12
7 continuous months of living in a gender role that is congruent
8 with their gender identity."
9 First, what does it mean by "living in a gender role"?
10 A. This is what we refer to as social role transition. So
11 it's the person's ability to appear in the world in their
12 affirmed gender, which, if you think about it, is the
13 sine qua non of the condition: the idea that the way I appear
14 doesn't reflect who I am.
15 So this is an important component of the treatment, and it
16 attenuates gender dysphoria.
17 Q. How does it accomplish that? How does it attenuate gender
18 dysphoria?
19 A. It helps to consolidate the identity, and it reduces some
20 of the dissonance of the incongruity of "I have this shell.
21 People think that this is who I am, but it isn't really who I
22 am."
23 So the person feels more congruent; they feel healthier;
24 they have a level of wellbeing; and they feel more authentic.
25 They describe it as just, "This is who I am."

1 Q. And why is this criterion of 12 continuous months of living
2 in a gender role -- why is that one of the criteria for the
3 surgery?
4 A. So that the person understands the limitations of living in
5 their affirmed gender; that some physical attributes will never
6 change, even with surgery and hormonal treatment; and that the
7 person is able to live in the world feeling safe and comfortable
8 and having been affirmed in their identity.
9 So, for instance, if a person is living in an isolated area
10 where there is no one else around -- let's say a forest
11 ranger -- and they were assigned male at birth but they are
12 experiencing gender dysphoria, they would choose to dress as a
13 female even though there is no one around to view them because
14 that is in consonance with how they view themselves, and that is
15 the psychological attenuation of the gender dysphoria.
16 Q. Is it possible to undergo the social transition of living
17 in a gender role congruent with gender identity in a prison
18 environment?
19 A. Yes. Living in one's affirmed -- in one's affirmed role,
20 what we used to call the "real life experience," takes place
21 wherever your real life occurs.
22 And so it's not about where you live; it's about living in
23 role to the extent that one can. And in a prison, that's
24 typically a very daunting task because one doesn't have often
25 the benefits of female clothing or some of the accoutrements

1 that one would have if they were living outside of prison.
2 Q. And is it possible to achieve a social transition for
3 someone who was assigned the sex of male and identifies as
4 female while living in a men's prison?
5 MR. HALL: Objection. Foundation.
6 Your Honor, if I may.
7 THE COURT: Let's lay a foundation as to the basis for
8 that opinion, whether she has had experience in working with
9 people in that setting and can actually cite from her own
10 experience or to studies she has evaluated in her role with
11 WPATH. And I think she chaired the incarceration committee, so
12 I'm assuming she has that background. It would be helpful to
13 know what background she has to offer that opinion.
14 Q. BY MS. RIFKIN: Dr. Ettner, I think you might have
15 mentioned some of this earlier, but can you describe your
16 experience assessing or treating individuals in a prison or jail
17 setting?
18 THE COURT: She did indicate it was 30 individuals.
19 THE WITNESS: Yes.
20 THE COURT: So I did hear that. But how that
21 translates into actual experience in the transition in a prison
22 setting is what I'm looking for. So go ahead.
23 THE WITNESS: So I have seen people in prisons who are
24 assigned male living in male prisons who, to the best of their
25 ability, attempt to appear female.

1 And that can mean growing their hair; in some cases,
2 tattooing makeup or actually making makeup if they are not
3 allowed to have it, if they are not allowed to purchase that or
4 if it's not given to them.
5 In some situations where people are not allowed any sort of
6 female accoutrements, they may still try, in one way or another,
7 to appear as female as possible, either piercing an ear or even,
8 in the case of someone I saw on death row who wasn't allowed to
9 feminize at all, attempting to make their fingernails shaped in
10 what they thought was a female shape so they could look at their
11 nails and remind themself of who they really were.
12 THE COURT: Counsel, we're going to take a break
13 sometime in the next five minutes. So I'll let you pick that
14 time. You can do it now, or you can ask a few more questions.
15 But generally, sometime in the next five minutes, we will try to
16 take the first recess.
17 MS. RIFKIN: I think a few more questions will be
18 good. That will allow us to get to the end of this part.
19 Q. BY MS. RIFKIN: Dr. Ettner, is there a clinical reason why
20 someone with gender dysphoria would need to have the
21 undergarments typically associated with the affirmed gender, the
22 opposite sex?
23 A. Yes.
24 Q. What is that?
25 A. If that individual is on hormones, they will have breast

1 growth, and they will need support for the breasts.
2 People who are assigned male at birth but are transitioning
3 will tuck their testicles and their penis, and that will require
4 a tighter undergarment than typically the undershorts that are
5 created for men. And it can be painful without that support to
6 tuck the testicles.
7 Q. And is there a clinical purpose for addressing someone with
8 gender dysphoria by their preferred gender pronoun?
9 A. Yes.
10 Q. What is that clinical purpose?
11 A. Well, misgendering a person who identifies as female is
12 considered identity threat. It's basically telling the person:
13 You aren't who you think you are. We don't take you seriously.
14 And it's a -- it's a bad thing to do to a person.
15 Q. From a psychological perspective, what effect can it have
16 on a patient to consistently be addressed using the wrong
17 pronoun?
18 A. There are numerous studies about minority stress, these
19 sorts of stigmatization, the shame that occurs when people are
20 in situations where they are stigmatized, they are misgendered,
21 they are victimized. And it has a very devastating effect.
22 Many, if not most, people with gender dysphoria have
23 experienced that at some point. And it's -- it's very
24 demoralizing.
25 We have had -- I have seen clients where people have called

1 them "it" as a way of being discriminating and hostile. And we
2 know that hate crimes take place against people who are
3 transgender. So I think the marginalization and the
4 stigmatization is well documented.
5 MS. RIFKIN: I think now would be a good time for a
6 break, Your Honor.
7 THE COURT: All right. Counsel, let's try to hold
8 this to about a 15-minute recess. We'll be in recess for 15
9 minutes.
10 (Recess at 10:41 a.m. until 11:00 a.m.)
11 THE COURT: We'll go ahead and proceed.
12 I'll remind the witness that you are still under oath,
13 Dr. Ettner.
14 Ms. Rifkin, you may resume your direct examination of the
15 witness.
16 MS. RIFKIN: Thank you, Your Honor.
17 Q. BY MS. RIFKIN: Dr. Ettner, you told us earlier that you
18 did an evaluation of Ms. Edmo.
19 What was the purpose of your evaluation?
20 A. To determine the adequacy of the treatment she was
21 receiving in the prison.
22 Q. And was it specifically concerning any particular condition
23 or --
24 A. Particularly, gender dysphoria, but I did address other
25 mental health concerns as well.

1 Q. And what components did your evaluation of Ms. Edmo
2 consistent of?
3 A. A clinical interview, the review of all the records that
4 were provided to me, and psychodiagnostic testing.
5 Q. Can you explain what you mean by psychodiagnostic testing.
6 A. Providing psychological tests to determine in a very
7 expeditious way a good deal of information about Ms. Edmo that I
8 couldn't otherwise obtain in the short period of time that I was
9 visiting with her.
10 Q. What kinds of information did these tests look for?
11 A. Psychological symptoms, aspects of trauma, and about 13
12 other domains of clinical issues, such as suicide, depression,
13 anxiety, hopelessness, ideas of self-reference, all sorts of
14 other behavioral tendencies, and different -- anxious arousal,
15 hyperarousal, a series of different psychological constructs.
16 Q. And what do the results of the tests show?
17 A. That in addition to severe gender dysphoria, Ms. Edmo has a
18 depressive disorder and anxiety features and suicidal ideation.
19 Q. Did the tests provide you any particular information about
20 her depression and anxiety disorders?
21 A. Yes. The depression is primarily somatic and vegetative,
22 not cognitive.
23 And by that I mean that it's not subject to cognitive
24 reappraisal. So it's not the sort of depression that someone
25 can talk through or process. It actually affects bodily

1 systems.

2 So, for instance, in the area of anxiety, someone could
3 have a rapid heartbeat. So it's not that they feel worried or
4 scared; it's more of a somatic symptom that arises that is
5 beyond their conscious control.

6 And you referenced the DSM-5 previously, and you will note
7 in the DSM-5 that depression and anxiety are very common, almost
8 universal, attendant issues with gender dysphoria.

9 Q. And do you have an understanding of why that is, how
10 depression and anxiety relate, if at all, to gender dysphoria?

11 A. Well, sure. I mean, when a person understands that they
12 are entirely different than other people and that expressions of
13 that difference are taboo and can actually put them in harm's
14 way, that, in and of itself, can be a source of depression.

15 We know that depression can be lifelong. And I believe
16 Ms. Edmo is taking the maximum amount of antidepressant
17 medication, Effexor, that's available. And the fact that that
18 doesn't -- that does not stop the depression is another
19 indication that the depression is really part and parcel of
20 gender dysphoria and less of a comorbid or cooccurring disorder
21 on its own.

22 Q. You mentioned -- I'll try to get the terms right, but
23 please correct me if I don't.

24 You said that the testing revealed that Ms. Edmo's
25 depression, you think, is more somatic than cognitive. Did I

1 get that right?
2 A. Yes.
3 Q. What are the differences in the kinds of treatment that can
4 be provided for somatic depression versus cognitive depression?
5 A. Well, in a person who doesn't have gender dysphoria, one
6 would attempt antidepressant medication for that.
7 For Ms. Edmo, I don't believe that attending a group or
8 processing her depression would impact the depression or
9 attenuate the symptoms.
10 Q. And why not?
11 A. Again, because it's not cognitive.
12 So if a person is, for instance, sad or depressed about a
13 particular issue and they can be taught to reframe that through
14 therapy or process it through therapy, that can be very helpful,
15 of course. But if the depression is primarily noncognitive,
16 then talk therapy is not really the modality of choice.
17 The same is true of posttraumatic stress disorder, which I
18 did not diagnose. I did not find that in Ms. Edmo in my
19 evaluation.
20 Q. Did you form an opinion about whether Ms. Edmo was
21 appropriately diagnosed with gender dysphoria?
22 A. Yes. The diagnosis is appropriate.
23 Q. And what is your opinion based on?
24 A. It's based on my own assessment that she meets the
25 criteria, and everything I have read in the medical records, her

1 response to hormones, and her recognition that she require
2 treatment and her awareness that -- and repeated requests for
3 treatment.
4 Q. And what is your understanding of what treatment Ms. Edmo
5 has received for gender dysphoria?
6 A. She has received some feminine undergarments and some other
7 commissary items, and she has received cross-sex hormones
8 although they have fluctuated greatly and, in my opinion, are
9 not -- are not adequately being monitored.
10 Q. How long has Ms. Edmo received cross-sex hormones?
11 A. Approximately six years.
12 Q. Given your testimony just now about your opinion that the
13 hormones are not appropriately being monitored, were you able to
14 evaluate whether -- to what extent Ms. Edmo has received as much
15 benefit from the hormones as she will receive?
16 MR. HALL: Objection.
17 MR. EATON: Foundation.
18 MR. HALL: Join on the foundation. Also goes beyond
19 the scope of the expert disclosure, Your Honor.
20 MR. EATON: Join.
21 THE COURT: Counsel, I am very strict that there has
22 to be a disclosure of any opinions that are going to be offered
23 through the witness. So if you want to just show counsel where
24 this opinion is set forth in the expert disclosure, that will
25 solve the problem. If not, you perhaps go into a different

1 area.
2 Now, the question -- well, go ahead if you have found
3 the --
4 Ms. Rifkin, I should have noted it. I try to tell counsel
5 at the outset, the lectern is actually adjustable. So you can
6 push -- there is a toggle that will bring it -- on the other
7 side, I believe.
8 MS. RIFKIN: Great. I think you told me that last
9 time I was here, and I forgot.
10 THE COURT: It just makes it a little bit easier and
11 helps us get the microphone at a proper height as well.
12 MS. RIFKIN: All right. I think that the best way to
13 address this issue, Your Honor, would be to put up Dr. Ettner's
14 report that was part of -- both filed with the court and an
15 expert disclosure to lay the foundation. And that way, there is
16 no dispute.
17 THE COURT: All right.
18 MS. RIFKIN: So can we put up -- it's -- for the
19 record reference, it's ECF 62-1. It's page 24 of 100, page 20
20 internally, paragraph 61.
21 THE COURT: Paragraph 61?
22 MS. RIFKIN: Yes, Your Honor.
23 Q. BY MS. RIFKIN: Do you have that on your screen,
24 Dr. Ettner?
25 A. Yes, I do.

1 Q. Okay. At the beginning of paragraph 61, you stated:
2 "Despite years of feminizing hormone therapy, Ms. Edmo
3 continues to suffer from severe gender dysphoria and
4 attendant depression. The long-term hormonal
5 treatment she has undergone has served to intensify
6 Ms. Edmo's anatomical dysphoria."
7 Did you evaluate -- did you review and evaluate Ms. Edmo's
8 hormone treatment and its effects on her in order to render this
9 opinion?
10 A. Yes. I saw lay reports.
11 Q. And did you discuss with Ms. Edmo the effects of hormone
12 treatment on her?
13 A. I did.
14 Q. And through that discussion, were you able to evaluate the
15 effects from a psychological perspective of hormone treatment on
16 Ms. Edmo?
17 A. I'm not certain what you're asking.
18 I know that Ms. Edmo has been on hormones long enough to
19 have attained secondary sex characteristics and the sex steroids
20 that would be comparable to female peers. In other words, she
21 has been hormonally reassigned.
22 However, it's important that those hormones be maintained
23 at appropriate levels. And recently, from what I saw --
24 MR. HALL: Objection.
25 THE COURT: Just a moment.

1 MR. HALL: Objection. Nonresponsive. Move to strike.
2 THE COURT: Sustained. I think we have gone beyond
3 counsel's question. Let's put another question before the
4 witness.
5 Q. BY MS. RIFKIN: Based on your evaluation of Ms. Edmo,
6 Dr. Ettner, did you form an opinion about whether she requires
7 further treatment for gender dysphoria?
8 A. Yes.
9 Q. And what is the further treatment that she requires in your
10 opinion?
11 A. She requires management of her hormonal medications with
12 follow-up laboratories, and she requires genital reconstruction
13 or gender confirmation surgery.
14 MR. HALL: Objection, Your Honor. Move to strike as
15 to the hormone therapy as nondisclosed opinions outside of the
16 witness's foundation. I can ask some questions in aid of an
17 objection if the court would permit.
18 MR. EATON: Join.
19 THE COURT: Well, I need to, I think, first give
20 Ms. Rifkin a chance to point to a portion of the expert
21 disclosure which would set forth Dr. Ettner's opinion concerning
22 management of hormonal medications.
23 MS. RIFKIN: Your Honor, that is actually in
24 Dr. Ettner's declaration, but I won't be pursuing that at the
25 moment. So I think --

1 THE COURT: All right. Let's go ahead and strike that
2 and move on. She has clearly offered the opinion that she
3 requires gender confirmation surgery, and we can go from there.
4 Q. BY MS. RIFKIN: Dr. Ettner, is the treatment of gender
5 confirmation surgery based in scientific evidence?
6 A. Yes.
7 Q. And can you briefly describe or summarize the basis for the
8 standard of care, including gender confirmation surgery as a
9 treatment?
10 A. Decades of scientific research have validated the efficacy
11 of gender confirmation surgery for individuals who have severe
12 gender dysphoria. And those studies have been done throughout
13 the world by different surgeons.
14 Some of that was collated in the Medicare decision when it
15 was determined that reassignment surgery is not experimental and
16 it has a relatively low rate of complications and there are
17 very -- has a very low rate of regrets and that, for some
18 people, it is the only treatment for gender dysphoria.
19 Q. Did you come to a determination about whether gender
20 confirmation surgery is medically necessary for Ms. Edmo?
21 A. Yes.
22 Q. And what was your opinion?
23 A. That gender confirmation surgery is medically indicated for
24 Ms. Edmo.
25 Q. And you used the word "medically indicated."

1 Is there a distinction in your mind between medically
2 indicated and medically necessary?
3 A. No.
4 Q. Did you consider -- in evaluating the medical necessity of
5 gender confirmation surgery for Ms. Edmo, did you consider the
6 criteria by the WPATH standard of care that we were looking at
7 earlier today?
8 A. Yes.
9 Q. Can we bring those back up, please. It's Joint Exhibit 15,
10 page 1566. And can we blow up the bottom half again, please.
11 Did you evaluate whether Ms. Edmo meets the first criteria
12 under this category, "persistent, well-documented gender
13 dysphoria?"
14 A. I did.
15 Q. And what is that based on?
16 A. Based on the review of records and my own assessment when I
17 met with Ms. Edmo.
18 Q. What did you conclude with respect to criteria 1 for
19 Ms. Edmo?
20 A. That she does, indeed, have persistent and well-documented
21 long-standing gender dysphoria.
22 Q. Was there specific information from the medical records
23 that you relied on in coming to this conclusion?
24 A. Other providers had made that diagnosis, and she meets the
25 criteria outlined in the DSM-5.

1 Q. And did you evaluate whether Ms. Edmo meets the criterion
2 No. 2, "capacity to make a fully informed decision and to
3 consent for treatment"?
4 A. Yes. Ms. Edmo has no thought disorders and no impaired
5 reality testing.
6 Q. And is Ms. Edmo above the age of majority for this country?
7 A. She is.
8 Q. Okay. Looking at criterion 4, did you evaluate whether
9 Ms. Edmo meets this criterion for surgery?
10 A. Yes.
11 Q. And what's your opinion?
12 A. My opinion is that she meets this criteria.
13 Q. Are you aware -- I believe that you testified just a few
14 moments ago that you concluded that Ms. Edmo has depression and
15 anxiety disorder; is that right?
16 A. Yes.
17 Q. Did you form an opinion about whether that is well
18 controlled?
19 A. It doesn't impair her ability to undergo surgery. It's as
20 controlled as it can be, and my opinion is that it will be
21 attenuated post surgery.
22 Q. When you say "it's as controlled as it can be," what do you
23 mean by that?
24 A. She is taking the maximum amount of medication that
25 controls depression, major depression.

1 Q. And based on your review of the records, are you aware of
2 whether Ms. Edmo is compliant with her prescribed medications
3 for depression or anxiety?
4 A. She is compliant with her medical recommendations.
5 Q. And looking at criterion No. 5, I think you testified that
6 Ms. Edmo has been on six years of hormone therapy; is that
7 accurate?
8 A. Yes.
9 Q. And looking at criterion 6, did you determine whether
10 Ms. Edmo has satisfied the -- I think you called it social
11 transition criterion of "12 continuous months of living in a
12 gender role that is congruent with her gender identity"?
13 A. Yes, she has satisfied the condition of social role
14 transition.
15 Q. And what was that conclusion of yours based on?
16 A. Based on her living as a woman to the best of her ability
17 in a male prison.
18 Q. Can you describe any factors or information that you
19 considered in arriving at the conclusion that Ms. Edmo has lived
20 as a woman to the best of her ability?
21 A. Her appearance when I met with her, her disciplinary
22 records, which indicated that she had attempted to wear her hair
23 in a feminine hairstyle and to wear makeup even though that was
24 against the rules and she was -- received some sort of
25 disciplinary action for that, and her -- the way that she was

1 receiving female undergarments and had developed the stigma of
2 femininity, the secondary sex characteristics, breast
3 development, et cetera.
4 Q. Did you evaluate whether Ms. Edmo's gender identity as
5 related to attention from male offenders?
6 A. Would you repeat that question for me. I'm sorry.
7 Q. Sure. Did you evaluate whether Ms. Edmo's gender identity
8 is related to attention from male offenders in prison?
9 A. I don't regard gender identity which, as I said earlier, is
10 an innate sense of belonging to one gender or another, as being
11 related to who pays attention to you.
12 MR. HALL: Objection. Nonresponsive to the question
13 asked.
14 THE COURT: The question is whether you evaluated
15 whether her gender identity is related to attention from male
16 offenders, not -- the question is: Did you evaluate it?
17 THE WITNESS: My opinion is that her gender identity
18 is not related to the attention that she may receive from other
19 inmates.
20 MR. HALL: Objection.
21 THE COURT: So you did evaluate it?
22 THE WITNESS: Yes. Thank you.
23 MR. HALL: Objection. Foundation and beyond the scope
24 of the disclosure.
25 MR. EATON: Join that.

1 MS. RIFKIN: Your Honor?
2 THE COURT: Ms. Rifkin.
3 MS. RIFKIN: Dr. Ettner has clearly testified that she
4 is an expert with respect to gender dysphoria and understanding
5 the condition of gender dysphoria.
6 Defendants have already made the argument here today about
7 the causes and contributing factors to gender dysphoria.
8 Dr. Ettner is an expert in gender dysphoria. She has a 23-page
9 declaration on it. Defendants deposed her for seven hours.
10 THE COURT: I don't think the question is her
11 expertise on gender dysphoria. It's a question of a -- well,
12 with her background in prison, I think chairing that committee
13 of the WPATH, I don't think that's an issue. I think the only
14 issue is whether or not it was disclosed.
15 MS. RIFKIN: Dr. Ettner was --
16 THE COURT: Just a moment. On further reflection, I'm
17 going to overrule the objection. The question is did you
18 evaluate it. She has not been asked to offer an opinion at this
19 point. If there was no opinion given, you may want to renew the
20 objection.
21 Q. BY MS. RIFKIN: Dr. Ettner, as part of your study and
22 expertise in gender dysphoria, have you -- do you understand the
23 contributing factors or the factors that may contribute to a
24 person's gender identity?
25 A. Gender identity, from all of the research and science to

1 date, appears to be a neurodevelopmental issue that occurs prior
2 to birth.
3 Q. Are you aware that -- based on your review of records, that
4 Ms. Edmo attempted to cut off her testicles?
5 A. Yes.
6 Q. And what is the clinical significance of this?
7 A. By definition, when an individual who is not psychotic or
8 delusional attempts what we call surgical self-treatment --
9 because we don't regard removal of the testicles or attempted
10 removal of the testicles as either mutilation or self-harm -- we
11 regard it as an intentional attempt to remove the target organ
12 that produces testosterone, which, in fact, is the cure for
13 gender dysphoria.
14 We typically see this in prisons when people are not
15 receiving adequate care for gender dysphoria. They will attempt
16 to perform their own surgery. Unfortunately, some people die
17 due to blood loss. There is far more blood involved than people
18 realize, and the elasticity of the vas deferens nerve bundle can
19 cause that to retract into the body cavity.
20 Q. Are you familiar with any other medical condition that is
21 associated with a person trying to cut off their testicles other
22 than gender dysphoria?
23 A. I, personally, am not.
24 Q. Did you form an opinion about what the risks are, if any,
25 to Ms. Edmo if she does not receive gender confirmation surgery?

1 A. Yes.
2 Q. And what is that opinion? What is your opinion about the
3 risks to Ms. Edmo, if any?
4 A. The risks would be, as typical in inadequately treated or
5 untreated gender dysphoria, either surgical self-treatment,
6 emotional decompensation, or suicide. I think that in
7 Ms. Edmo's case, she is at particular risk for suicide given
8 that she has a high degree of suicide ideation.
9 Q. And what -- what is that last statement that you made based
10 on?
11 A. Based on the testing I did and the fact that she has had a
12 history of suicide attempts in the past.
13 Q. Do you agree that gender confirmation surgery is
14 potentially harmful for Ms. Edmo?
15 A. No.
16 Q. Why not?
17 A. Gender confirmation surgery is the cure for gender
18 dysphoria, so I don't know how the cure could be anything other
19 than therapeutic and beneficial.
20 Q. I would like to show you the -- one of the slides that was
21 used in defendants' opening statement.
22 Is gender dysphoria a personality disorder trait,
23 Dr. Ettner?
24 A. No.
25 Q. Can you explain the difference between gender dysphoria and

1 a personality disorder trait?
2 A. Two entirely different things. Gender dysphoria is a
3 medical condition. Personality disorder traits are -- there are
4 many different personality disorders, as you can see in the
5 DSM-5. And traits are some aspects of those various disorders
6 which may or may not result in a diagnosis of a personality
7 disorder, and personality disorders are characterological and
8 typically lifelong.
9 Q. What do you mean by characterological?
10 A. It means that they are sort of baked into a person's
11 personality. They don't change with time. They don't usually
12 remit with medication. They are sort of the way a person goes
13 through life.
14 So, for instance, you could have a personality disorder of,
15 let's say, a narcissistic personality disorder where a person
16 would have an overidealized view of themselves, a lack of
17 empathy, and some of the other criteria that are outlined in the
18 DSM-5.
19 Q. Did you -- based on your review of Ms. Edmo's records and
20 your evaluation of Ms. Edmo, are you aware of whether Ms. Edmo
21 has been diagnosed with a personality disorder?
22 A. I don't recall seeing that diagnosis in her medical
23 records.
24 Q. And did you -- based on your review of Ms. Edmo's records
25 and your evaluation of Ms. Edmo, does she have a substance abuse

1 disorder that is currently uncontrolled?
2 A. She has a history of substance abuse. She has not had
3 substance abuse issues since her incarceration.
4 Q. And based on your review of the medical records and your
5 evaluation of Ms. Edmo, does she have sexual concerns?
6 A. She did not voice sexual concerns during our interview.
7 Q. Do you know, is there -- is sexual concerns a medical term
8 you're familiar with?
9 A. It's not a medical term, per se. No.
10 Q. Does any history of abuse that Ms. Edmo has result in an
11 uncontrolled mental health concern currently?
12 MR. HALL: Objection. Foundation, Your Honor.
13 Speculative, and it goes beyond the scope of disclosure.
14 MS. RIFKIN: Your Honor, may I?
15 THE COURT: Yes.
16 MS. RIFKIN: Defendants in their opening statement
17 presented these as mental health concerns for Ms. Edmo that
18 interfere with her ability to receive gender -- satisfy the
19 criteria for surgery, which Dr. Ettner was disclosed to opine on
20 her meeting the criteria for surgery. She is a psychologist. I
21 don't see how this can possibly be beyond the scope.
22 MR. HALL: Your Honor, they were not provided in the
23 disclosure.
24 THE COURT: Well, I understand that. This chart, I
25 assume, was not disclosed, either. So there was no way to

1 really respond to it.
2 As long as you stay generally within the opinions already
3 offered, I'll allow you to ask specific questions tied just to
4 the chart which counsel used during the opening statement. But,
5 again, the general things have to still be within the report,
6 but I'll allow some elaboration here to address the issues
7 raised during opening statements.
8 Go ahead and proceed. The objection is overruled.
9 Q. BY MS. RIFKIN: Dr. Ettner, does any abuse history of
10 Ms. Edmo that you're aware of, from your review of records and
11 interview with her, create any mental health concerns that are
12 currently not controlled?
13 A. No. Many people, as we know, are victims of abuse, either
14 in childhood or beyond, but we don't deny medically necessary
15 treatment on that basis.
16 Q. Dr. Ettner, as part of your review of Ms. Edmo's medical
17 records, did you review a progress note from Dr. Eliason
18 regarding Ms. Edmo's appropriateness for gender confirmation
19 surgery?
20 A. I did.
21 MS. RIFKIN: Can we show Joint Exhibit 1.
22 Your Honor, the parties have stipulated to the authenticity
23 of Joint Exhibit 1, which are Ms. Edmo's medical records from
24 her incarceration. And I'd move to admit them into evidence.
25 THE COURT: Well, Counsel, my notes indicate that

1 Exhibits 1 --
2 MS. RIFKIN: I'm sorry. Joint Exhibit 1.
3 THE COURT: Right. Joint Exhibit 1 through 19 have
4 all been stipulated as to their be admissibility. So,
5 therefore, I'll admit all 19 of those exhibits without the need
6 for any further motions.
7 (Joint Exhibits 1 through 19 admitted.)
8 Q. BY MS. RIFKIN: All right, Dr. Ettner, if you can look at
9 the Joint Exhibit 1-538 that's in front of you.
10 Is this the progress note that you reviewed from
11 Dr. Eliason from April 20, 2016?
12 A. Yes.
13 Q. And what is your understanding of the purpose of
14 Dr. Eliason's assessment of Ms. Edmo on this date?
15 A. To assess the necessity of gender confirmation surgery for
16 Ms. Edmo.
17 Q. And did you form an opinion about the adequacy of
18 Dr. Eliason's assessment for whether gender confirmation surgery
19 was necessary for Ms. Edmo?
20 MR. EATON: Object, Your Honor. I don't believe
21 that's disclosed in the expert disclosures.
22 THE COURT: Counsel, I apologize. I was -- my
23 note-taking distracted me. Give me just a moment to review the
24 question.
25 All right. That is a pretty specific opinion that I would

1 expect to have been disclosed. If you are going to use
2 Dr. Ettner to challenge Dr. Eliason's assessment and opinion, I
3 think that should have been disclosed.
4 MR. EATON: I'd also object on foundation. She is not
5 a psychiatrist.
6 MS. RIFKIN: Your Honor --
7 THE COURT: Well, from the point of view of a
8 psychologist, she, obviously, cannot offer the same opinion as a
9 psychiatrist, but they work in a related field. So I think she
10 can assess, but I'm going to take into account the fact that she
11 is a psychologist, not a psychiatrist.
12 MS. RIFKIN: I would like to show Dr. Ettner's expert
13 report, page 21, paragraph 64.
14 Can you zoom in, please, to paragraph 64.
15 Paragraph 64 reads:
16 "Despite the obvious severity of her gender dysphoria,
17 the Idaho" --
18 THE COURT: Counsel, I can read it.
19 MS. RIFKIN: Okay.
20 THE COURT: I'm going to overrule the objection. You
21 may go ahead and proceed. But if you want to use that report to
22 indicate her opinion, you may, but that was clearly disclosed
23 that Dr. Ettner was going to call into question the adequacy of
24 the opinions rendered by IDOC using Dr. Eliason.
25 So go ahead.

1 MS. RIFKIN: Okay. Thank you.
2 Q. BY MS. RIFKIN: Let's go back to Dr. Eliason's note here.
3 All right. So, Dr. Ettner, I believe the question was:
4 Did you form an opinion about the adequacy of Dr. Eliason's
5 assessment?
6 THE COURT: Is it "Elison" or "Eliason"?
7 MR. EATON: "Elison," Your Honor.
8 THE COURT: It is "Elison." My apologies.
9 MR. EATON: He told me. He is a psychiatrist, so you
10 listen. That's how I remember it.
11 THE COURT: Okay. All right. Go ahead. But it is
12 spelled -- at least the spelling would support my pronunciation.
13 But he, in fact, pronounces it "Elison."
14 MR. EATON: Correct, Your Honor.
15 THE COURT: All right. Thank you. Because I actually
16 know some people with that spelling, and they say "Eliason."
17 So, obviously, there is a difference of opinion.
18 Go ahead.
19 MR. EATON: Your Honor, with due respect, I do renew
20 my objection. I think it simply says in that disclosure -- it
21 talks about not being qualified. And it's a very, very vague
22 statement. And I don't believe there is any -- any disclosures
23 about specifics about this document or opining about this
24 document in there.
25 MR. HALL: Join.

1 MS. RIFKIN: Your Honor, can we go back --
2 THE COURT: Let's go back to that paragraph.
3 MS. RIFKIN: Can we go back to that paragraph, please.
4 And in addition to this paragraph, Your Honor, defendants
5 deposed Dr. Ettner for seven hours. And we'll look for the
6 relevant portions of her deposition transcript, but defendants
7 have this report. In fact, they had it when we moved for
8 preliminary injunction. And if they felt they needed to explore
9 the bases for her opinions clearly laid out in here, they had
10 seven hours to ask for further information about it.
11 THE COURT: Let me just clarify. The purpose under
12 the federal rules of requiring expert disclosures is to ensure
13 that there is not trial by ambush and that the opinions are
14 clearly spelled out and the basis for the opinions.
15 It is quite specific. And the rules do not envision or put
16 a burden upon the opposing party to flesh out the opinions in
17 deposition. However, if they do and if the subject matter is
18 covered during a deposition, then I think the matters covered in
19 the deposition are fair game.
20 So if, in fact, questions were asked by defense counsel of
21 Dr. Ettner, she can broach those subjects, offer the same
22 opinions that she did in response to questions during
23 deposition. She can offer those opinions here.
24 So your sources will be either was the opinion stated
25 specifically or at least fairly in the opinion, or was it

1 covered by defense counsel during the deposition of Dr. Ettner.
2 And if the answer is no to either or to both of those, then we
3 don't get into it here.
4 MS. RIFKIN: Your Honor, in this particular instance,
5 I don't think it's necessary to go to the transcript. There is
6 clearly an error between April and May, but Dr. Ettner
7 specifically wrote -- referred to a note, Dr. Eliason's note,
8 that sex assignment surgery was not medically indicated. And
9 she said at the end of this exact paragraph where it refers to
10 this exact note that these notes suggest that these providers
11 are not qualified to provide appropriate care to Ms. Edmo, and
12 they do not understand gender dysphoria generally or the
13 severity of Ms. Edmo's medical issues in particular. And this
14 note is the exact one she referenced.
15 THE COURT: Okay. Then what you need to do is just
16 have her offer the opinion set forth in paragraph 64 and move
17 on. Okay?
18 You know, it's -- you know, I take the Federal Rules of
19 Civil Procedure as being rules, not suggestions. They say what
20 they mean, and they mean what they say. And I think the rule is
21 quite clear that if you want to offer an expert opinion, you're
22 required to make a disclosure, and then the opinions offered
23 have to be tied to the opinions offered in that disclosure.
24 One additional matter is that I generally feel that if
25 defense counsel wants to take the deposition, they can expand

1 the scope through their questioning because they are the ones
2 that injected that into the case.
3 MR. EATON: But, Your Honor, I did find appropriate
4 quotes from the deposition, and I specifically asked them that
5 you didn't opine about this note, and I believe she said
6 correct. And I have that pulled up on my computer right now.
7 THE COURT: Well, I have given -- again, Ms. Rifkin, I
8 think you can ask the question set forth in paragraph 64 or the
9 opinions set forth there in any other numbered paragraphs that
10 are in the report. And if they -- an opinion was offered in
11 response to questions by Mr. Eaton or Mr. Hall during the
12 deposition of Dr. Ettner -- or I guess if they didn't take the
13 deposition, someone from their firms -- then you can ask. But I
14 think we just need to move on at this point. All right?
15 So the objection is sustained at this point, but I'll allow
16 you the leeway that I described, Ms. Rifkin.
17 Q. BY MS. RIFKIN: Based on your review of Ms. Edmo's medical
18 records, Dr. Ettner, did you form an opinion about whether
19 Ms. Edmo's treatment providers while she has been incarcerated
20 are qualified to provide appropriate care for gender dysphoria?
21 A. Yes.
22 Q. And what is the opinion that you came to about whether
23 Ms. Edmo's treatment providers are qualified to provide
24 appropriate treatment for gender dysphoria?
25 A. My opinion is the providers are not qualified.

1 MR. HALL: Objection, Your Honor, I had registered.
2 It's very vague, lacks foundation, and goes beyond the scope.
3 Paragraph 64 only talks about Dr. Eliason by name.
4 MR. EATON: Join the objection.
5 MS. RIFKIN: Your Honor, may I --
6 THE COURT: The objection is overruled. Go ahead.
7 Q. BY MS. RIFKIN: Do you need me to reask the question,
8 Doctor?
9 THE COURT: I think she answered it. No, she began.
10 Offer your opinion. Go ahead.
11 THE WITNESS: My opinion is that the providers who
12 were offering care and generating treatment plans were not
13 qualified to do so.
14 Q. BY MS. RIFKIN: And what is that opinion based on?
15 A. It's based on the notes that I read in the medical reports
16 I was provided, and it was also based on the training that those
17 providers had received which I was able to review.
18 MS. RIFKIN: Your Honor, I think for the sake of
19 avoiding some objection back and forth, I have a question if
20 Your Honor will permit --
21 THE COURT: Yes.
22 MS. RIFKIN: -- on proceeding.
23 Plaintiffs filed these expert reports with their motion for
24 preliminary injunction. We agreed on a schedule of discovery
25 with defendants that included plaintiffs resubmitting their

1 expert reports and then discovery and then defendants' expert
2 reports.
3 And we received documents in discovery which were provided
4 to our experts. Defendants then deposed them, but our experts
5 didn't produce new reports based on the documents that they were
6 then provided.
7 And so in discovery -- I mean in deposition, defendants
8 explored the bases for their opinions and asked whether they had
9 changed based on all this information. So I would like to be
10 able to ask the witness about documents she doesn't reference in
11 her declaration because they weren't provided to plaintiff but
12 that she had reviewed and defendants knew that she had reviewed
13 and she talked about in her deposition.
14 THE COURT: Mr. Eaton, Mr. Hall.
15 MR. EATON: Your Honor, I think they need to stick
16 with the declarations and whatnot that they filed in support of
17 this. I think this is the first time this issue has been
18 raised. They could have filed a motion well before now if they
19 wanted to supplement expert disclosures, but to solicit new
20 opinions at the time of the hearing, we believe would be
21 inappropriate.
22 THE COURT: All right.
23 MR. HALL: Your Honor --
24 THE COURT: Yes.
25 MR. HALL: I will represent that at the time of

1 Dr. Ettner's deposition, it was asked if -- when she received
2 these documents. The documents were received, many of them,
3 after her initial declaration.
4 I did ask if she has produced or has any other opinions
5 after the declaration, and the answer was no. I believe that we
6 asked, as well, whether or not she intended to provide any new
7 opinions, and the answer was no, nor was she asked by counsel to
8 provide any new opinions that were not contained in the
9 declaration.
10 THE COURT: All right. Brief response.
11 MS. RIFKIN: Well, Your Honor, I think to the extent
12 that Dr. Ettner did testify about -- as Your Honor said earlier,
13 to testify about these opinions during her deposition, that we
14 should be permitted to ask her about those opinions and provide
15 the court with any exhibits that are related to those that have
16 already been jointly stipulated to be admitted into evidence.
17 THE COURT: At this point, I'll sustain the objection.
18 The ground rules will be just as I've described. I would point
19 out that Rule 26(a)(2)(D) does provide for supplementation. And
20 we often get into a fight about whether supplementation is
21 really supplementation or new opinions.
22 We don't allow new opinions, but you're allowed to
23 supplement prior opinions or move to amend the report if, in
24 fact, new information was provided that you did not have access
25 to.

1 Apparently, none of that happened. So the ground rules are
2 roughly as I described. It either has to be in the opinion that
3 she relied upon the documents; if not, the mere fact that it's
4 mentioned in Dr. Ettner's deposition is not enough to open the
5 door.
6 But if, in fact, she referred to the exhibits if questions
7 were asked about her -- or of her about the exhibits, then that
8 opens the door, and she is allowed to get into the same area
9 that she was asked about during her deposition -- but not just
10 the fact that it was mentioned. She has to actually have been
11 asked questions about the exhibit, and she has to have offered
12 opinions or statements responsive to counsel's questions that's
13 relevant to the proceedings here.
14 All right?
15 MS. RIFKIN: Yes, Your Honor.
16 THE COURT: I understand -- you know, I'm sure
17 different courts approach it in different ways. But this is --
18 you know, I have been here 23-plus years. As long as I have
19 been on the federal bench, that's the way I have applied it.
20 And there is a lot of attorneys who are not particularly
21 happy when they got into court and found out. In some
22 instances, they never filed any report and thought somehow that
23 they could just ignore Rule 26 completely.
24 Here, you did comply with Rule 26, but we're limited by the
25 rules just to the opinions offered here and as expanded by

1 counsel during the deposition.

2 So that's going to be -- and that applies also to what she

3 relied upon. If there were documents disclosed afterwards, then

4 the process should have included filing a supplemental

5 declaration or disclosure.

6 But I certainly will allow some leeway. If a particular

7 document was identified during the deposition and discussed, I'm

8 going to give some leeway in that regard. Okay?

9 MS. RIFKIN: Yes. I understand, Your Honor. And

10 thank you for that clarification. I think it will hopefully

11 avoid future back-and-forth.

12 THE COURT: And I should say I really don't think this

13 is a deal breaker. I mean, the opinions are there that you

14 need, and a lot of this is kind of nibbling around the edges

15 anyway.

16 So go ahead and proceed.

17 Q. BY MS. RIFKIN: Dr. Ettner, at the time that you first

18 provided the expert declaration you have been looking at in this

19 case, you hadn't reviewed Ms. Edmo's medical records from before

20 she was incarcerated; is that right?

21 At the time that you first provided an expert declaration,

22 you had not yet reviewed the medical records from prior to her

23 incarceration; is that correct?

24 A. Yes.

25 Q. Did you think that those were important in assessing the

1 medical necessity of gender confirmation surgery?
2 A. No.
3 Q. Why not?
4 A. Because I was concerned with the medical condition that
5 Ms. Edmo is presently suffering from.
6 Q. And did you consider Ms. Edmo's disciplinary history in
7 IDOC in assessing the medical necessity of gender confirmation
8 surgery?
9 A. No. I considered that to be unrelated to whether or not
10 she requires a particular treatment at this time.
11 Q. And why is that?
12 A. Providers don't distinguish whether someone got a parking
13 ticket or committed a crime when providing medical care when
14 it's necessary.
15 Q. Dr. Ettner, in your deposition, you were asked about
16 specific photographs of Ms. Edmo for when she first came into
17 custody in 2012 and prior to that in 2010.
18 Do you recall that?
19 A. Yes.
20 Q. Okay. I would like to put Joint Exhibit 4 up.
21 THE COURT: Are you having trouble switching over?
22 There we go.
23 Q. BY MS. RIFKIN: All right. If you can turn to -- let's
24 see -- Joint Exhibit 4-4, page 4 of this exhibit.
25 A. I'm looking at exhibit marked 4-1.

1 Q. All right. You were asked in deposition whether you have
2 reviewed this particular photograph of Ms. Edmo from 2010;
3 correct?
4 A. Yes.
5 Q. Did you think that this photograph of Ms. Edmo from 2010 --
6 did you need to evaluate this photograph in order to determine
7 whether gender confirmation surgery is presently medically
8 necessary for her?
9 A. No.
10 Q. And why not?
11 A. Many patients that we see prior to hormone treatment or a
12 social role transition come in with full beards and looking very
13 distinctly male, and it doesn't have a bearing on their
14 diagnosis of gender dysphoria.
15 Q. Does a patient's history of hair length or gender
16 presentation six or eight years prior to when you see them have
17 a bearing on the treatment that is necessary for gender
18 dysphoria?
19 A. No.
20 Q. If we can put up 4-6, please.
21 This is another photo you were asked about in deposition,
22 Dr. Ettner, from when Ms. Edmo entered IDOC custody in 2012.
23 Did you consider this photo relevant to determination of
24 whether gender confirmation surgery is medically necessary for
25 Ms. Edmo today?

1 A. That's not a consideration that would enter into my present
2 decision-making; no.
3 Q. In your opinion, does Ms. Edmo presently have unresolved
4 mental health issues that result in her not being appropriate
5 for gender confirmation surgery?
6 A. No.
7 Q. In your opinion, does Ms. Edmo have unresolved mental
8 health issues that result in her not being ready for gender
9 confirmation surgery?
10 A. No.
11 Q. Do you believe that Ms. Edmo's attempts to cut off her
12 testicles indicate that she has mental health concerns that are
13 not well controlled?
14 A. No. It indicates the need for treatment for gender
15 dysphoria.
16 Q. And do you believe that Ms. Edmo's cutting of her arm in
17 recent months indicates that she has mental health concerns that
18 are not well controlled?
19 A. No. I think it's attention-reduction behavior that she
20 uses with the knowledge that she cannot cut her genitals because
21 she is aware that she needs to preserve that tissue if she is to
22 undergo gender confirmation surgery.
23 Q. And do you believe that Ms. Edmo must participate in
24 psychotherapy to treat other mental health conditions before she
25 is ready to receive gender confirmation surgery?

1 A. No. Psychotherapy is neither a precondition for treatment
2 or a condition -- a precondition for surgery.
3 Q. Does Ms. Edmo have the capacity to comply with postsurgical
4 treatment? Earlier you gave an example of dilation, for
5 example.
6 A. Yes. Ms. Edmo is intelligent and has the capacity to
7 follow through with the postsurgical care that she would
8 require.
9 Q. As far as you're aware, has Ms. Edmo been compliant with
10 the hormone therapy that she has been prescribed while she has
11 been in IDOC custody?
12 A. Yes.
13 Q. In deposition, Dr. Ettner, you were asked about an article
14 by the authors Osborne and Lawrence.
15 Do you recall that?
16 A. Yes.
17 Q. The article was entitled "Male Prison Inmates with Gender
18 Dysphoria: When is Sex Reassignment Surgery Appropriate?"
19 Is that the article you were asked about in deposition?
20 A. Yes.
21 Q. And are you familiar with this article?
22 A. Yes.
23 Q. You were asked whether you're familiar with the authors
24 Osborne and Lawrence. Are you?
25 A. Yes.

1 Q. And what is the -- in this article, what is sort of the
2 main point of this article that you were asked about?
3 MR. HALL: Objection, Your Honor. This goes beyond
4 the scope. The witness testified at her deposition that she had
5 never read it -- read this article. I object to the question
6 asking her to paraphrase now what the basis was or the point of
7 this article was and any opinions that may come out of it as to
8 what her thoughts are now or even the authors for lack of
9 relevance, because she has not reviewed the article or had not
10 prior to her deposition or prior to her expert report.
11 MS. RIFKIN: Your Honor, I'll withdraw that question.
12 THE COURT: Well, I'm not sure I was going to grant
13 it, but I'll -- let me just indicate the question is withdrawn.
14 Again, I wasn't at the deposition. But if an expert
15 witness is being impeached by being shown some scholarly article
16 that he or she has not previously seen, you know, it's one thing
17 to say, well, this is something everybody who has expertise in
18 the field should know about. But if the question is asked about
19 apart from that, it's just -- I'm sure there is hundreds of
20 articles that -- heaven knows there is a lot of Law Review
21 articles that I don't review. But I think if I were to be asked
22 as an expert witness to offer an opinion and be challenged
23 because I didn't agree with what someone had said in an expert
24 opinion, I'm not sure it would be unfair for me to then go back
25 and review that and be prepared to respond to that at trial.

1 But the question is withdrawn. Let's go ahead and proceed.
2 Q. BY MS. RIFKIN: Are you familiar with the work of Cynthia
3 Osborne and Anne Lawrence, the authors of that article,
4 Dr. Ettner?
5 A. Yes. I know both of those individuals.
6 Q. And do you know if either of those individuals are members
7 of WPATH?
8 A. They are not. Anne Lawrence was at one time.
9 Q. And are you familiar with the professional reputation of
10 these authors within the field of gender dysphoria treatment?
11 A. Yes.
12 Q. And what are their reputations?
13 A. They are regarded as outliers in the field. They don't
14 ascribe to the WPATH standards of care.
15 Q. And are you familiar with the new standards of care that
16 Osborne and Lawrence propose for incarcerated people and whether
17 they should have surgery that they propose in this article? Are
18 you familiar with that proposal by them?
19 A. My understanding is that Cynthia Osborne thinks that
20 surgery may be appropriate in some cases but has suggested
21 additional conditions or hoops that individuals would have to
22 have gone through in order to be considered for surgery.
23 Q. And are you aware of any scientific studies that support
24 those extra conditions or hoops that they propose that
25 incarcerated persons should have to go through in order to

1 receive gender confirmation surgery?
2 A. I don't know --
3 MR. HALL: Objection. Beyond the scope.
4 MR. EATON: Join.
5 THE COURT: I'll sustain the objection. If we're now
6 getting into the substance of that, and questioning what her
7 opinion was, I think -- I'm going to give you some leeway to
8 recall Dr. Ettner in rebuttal if, in fact, the defendants offer
9 opinions along those lines that you're getting into. But as a
10 preemptive strike, I'll sustain the objection.
11 MS. RIFKIN: Well, Your Honor, I mean, Dr. Ettner is
12 limited in her ability to -- we can't recall her on Friday
13 because she isn't able to still be here. But I can offer the
14 deposition transcripts where counsel specifically asked
15 Dr. Ettner, as you suggested, about this article. Why hadn't
16 she read it, whether she has opinion about it, et cetera.
17 THE COURT: Well, you know, it's a court trial. I'm
18 going to allow it. Let's move on.
19 I'm worried we are wasting a lot of time here. And I'm
20 worried that whether we can get done by Friday. I mean, we will
21 be done by Friday because I start a trial in Pocatello on
22 Monday.
23 So I'll sustain the objection. Counsel can raise this.
24 And if I end up feeling it's somehow critical, I'll notify
25 counsel and give them a chance to respond. I may strike it at

1 that point. But in order to get the evidence in, let's go ahead
2 and allow the inquiry.
3 Go ahead.
4 Q. BY MS. RIFKIN: So, Dr. Ettner, are you aware of any
5 scientific studies that support the new standards or
6 requirements for incarcerated persons to receive gender
7 confirmation surgery that are proposed by Osborne and Lawrence?
8 A. No.
9 Q. And have the standards proposed by Osborne and Lawrence for
10 incarcerated persons to receive gender confirmation surgery been
11 endorsed by any professional associations or organizations that
12 you're aware of?
13 A. No.
14 Q. And how do the standards that they have proposed relate to
15 the WPATH standard of care as far as how it considers treatment
16 of surgery for incarcerated persons?
17 A. They get additional requirements.
18 Q. And what is the relationship of that, if any, to the WPATH
19 standard of care?
20 A. It's in opposition to the WPATH standards of care.
21 Q. And, Dr. Ettner, earlier in your testimony, you were asked
22 about risks to Ms. Edmo, possible risks, if she undergoes gender
23 confirmation surgery. You also testified about low -- about
24 regret rates.
25 Are you aware of what the regret rates are? Are you aware

1 of whether there have been studies on regret rates for persons
2 who go through with gender confirmation surgery?
3 A. Yes.
4 Q. What does "regret rate" mean in a medical context?
5 A. People who regret that they underwent surgery and wish that
6 they could reverse that decision.
7 Q. And what is -- what are the regret rates? Based on your
8 experience and knowledge of treatment of this condition, what
9 are the regret rates for gender confirmation surgery?
10 A. Historically, they were approximately 1 percent. As
11 surgical techniques have improved, the regret rate is now
12 somewhere between 0.23 and 0.4. So I would say under 1 percent.
13 Q. In your opinion, what is the likelihood that Ms. Edmo will
14 regret gender confirmation surgery if provided to her?
15 MR. EATON: Objection. Speculation.
16 MR. HALL: Join.
17 THE COURT: Counsel, I don't know how you can -- how
18 she can answer the question without just speculating. I mean,
19 perhaps there is statistical studies showing that 99 percent of
20 the people do not regret the decision later. But in terms of
21 tying it down specifically to Ms. Edmo, I think it just has to
22 involve speculation.
23 So I'll sustain the objection.
24 Q. BY MS. RIFKIN: In your opinion, Dr. Ettner, what effect
25 will gender confirmation surgery have on Ms. Edmo based on your

1 experience of treating, I believe you said, 3,000 patients with
2 gender dysphoria?
3 A. It would eliminate the gender dysphoria. It would provide
4 a level of wellbeing that she hasn't had previously. It would
5 eliminate 80 percent of the testosterone in her body,
6 necessitating a lower dose of hormones going forward, which
7 would be particularly helpful given that she has elevated liver
8 enzymes. And it would, I believe, eliminate much of the
9 depression and the attendant symptoms that she is experiencing.
10 MS. RIFKIN: Thank you, Dr. Ettner. No further
11 questions at this time.
12 THE COURT: All right. Cross.
13 MR. HALL: Yes, Your Honor.
14 THE COURT: Mr. Hall.
15 THE WITNESS: Your Honor, could we take a short break?
16 I have to go to the restroom.
17 THE COURT: Yes. We'll take a short break. Let's try
18 to keep this to five minutes because we have -- we'll probably
19 want to take another break before the end of the day.
20 We will be in recess for five minutes.
21 (Recess at 12:10 p.m. until 12:19 p.m.)
22 THE COURT: Dr. Ettner, I'll again remind you you are
23 still under oath.
24 With that, Mr. Hall, you may cross-examine the witness.
25 MR. HALL: Thank you, Your Honor.

1 CROSS-EXAMINATION

2 BY MR. HALL:

3 Q. Dr. Ettner, nice to see you again.

4 We had an opportunity to spend a few hours out in Chicago

5 recently, didn't we?

6 A. Yes.

7 Q. And I told you I wasn't wearing a tie then, but I would

8 wear a tie today. And I did wear a tie, as I promised.

9 A. Yes. I recall your making that promise.

10 Q. I keep my promises.

11 Doctor, I don't have a lot of time with you today. So in

12 the interest of time, I'm going to ask some very pointed

13 questions. It's really going to call for just a yes, no,

14 correct, incorrect. And I would appreciate if you could answer

15 that way.

16 A lot of these you have already answered in your

17 deposition, but I have to get them on the record here today.

18 Is that fair?

19 A. Yes.

20 Q. Okay. Thank you.

21 Now, Doctor, you are not a certified correctional health

22 professional, also known as CCHP, which is a designation from

23 the National Commission of Correctional Health; correct?

24 A. That's correct.

25 Q. And you have never been an employee of a prison; correct?

1 A. Correct.
2 Q. And you have no formal training on prison operations;
3 correct?
4 A. That's correct.
5 Q. Okay. And you have no formal training on prison security
6 issues; correct?
7 A. Correct.
8 Q. And you have never been employed in a prison as a mental
9 health provider; correct?
10 A. Correct.
11 Q. And you have never treated a patient of yours who was, at
12 the time you provided treatment, incarcerated in a prison;
13 correct?
14 A. Correct.
15 Q. So with someone who is currently incarcerated, you have
16 never had a patient-psychologist relationship with them;
17 correct?
18 A. Not as a provider.
19 Q. As an expert?
20 A. Correct.
21 Q. And I believe from your deposition -- correct me if I'm
22 wrong -- you've had about 25 cases where you were retained as an
23 expert involving one of the parties who was a transgender
24 individual; is that correct? Does that sound fair?
25 A. I'm sorry. Would you repeat that, please.

1 Q. You have been retained on approximately 25 cases where you
2 were in a case involving a transgender individual; correct?
3 A. Incarcerated or in general, are you asking?
4 Q. In general.
5 A. It may have been more than that.
6 Q. And I believe you said at the time of your deposition that
7 about 20 lawsuits you were involved in were against a
8 correctional institution when it was involving a transgender
9 individual; correct?
10 A. Yes.
11 Q. And you have never been retained by lawyers representing a
12 correctional institution; correct?
13 A. Correct.
14 Q. Now, Doctor, you have never been published in a
15 peer-reviewed journal on a topic related to providing care to
16 transgender inmates in a correctional setting; correct?
17 A. Correct.
18 Q. Okay. And you have never, then, of course, provided or
19 published any writings in a peer-reviewed journal on the topic
20 of providing treatment to transgender individuals who have
21 gender dysphoria in a prison; correct?
22 A. Correct.
23 Q. Now, Doctor, at the time of your deposition, I asked you if
24 you had read the article by Osborne and Lawrence which was just
25 discussed here briefly.

1 Do you recall that?
2 A. Yes.
3 Q. At the time of your deposition, you had not read it;
4 correct?
5 A. Yes.
6 MR. HALL: And for Your Honor, reference to this is
7 Joint Exhibit 19, which is stipulated admissible, admitted into
8 evidence.
9 THE COURT: Yes.
10 Q. BY MR. HALL: You understand that was published in "The
11 Archives of Sexual Behavior" -- "The Archives of Sexual
12 Behavior"; correct?
13 A. Yes.
14 Q. And that's a peer-reviewed journal, is it not?
15 A. It is.
16 Q. And the WPATH actually cites and relies upon a number of
17 articles that are contained and been published by "The Archives
18 of Sexual Behavior"; correct?
19 A. Yes.
20 Q. You were involved in writing the WPATH; correct?
21 A. Writing the WPATH?
22 Q. The standards of care.
23 A. Yes.
24 Q. And just for reference, those were -- that was provided and
25 is admitted under Joint Exhibit 15.

1 Isn't it true that there is only two pages -- approximately
2 two pages of the WPATH that talk about how to apply the WPATH
3 standards of care in a correctional institution?
4 A. Yes.
5 Q. And that actually applies more generally to just
6 institutionalized persons from mental hospitals to corrections;
7 correct?
8 A. It applies to all institutionalized persons.
9 Q. Right. Currently, you're aware of only one person in the
10 United States that has been provided sexual reassignment surgery
11 or gender confirming surgery while incarcerated; correct?
12 A. Yes.
13 Q. So there is not a lot of data, is there, in that regard;
14 correct?
15 MS. RIFKIN: Objection. Vague.
16 THE WITNESS: Data regarding what?
17 THE COURT: Just a second. There is an objection?
18 MS. RIFKIN: Objection. Vague.
19 THE COURT: Overruled. The question is whether there
20 is a lot of data or not. The witness can -- there either is or
21 is not.
22 THE WITNESS: Data regarding?
23 Q. BY MR. HALL: Well, there is only one instance where an
24 inmate was provided sexual reassignment in a United States
25 prison; correct?

1 A. Yes.
2 Q. You're not aware of any other studies out there -- let me
3 rephrase it.
4 You're not aware of any studies that speak to the issue of
5 providing sexual reassignment to inmates in a correctional
6 facility; correct?
7 A. I'm aware of studies discussing gender dysphoria in prison
8 environments.
9 Q. Now, at the time of your deposition, you had not read the
10 Osborne and Lawrence article that's been admitted; correct?
11 A. Correct.
12 Q. And you did not rely upon that in drafting your declaration
13 which provided your opinions, which was provided in June of this
14 year; correct?
15 A. Correct.
16 Q. Now, let's talk about that declaration. I think the date
17 was actually May 29, 2018.
18 Isn't it correct that prior to signing that declaration,
19 you had not talked with any of the defendants in this case?
20 A. Correct.
21 Q. And do you know or have any idea who the defendants are in
22 this case, the actual named individuals?
23 A. You mean other than the Department of Correction and
24 Corizon?
25 Q. Correct.

1 A. No. I didn't know any of the other individuals.
2 Q. Okay. And you have never interviewed any of Ms. Edmo's
3 medical or mental health providers who provided treatment to her
4 over the last six years at the prison; correct?
5 A. I have not; correct.
6 Q. And prior to signing your declaration, you never reviewed
7 any of IDOC's, Department of Corrections, standard operating
8 procedures regarding the treatment of gender dysphoria or gender
9 identity disorder; correct?
10 A. Correct.
11 Q. And you did not review any records from the prison
12 regarding Ms. Edmo other than her medical and mental health
13 records; correct?
14 A. Just what was provided to me, yes. Correct.
15 Q. Well, the only thing that was provided to you prior to you
16 signing your declaration were medical and mental health records;
17 correct?
18 A. Yes.
19 Q. Okay. And it's your understanding that those were not
20 complete at the time that you reviewed them and signed your
21 declaration; correct?
22 A. Yes.
23 Q. You did not review the disciplinary records?
24 A. I did not --
25 Q. Okay.

1 A. -- at that time.

2 Q. At that time, you didn't know Ms. Edmo had approximately 30

3 disciplinary offense reports; correct?

4 A. I didn't know the number of disciplinary reports; correct.

5 Q. At the time of signing your declaration, you did not know

6 that the IDOC had a management treatment committee; correct?

7 A. I didn't know that's what it was called; correct.

8 Q. Okay. But you didn't see any records from the management

9 treatment committee regarding the discussions that they had

10 regarding Ms. Edmo and her treatment for gender dysphoria;

11 correct?

12 A. Only what Ms. Edmo had related to me during our

13 discussions.

14 Q. But you didn't see those records; correct?

15 A. Correct.

16 Q. And you did not review Ms. Edmo's offender history

17 statement, which was approximately 74 pages, that was

18 subsequently produced in discovery as Exhibit B; correct?

19 A. Correct.

20 Q. Now, you also, at the time of providing your declaration in

21 this case in May, May 29, you did not review any medical records

22 or mental health records regarding treatment provided to

23 Ms. Edmo preincarceration; correct?

24 A. Correct.

25 Q. So that would include the mental health records from the

1 Sho-Ban tribe; correct?
2 A. Correct.
3 Q. And mental and medical health records from Portneuf Medical
4 Center Behavioral Health Unit; correct?
5 A. Correct.
6 Q. And you had an interview with Ms. Edmo, at which time she
7 provided to you statements as to her preincarceration history;
8 correct?
9 A. We talked briefly about some elements of her childhood and
10 early life; correct.
11 Q. And she told you about her prior mental health treatment in
12 general; correct?
13 A. Yes.
14 Q. And she told you that she lived full time as a woman during
15 the years prior to her incarceration in 2012; correct?
16 A. She had presented as female, yes.
17 Q. Well, no. She had told you that she had lived, quote,
18 "full time as a woman" in the years prior to her 2012
19 incarceration; isn't that correct?
20 A. I'm not sure if it was all the years prior to her
21 incarceration.
22 Q. But she used the word "full time," and you actually
23 included that in your report; correct?
24 A. I did; yes.
25 Q. Okay. And your understanding was that she claimed she

1 lived full time as a woman for at least three to four years
2 prior to her incarceration in 2012; isn't that correct?
3 A. For some time prior to her incarceration.
4 Q. And she told you that she lived full time as a woman by
5 wearing female clothing; correct?
6 A. I don't remember precisely if she said "female clothing."
7 I know nail polish and whatever I have written in my
8 declaration.
9 Q. Right. And she also told you that she styled her long hair
10 in a feminine fashion; correct?
11 A. I don't recall her saying "long hair."
12 Q. Now, prior to writing your declaration in May of 2018, did
13 you at any time seek out documents or information that would
14 corroborate Ms. Edmo's history that she gave you regarding her
15 time preincarceration?
16 A. No. Neither do I do that with my clients in the community.
17 Q. You understood that Ms. Edmo had attempted suicide on
18 multiple prior occasions; correct?
19 A. Yes.
20 Q. And you didn't think that it was necessary or warranted to
21 go and seek out those medical records regarding those prior
22 suicide attempts?
23 A. That's correct.
24 Q. You're not saying that if a patient comes into your office
25 and wants treatment and they have multiple prior suicide

1 attempts, that you wouldn't consider those prior suicide
2 attempts in your evaluation?
3 A. I would discuss it with them, as I did with Ms. Edmo.
4 Q. You understand now, though, that Ms. Edmo's statement to
5 you that she lived full time as a woman is inconsistent with
6 other statements she has made; correct?
7 A. I don't know.
8 Q. Well, you understood at the time of your deposition that
9 Ms. Edmo had told a medical provider in 2012 -- namely,
10 Dr. Eliason -- that she only dressed as a woman on rare
11 occasions. Are you aware of that?
12 MS. RIFKIN: Objection, Your Honor. Lacks foundation.
13 THE COURT: The question is: Were you aware? Yes or
14 no.
15 THE WITNESS: Would you repeat the question? Was I
16 aware of?
17 MR. HALL: Could I have the court reporter read the
18 question back, please.
19 (Question read by reporter.)
20 THE WITNESS: I'm aware that that different providers
21 have had different -- different accounts of Ms. Edmo's dressing
22 prior to her incarceration than what I was told.
23 Q. BY MR. HALL: Than what you were told by Ms. Edmo; correct?
24 A. Correct.
25 Q. So you're aware of inconsistent statements that Ms. Edmo

1 had made to you and other providers about her history of living
2 full time as a woman?
3 A. I'm aware that there are variations in the accounts.
4 Q. And you're aware that those statements creating variations
5 or inconsistencies come from Ms. Edmo; correct?
6 A. That's quite likely.
7 Q. And have you reviewed or did you review the presentence
8 investigation report that was produced in discovery in this
9 case?
10 A. If it was provided to me, I reviewed it.
11 Q. Okay. But did you review that presentence investigation
12 prior to you signing your declaration?
13 A. No.
14 Q. And you're aware that in that presentence investigation,
15 one document is a psychosexual examination; correct?
16 A. Yes.
17 Q. Okay. And are you aware that in that psychosexual
18 examination, Ms. Edmo told the evaluator that she had never
19 cross-dressed?
20 A. Yes.
21 Q. Do you understand cross-dressing as dressing as the
22 opposite sex?
23 A. That's my understanding of cross-dressing, yes.
24 Q. Prior to you signing your declaration in May, did you reach
25 out to any of Ms. Edmo's family members to discuss her

1 preincarceration history?
2 A. No.
3 Q. So you didn't talk to her mother?
4 A. No, I did not.
5 Q. You didn't talk to her sisters?
6 A. No.
7 Q. I would like to refer you to the WPATH standards of care,
8 Joint Exhibit 15. I'm going to spend some time on this with
9 you, Dr. Ettner.
10 MR. HALL: Do I need to flip a switch to have this
11 iPad show up here?
12 THE COURT: I don't -- what do you want? You want the
13 input changed?
14 MR. HALL: Yeah. There it is right there. It looks
15 like it's -- there we go.
16 Q. BY MR. HALL: Now, Dr. Ettner, what we're looking at here
17 is the portion of the WPATH standards of care under the heading
18 "The standards of care are flexible clinical guidelines";
19 correct?
20 A. Yes.
21 Q. Do you agree with that statement that's contained in the
22 WPATH, that the standards of care are, quote, "flexible clinical
23 guidelines"?
24 A. I do.
25 Q. And you interpret guidelines as recommendations; correct?

1 A. As criteria, yes, clinical guidelines.
2 Q. But guidelines are recommendations; standards are
3 mandatory; correct?
4 A. Yes.
5 Q. You agree with that. And I believe that was your testimony
6 in your deposition; correct?
7 A. Yes.
8 Q. I'm having some technical difficulties here.
9 Down in the middle paragraph there on this page, it states
10 that:
11 "As for all previous versions of the standards of
12 care, SOC, the criteria put forth in this document for
13 hormone therapy and surgical treatments for gender
14 dysphoria are clinical guidelines."
15 Did I read that correctly?
16 A. Yes.
17 Q. And you agree with that; correct?
18 A. I do.
19 Q. Okay. And then it continues:
20 "Individual health professionals and programs may
21 modify that."
22 Did I read that correctly?
23 A. Yes.
24 Q. And you agree with that; correct?
25 A. I do.

1 Q. I would like to turn your attention to page No. 22 of the
2 standards of care.
3 Do you see that there in front of you?
4 A. I don't know what page I'm looking at, but it starts with
5 the sentence, "The competency of mental health professionals."
6 Q. Right. And I'll represent that it's page No. 22 of Joint
7 Exhibit 15-28.
8 And this is the section of WPATH which talks about the
9 minimum criteria that individuals who are mental health
10 providers should have if they are going to treat
11 gender-dysphoric offenders; correct?
12 A. Yes.
13 Q. To your knowledge, at the time that you wrote the
14 declaration in May of 2018, you didn't have any idea as to
15 whether or not any of the medical or mental health providers at
16 the prison met these standards; correct -- as for competency of
17 working with gender dysphoric?
18 A. I deduced that from the medical records I reviewed.
19 Q. But you didn't know the actual qualifications,
20 certifications, or trainings of any of the individuals who
21 provided treatment to Ms. Edmo at the prison; correct?
22 A. I hadn't seen their individual qualifications. I made a
23 judgment based on the notes that they wrote regarding Ms. Edmo
24 and her medical condition.
25 Q. But you did not know the qualifications, certifications, or

1 training that those individuals had received; correct?
2 A. No, I did not.
3 Q. Okay. And as you sit here today, can you name any of those
4 individuals?
5 A. The individuals that treated her?
6 Q. Correct.
7 A. Yes.
8 Q. And you did not include any of their names in the -- your
9 declaration, did you, other than a Dr. Eliason; correct?
10 A. Correct.
11 Q. I would like to turn your attention to page No. 24 of the
12 standards of care, which is Joint Exhibit 15-30.
13 Do you see that there in front of you?
14 A. Yes.
15 Q. In that section under subpart 3, "Assess, diagnose, and
16 discuss treatment options for coexisting mental health
17 concerns," this is a portion that is found in the WPATH;
18 correct?
19 A. Yes.
20 Q. And this is the WPATH's language; correct?
21 A. Pardon me?
22 Q. This is the WPATH -- their language; correct?
23 A. Yes.
24 Q. And you were -- you assisted in writing this version;
25 correct?

1 A. Yes.
2 Q. In this paragraph, Doctor, it states that:
3 "Clients presenting with gender dysphoria may struggle
4 with a range of mental health concerns, whether
5 related or unrelated to what is often a long history
6 of gender dysphoria and/or chronic minority stress."
7 Did I read that correctly?
8 A. You did, yes.
9 Q. And isn't it true that it then states that these possible
10 concerns that mental health providers should be looking for
11 include, quote, "anxiety, depression, self-harm, a history of
12 abuse and neglect, compulsivity, substance abuse, sexual
13 concerns, personality disorders," and then it names a few
14 others; correct?
15 A. Yes.
16 Q. And it's important that under the WPATH, mental health
17 providers treating someone with gender dysphoria, look and
18 address those coexisting mental health concerns; isn't that
19 true?
20 A. That's true.
21 Q. It continues on to the next page that these concerns that
22 were just listed previously can, quote:
23 "Be significant sources of distress and, if left
24 untreated, can complicate the process of gender
25 identity exploration and resolution of gender

1 dysphoria."

2 Did I read that correctly?

3 A. Yes.

4 Q. And you agree with that, don't you?

5 A. I do.

6 Q. And then it continues:

7 "Addressing these concerns can greatly facilitate the

8 resolution of gender dysphoria, possible changes in

9 gender role, the making of informed decisions about

10 medical interventions, and improvements in quality of

11 life."

12 Correct?

13 A. Yes.

14 Q. Now, further down on the paragraph beginning with "Some

15 clients," it states that "The presence of coexisting mental

16 health concerns does not necessarily preclude possible changes

17 in gender role or access to feminizing/masculinizing hormones or

18 surgery"; correct?

19 A. Correct.

20 Q. Rather, it continues:

21 "These concerns need to be optimally managed prior to

22 or concurrent with treatment of gender dysphoria."

23 Did I read that correctly?

24 A. Yes.

25 Q. You agree with that statement, don't you?

1 A. I do.
2 Q. And how do you define "optimally"?
3 A. In this context?
4 Q. I believe I asked you that question in your deposition, and
5 how do you -- do you recall how you answered that question?
6 A. Not precisely, no.
7 Q. Would you agree that optimal is the -- how it's used here
8 and how you interpreted it is the maximum therapeutical point to
9 it that it has to be maximally controlled?
10 A. With the best evidence-based treatment for that particular
11 mental health issue.
12 Q. Right. And you agree that under the WPATH, whether or not
13 a patient with gender dysphoria has coexisting mental health
14 concerns that need to be optimally managed prior to a certain
15 type of treatment, that that should be left to the sound
16 clinical judgment of the providers?
17 A. Of a qualified mental health provider of which they
18 specified the criteria.
19 Q. Thank you.
20 So if someone meets the qualifications that are found
21 within the WPATH that we discussed, you would agree that they
22 are competent to render sound clinical judgment?
23 A. Yes. One of those qualifications being the ability to
24 distinguish coexisting conditions that arise from gender
25 dysphoria or are distinct from the gender dysphoria.

1 Q. Now, prior to your writing your declaration, were you aware
2 that Ms. Edmo had a long history of anxiety disorder?
3 A. Depression predominantly with anxiety features.
4 Q. It was not your understanding that she also had anxiety and
5 had complained of severe anxiety in the past?
6 A. Yes. But anxiety and depression usually are hand in hand.
7 Q. Now, you performed testing of Ms. Edmo in 2018 in March;
8 correct?
9 A. Yes.
10 Q. The psychodiagnostic testing?
11 A. Correct.
12 Q. All right. And the results of that testing was that
13 Ms. Edmo, at the time of the testing, was that she experiences
14 severe anxiety symptoms; correct?
15 A. Yes.
16 Q. And as for impression, that she also exhibited severe
17 depressive symptoms; correct?
18 A. Yes.
19 Q. And feelings of worthlessness; correct?
20 A. Yes.
21 Q. These tests that you perform, isn't it true that they do
22 not identify the cause or the source of that depression or
23 anxiety?
24 A. Specifically, they cannot tell the cause of the anxiety or
25 depression.

1 Q. Thank you.
2 A. But one of the tests can determine if they are the result
3 of trauma.
4 Q. Right. And I believe you talked about that earlier.
5 But the point is that those tests do not identify the
6 source or the cause of someone's depression or anxiety; correct?
7 A. Correct.
8 Q. And one of the tests that you performed was the Beck
9 Hopelessness Scale; correct?
10 A. Yes.
11 Q. At the time of the testing, Ms. Edmo scored moderately
12 high, did she not?
13 A. Yes.
14 Q. And you're not aware of any records that you have seen from
15 her preincarceration days that would suggest to you that her
16 prior suicide attempts, history of depression and anxiety were
17 related to gender dysphoria; correct?
18 A. I can't opine what was the basis of her previous suicidal
19 attempts other than what she has reported and what was written
20 in those documents.
21 Q. The question was: Have you seen any records that would
22 support that?
23 And that's no; correct?
24 A. Support what?
25 Q. Well, support or suggest that her prior anxiety, prior

1 depression, prior suicide attempts were caused at least in part
2 by gender dysphoria.
3 A. My understanding is that she wasn't aware of gender
4 dysphoria as a diagnosis prior to entering the prison.
5 Q. But to answer my question, you have seen no records;
6 correct?
7 A. Correct.
8 Q. Okay. And you have seen records, though, where Ms. Edmo is
9 stating after suicide attempts prior to her incarceration, that
10 she was -- that she was suicidal and depressed due to loss of
11 employment and difficulty finding employment; correct?
12 A. That was something she attributed her depression to.
13 Q. And another one was that she attributed her depression to
14 unstable relationships with significant others; correct?
15 A. Yes.
16 Q. Right. Who were abusive to her and for whom she claimed to
17 have an obsession over; correct?
18 A. I don't remember obsession. I do remember relationships
19 and abuse.
20 Q. Right. And substance abuse was also identified as one of
21 the causes of her suicide attempts, depression, and anxiety;
22 correct?
23 A. Yes.
24 Q. You understood that in the years prior to her
25 incarceration, she attempted to commit suicide several times by

1 overdose; correct?
2 A. At least once that I was aware of.
3 Q. And at one point, she made a very deep laceration to her
4 right forearm and required reconstructive surgery; correct?
5 A. I think it was suturing. I'm not -- I don't remember if it
6 was reconstructive surgery.
7 Q. And at the time of your 2018 testing, Ms. Edmo scored a
8 100, which is the highest possible score on a scale that you
9 stated measures suicide ideation and suicide behavior; is that
10 correct?
11 A. Suicide ideation, yes.
12 Q. But not suicide behavior?
13 A. Suicide behavior is less than suicide ideation, which is
14 the highest score. Yes, she scored the highest possible score
15 on that.
16 Q. So you understood at the time of your clinical interview
17 with Ms. Edmo that she had a long history of depression,
18 anxiety, and suicide attempts; correct?
19 A. Yes.
20 Q. And that at the time -- and that predated the incarceration
21 in 2012; correct?
22 A. Yes.
23 Q. Okay. And it -- at the time of your testing, she still had
24 severe depression, anxiety, and suicide ideations; correct?
25 A. Yes.

1 Q. You also understand that Ms. Edmo had a history of sexual
2 abuse and neglect; correct?
3 A. Yes.
4 Q. Both by family members and then physical abuse by
5 significant others; correct?
6 A. By a boyfriend, yes.
7 Q. Okay. And that you understood that that was a significant
8 factor in her preincarceration attempts to self-harm, kill
9 herself?
10 A. That's what she related was the triggering event.
11 Q. You also understand that prior to Ms. Edmo's incarceration,
12 she had a significant history of substance abuse; correct?
13 A. Yes.
14 Q. Including methamphetamines, heroin, and primarily alcohol;
15 correct?
16 A. Yes.
17 Q. And you understood that in the three to four years prior to
18 her incarceration in 2012, that she was on a daily basis
19 drinking to intoxication?
20 A. Yes.
21 Q. And that during those years where she was reportedly living
22 full time as a woman, she was under the influence that entire
23 time?
24 A. I -- that I don't recall. I don't -- can't say that she
25 was under the influence the entire time and that that coincided

1 with the period that she said she was living full time.
2 Q. Now, you understand that prior to Ms. Edmo's incarceration,
3 she had a history of high-risk sexual behaviors?
4 A. By "high-risk sexual behaviors," how are you defining that?
5 Q. Well, did you review the psychosexual evaluation?
6 A. Yes.
7 Q. -- in the PSI?
8 A. Yes.
9 Q. Okay. And that included statements about multiple prior
10 partners; correct?
11 A. Multiple prior partners, I recall.
12 Q. Right. And unsafe sex?
13 A. Okay. Yes.
14 Q. Right?
15 A. I remember that.
16 Q. You do remember that?
17 A. Yes.
18 Q. You agree that some of those can be high-risk sexual
19 behaviors?
20 A. Possibly, yes.
21 Q. And that since Ms. Edmo has been incarcerated, you
22 understand that she has had multiple prior -- multiple sexual
23 encounters with offenders, other inmates; correct?
24 A. Encounters with other inmates, yes.
25 Q. Which included sexual activity; correct?

1 A. Yes.
2 Q. And that she has been disciplined for that; correct?
3 A. Yes.
4 Q. Did you see records indicating that Ms. Edmo has admitted
5 that she -- she relies or she is dependent on male attention in
6 the prison?
7 A. I don't recall that specifically in those words, no.
8 Q. Now, you're also aware that from very early on in her
9 incarceration in 2012, Ms. Edmo exhibited traits of personality
10 disorder?
11 A. No, I'm not aware of that.
12 Q. You haven't seen the records upon her admission and intake
13 in 2012 where clinicians were indicating that she displays
14 personality trait disorders?
15 A. I'm aware that some people suggested that she may have
16 personality disorder traits, but I don't recall her being
17 diagnosed with a specific personality disorder that meets the
18 DSM-5 criteria.
19 Q. Right. I didn't ask about a diagnosis, but just the
20 presence of personality disorder traits.
21 You were aware of that; correct?
22 A. I recall someone suggesting that she had personality
23 disorder traits.
24 Q. And you would agree that that is correct, that Ms. Edmo has
25 exhibited multiple traits or criteria of personality disorders;

1 correct?
2 A. My evaluation of Ms. Edmo, I did not see evidence of a
3 personality disorder.
4 Q. Okay. But you did see that she had a pattern of unstable
5 and intense personal relationships?
6 A. That does not necessarily equate with a personality
7 disorder.
8 Q. I understand that.
9 But that is one of the criteria; correct?
10 A. It is a criteria of some of the personality disorders.
11 Q. And another criteria is impulsivity, is it not?
12 A. It can be, yes.
13 Q. Right. And that can include impulsive sexual actions as
14 well as substance abuse; correct?
15 A. It's possible, depending on what personality disorders
16 you're talking about.
17 Q. But it is one of the criteria; correct?
18 A. For some of the personality disorders.
19 Q. And recurrent suicidal behavior, gestures, threats, or
20 self-mutilating behavior is another criteria of
21 personality -- borderline personality disorder; correct?
22 A. You're asking about borderline personality disorder?
23 Q. Yes, borderline.
24 A. Yes.
25 Q. Okay. As is an unstable mood; correct?

1 A. Yes.

2 Q. And chronic feelings of emptiness; correct?

3 A. Yes, can be.

4 Q. And another trait or criteria is frequent displays of

5 temper and aggression; correct?

6 A. Are you talking about borderline --

7 Q. Borderline.

8 A. -- disorder?

9 Q. Yes.

10 A. It can be a criteria.

11 Q. Okay. And you understand that while she was incarcerated

12 or has been incarcerated, Ms. Edmo has been a perpetrator of a

13 number of sex -- a number of physical assaults?

14 A. I saw indications that there had been altercations that

15 Ms. Edmo had been involved in.

16 Q. And you have seen records that indicate that she has

17 received disciplinary offense reports, punishment for fighting?

18 A. Correct.

19 Q. You understand that she attacked on more than one occasion

20 another transgender offender at the prison?

21 A. Yes. I saw that.

22 Q. And you understand that preincarceration, she had a history

23 of fighting and abuse with her significant others?

24 A. Yes. There was abuse issues in a relationship.

25 Q. You understand that she has also received a number of DORs

1 while incarcerated at the prison for disobedience to direct
2 orders?
3 A. Yes.
4 Q. And she has displayed aggression during her incarceration?
5 You would agree with that?
6 A. I agree that she received a disciplinary report for
7 aggression.
8 Q. Excuse me. You understand that during her incarceration,
9 her mental health providers have recommended multiple times that
10 Ms. Edmo undergo a variety of treatments, including therapies;
11 correct?
12 A. They've recommended that she join certain groups.
13 Q. One was mood management; correct?
14 A. Yes.
15 Q. And Ms. Edmo refused repeatedly; correct?
16 A. Correct.
17 Q. And she still has not completed that; correct?
18 A. Correct.
19 Q. Another one is social skills.
20 That was referred to Ms. Edmo, and she refused again;
21 correct?
22 A. I believe so.
23 Q. And she has not completed it to date; correct?
24 A. That, I'm not aware of, but I would presume no.
25 Q. Another one is healthy relationships.

1 You're aware that she was referred to that therapy by her
2 mental health providers at the prison; correct?
3 A. Yes.
4 Q. And she has -- she refused; correct?
5 A. That's my understanding.
6 Q. She has not completed that group at this time; correct?
7 A. That I don't know.
8 Q. Now, you understand that Ms. Edmo was referred and required
9 to go to sex offender treatment programming.
10 Are you aware of that?
11 A. Yes.
12 Q. And are you aware that Ms. Edmo has, to this day, not
13 completed that?
14 A. I believe I saw that, yes.
15 Q. And you understand that one of the reasons why she was not
16 eligible for parole years ago is because she did not complete
17 the sex offender treatment program; correct?
18 A. Yes.
19 Q. And finally, gender dysphoria group, you understand that
20 the department and the mental health providers have recommended
21 and provided an opportunity for Ms. Edmo to go to a gender
22 dysphoria group; correct?
23 A. Yes.
24 Q. And that Ms. Edmo has been inconsistent with her commitment
25 to attend --

1 A. Correct.
2 Q. -- correct?
3 Sometimes she will go, sometimes she won't; correct?
4 A. Yes.
5 Q. There has been long periods of time where she hasn't gone
6 to that group; correct?
7 A. I don't know about long periods of time. I know her
8 participation has been intermittent.
9 Q. Right. And there has been periods where she hasn't gone
10 for up to six months; correct?
11 A. I'm not aware of how many months she has not attended.
12 Q. And you're also aware from the records that Ms. Edmo has
13 been provided primary clinicians who she can have clinical
14 contacts with on a regular basis; correct?
15 A. Yes.
16 Q. And it's your understanding that Ms. Edmo has frequent
17 no-shows or does not appear for those; correct?
18 A. Yes.
19 Q. Do you agree that -- well, do you know -- never mind.
20 We talked during your deposition about an explosion in the
21 social and medical understanding of gender dysphoria that was
22 very recent.
23 Do you remember that discussion?
24 A. Yes.
25 Q. And it really started after Caitlyn Jenner announced that

1 she was transitioning; correct?
2 A. A tremendous amount of media attention.
3 Q. Since that time, it's -- you have been required to update
4 some of your textbooks as well; correct?
5 A. Since that time?
6 Q. Yes.
7 A. No. Prior to that time.
8 Q. And over the last 10 years, there has been this rapid
9 awareness in the public of gender dysphoria; correct?
10 A. Public awareness has increased, yes.
11 Q. Right. At the time of your deposition, you stated that as
12 a result of that, research and science has mushroomed at the
13 same time that this public awareness of the condition has also
14 mushroomed.
15 Do you remember saying that?
16 A. Yes.
17 Q. And the terminology has changed, has it not?
18 A. Some terms have changed.
19 Q. Just today, I have heard multiple witnesses -- I believe
20 yourself -- use the word "sexual reassignment surgery"; correct?
21 A. That's the old term.
22 Q. Right. And now it's "gender confirming surgery"; right?
23 A. That's correct.
24 Q. Now, you agree that in 2012, Ms. Edmo was provided an
25 evaluation for the purpose of determining if she had gender

1 dysphoria; correct?
2 A. I agree that someone was asked to evaluate her. I don't
3 agree that it was an evaluation in alignment with what WPATH
4 considers to be an evaluation.
5 Q. Okay. That's not what I asked.
6 You are aware that there was an evaluation done to
7 determine if Ms. Edmo had gender dysphoria; correct?
8 A. An evaluation was requested and performed.
9 Q. Okay. And at the time you wrote your declaration, you did
10 not -- you did not have an opportunity to review that
11 evaluation; correct?
12 A. I don't believe I did.
13 Q. Okay. Only after your declaration did you then receive and
14 read and consider the evaluation that was done in 2012; correct?
15 A. Are you referring to the evaluation by Dr. Eliason?
16 Q. No. This is the 2012 evaluation for gender dysphoria --
17 A. Okay. Yes.
18 Q. -- not surgery.
19 A. Yes.
20 Q. Okay. You understand one was done?
21 A. Yes.
22 Q. And I think in your declaration, you determined that she
23 was appropriately diagnosed with gender dysphoria at that time.
24 A. Correct.
25 Q. You understand that within a month of asking for an

1 evaluation, she received one and then was diagnosed with gender
2 dysphoria; correct?
3 A. Yes.
4 Q. And then a short period of time after that, she was placed
5 on hormone therapy; correct?
6 A. Correct.
7 Q. And then she was provided access to clinical contacts with
8 mental health providers; correct?
9 A. Yes.
10 Q. Which she did not always attend; correct?
11 A. Yes.
12 Q. And she was permitted to attend groups, and it was
13 recommended that she attend various groups that could work on a
14 number of her coexisting mental health concerns; correct?
15 A. Groups for various purposes, she was suggested to. I
16 don't -- something like healthy relationships is not technically
17 a mental health concern. She was recommended to attend several
18 different groups, yes.
19 Q. But you agree that a healthy relationship class or mood
20 management class could be helpful to someone who has
21 personality -- borderline personality disorder traits; correct?
22 A. I don't know that -- I don't agree that Ms. Edmo has
23 borderline personality disorder, nor is that group considered
24 the evidence-based care for personality disorder.
25 Q. Okay. Maybe I should have asked this: You're not aware of

1 what they teach in those classes or groups; correct?
2 A. Correct.
3 Q. So you would be speculating as to whether or not it would
4 help either way; correct?
5 A. Correct.
6 Q. And you understand, though, that in addition to being
7 provided with an evaluation and diagnosis of GD, being placed on
8 hormone therapy, being given access to psychotherapy and groups
9 and clinical contacts with mental health providers, Ms. Edmo has
10 also been permitted to feminize in a manner that is appropriate
11 within the prison?
12 MS. RIFKIN: Objection, Your Honor. There has been no
13 foundation Ms. Edmo was provided psychotherapy.
14 Q. BY MR. HALL: Are you aware?
15 THE COURT: Well, the question is: Are you aware?
16 We're going to take a break here, Counsel.
17 What's your understanding in that regard?
18 THE WITNESS: That she was able to contact certain
19 clinicians and that she was referred to groups and that she
20 could request individual psychotherapy.
21 MR. HALL: Your Honor, would you like to take a break
22 now?
23 THE COURT: Is this a good breaking point?
24 MR. HALL: I think it would.
25 THE COURT: We'll try to hold this to about 10 minutes

1 since we took a short break earlier. We'll be in recess for
2 about 10 minutes.
3 (Recess at 1:08 p.m. until 1:25 p.m.)
4 THE COURT: Dr. Ettner, I'll remind you you are still
5 under oath.
6 Mr. Hall, you may resume your cross-examination of the
7 witness.
8 MR. HALL: Thank you, Your Honor.
9 Q. BY MR. HALL: Prior to going off the record, we were
10 talking about Ms. Edmo's feminizing in prison.
11 And after receiving the hormone therapy in 2012, Ms. Edmo
12 started to grow breasts; correct?
13 A. I presume so. I don't have any independent knowledge of
14 that, but she would at some point have begun to grow breasts.
15 Q. And you're aware that it was determined for her to have a
16 bra was medically necessary; correct?
17 A. Yes.
18 Q. And it's your understanding that she was provided, then,
19 with a bra; correct?
20 A. Yes.
21 Q. And she has always had access since that time, with a bra;
22 correct?
23 A. Yes.
24 Q. Okay. And you understand that she was permitted to grow
25 her hair out long; correct?

1 A. As long as she wore it in a certain fashion, yes.
2 Q. You saw that she was warned for having her hair in a high
3 ponytail which the records referenced; correct?
4 A. Yes.
5 Q. Okay. And your understanding from those records is that
6 the security staff felt that this created a sexually charged
7 environment; correct?
8 A. That's what I read, yes.
9 Q. Okay. And -- but, nonetheless, you haven't seen anything
10 where she has been forced to cut her hair short; correct?
11 A. I have not.
12 Q. Okay. She has been also allowed to shape her eyebrows;
13 correct?
14 A. Yes.
15 Q. In fact, ever since you met her, she's shaved and styled
16 her eyebrows; correct?
17 A. I have only met her on one occasion prior to today.
18 Q. And she has been able to feminize in other ways, like
19 having female handwriting; correct?
20 A. Excuse me?
21 Q. She has been able to feminize in other ways, like
22 exhibiting female handwriting?
23 A. I have never heard of female handwriting being a
24 gender-affirming exhibition.
25 Q. But you're not aware of any -- any records that suggest

1 that IDOC's security staff were not permitting her to handwrite
2 in a more feminine fashion than a, say, masculine fashion;
3 correct?
4 A. Personally, I don't know what the difference is between a
5 feminine handwriting and a masculine handwriting.
6 Q. Okay. You understand that she has been permitted and
7 assisted by the Department to change her gender marker with the
8 Idaho Department of Transportation?
9 A. Yes.
10 Q. You understand that Ms. Edmo has been permitted to feminize
11 in a manner of her speech, that she speaks effeminately;
12 correct?
13 A. When I met with Ms. Edmo, her voice was in a female range.
14 I don't know what the Department of Corrections had to do with
15 that.
16 Q. Well, you're not aware of the Department of Corrections
17 prohibiting her from doing that; correct?
18 A. I didn't know that that wasn't her natural speaking voice.
19 I would have no way of knowing that.
20 Q. Do you agree that the treatment options under the WPATH are
21 really fourfold, the first one being hormone therapy; correct?
22 A. I don't know that they are in order with hormone therapy
23 being first, necessarily.
24 Q. Right. Not -- there is no order to what I'm trying to say
25 there. There is just -- there is four real treatment options

1 for treating gender dysphoria; correct?
2 A. There are three real options, and some people may opt for
3 psychotherapy as well.
4 Q. Okay. But those four are options are -- one, in no
5 particular order, is hormone therapy; correct?
6 A. That's one of the options for treatment.
7 Q. Right. Another option is psychotherapy, which could
8 include group or individual counseling; correct?
9 A. Yes.
10 Q. Another option is allowing the individual to appear and
11 present in a manner that's congruent with their preferred
12 gender; correct?
13 A. I wouldn't described it as "allowing" because the standards
14 of care emphasize shared decision-making.
15 Q. But that is one of the treatment options?
16 A. It's one of the options.
17 Q. Okay. And then the other option is surgery; correct?
18 A. Correct.
19 Q. Okay. And the criteria for surgery you discussed earlier,
20 and I want to take a look at that.
21 Have I identified the correct section of the WPATH that
22 deals with surgery for adults, either female to male, or male to
23 female?
24 A. I am looking at the criteria for genital reconstructive
25 surgery.

1 Q. Okay. Are those the criteria that you believe apply in
2 this instance?
3 A. Yes.
4 Q. Okay. And the second one is "capacity to make a fully
5 informed decision and to consent for treatment"; correct?
6 A. Yes.
7 Q. Okay. And then you agree there is a different one, No. 4,
8 which talks about "if significant medical or mental health
9 concerns are present, they must be well controlled"; correct?
10 A. Yes.
11 Q. And that's No. 4; correct?
12 A. Yes.
13 Q. And in No. 4, it says nothing about informed consent;
14 correct?
15 A. In that sentence?
16 Q. Yes.
17 A. It does not.
18 Q. Okay. Informed consent is addressed in No. 2; correct?
19 A. Yes.
20 Q. Okay. And nowhere in the criteria depicted on this page,
21 which is 68 of the WPATH standards of care marked Joint Exhibit
22 15-66, are the words "benefit outweighs the risk" found;
23 correct?
24 A. The page I'm looking at is marked No. 60 -- page 60.
25 Q. Right. Joint Exhibit 15-66. Do you see that?

1 A. Yes.
2 Q. And nowhere on that -- in those criteria captured on that
3 page can be found the words "benefit outweighs the risk";
4 correct?
5 A. Correct.
6 Q. Now, I believe earlier today and at the time of your
7 deposition, you testified that you're not aware of any members
8 of WPATH providing concerns to leadership at the WPATH that the
9 standards are not grounded in sufficient scientific evidence.
10 Do you remember that?
11 A. Could you repeat that question.
12 MR. HALL: Could I have the question read back,
13 please.
14 (Question read by reporter.)
15 THE WITNESS: The standards which were created in 2011
16 were based on the best available scientific evidence at that
17 time.
18 Q. BY MR. HALL: Right. And that doesn't answer my question.
19 Would you answer my question, please.
20 A. I don't know that I can answer the question in a yes-or-no
21 fashion.
22 Q. Do you recall your testimony when you stated that that has
23 not been an issue with the WPATH where members have not come
24 forward expressing concerns about the criteria in the WPATH's
25 standards of care being based on scientific evidence?

1 A. That's correct. Members are now suggesting changes for our
2 future iterations.
3 Q. Right. And you're familiar with a Gail Knudson; correct?
4 A. Yes.
5 Q. And she is the president of the WPATH; correct?
6 A. Yes.
7 Q. And you're aware of a letter or email that she wrote to
8 membership on May 23, 2017, where she discussed, did she not,
9 that membership had concerns with the lack of scientific
10 evidence to ground the standards of care; correct?
11 A. Yes, which is why our SOC 8 are now being evidence-reviewed
12 by an outside authority as a result of not only Gail's concerns
13 but, as I mentioned in my deposition, new information about
14 children and adolescents that will be included in our next
15 iteration.
16 Q. And isn't it true that in May of 2017, Dr. Knudson,
17 president, wrote in her letter to membership that one of the
18 primary concerns of membership was related to, quote, "the
19 increased need for scientific evidence to ground the standards
20 of care," end quote?
21 A. Yes.
22 Q. And isn't it true that as a result of that concern from the
23 membership, that Ms. Knudson and the WPATH leadership determined
24 to, quote, "endeavor to commission an evidence-based medicine
25 team to independently review the literature and grade the

1 evidence in select topic areas"; correct?
2 A. Dr. Knudson, myself, and the other members of the executive
3 committee have hired Johns Hopkins, who we are working with to
4 do the evidence-based review of the literature for our next
5 iteration.
6 Q. In prior iterations, including Version 7, WPATH didn't
7 reach out to Johns Hopkins to do evidence-based research;
8 correct?
9 A. No, but we did have an evidence-based review of the
10 available literature at the time.
11 Q. That was not determined to be sufficient, and that's why
12 WPATH has reached out to Johns Hopkins for support; correct?
13 A. No. I believe that what's happened is information about
14 children and adults, which is the majority of the new work in
15 the field, requires an evidence-based review since the
16 administration of hormone blockers to prepubertal children is a
17 relatively new phenomena that needs to be evidence based.
18 MR. HALL: Your Honor, I would move to admit the
19 May 23, 2017, email and letter from Dr. Knudson as impeachment
20 testimony.
21 THE COURT: Do you have it marked?
22 MR. HALL: We -- I just received this last night,
23 Your Honor. And I think that it was really a nonissue until I
24 heard the witness's testimony today saying that there were no
25 concerns, were no requests from membership.

1 And what I can do is we can have this marked and submitted.
2 THE COURT: All right. Ms. Rifkin.
3 MS. RIFKIN: Yes, Your Honor. We have never been
4 provided a copy of this. It sounds like a hearsay statement
5 that could not be admitted even as impeachment evidence.
6 THE COURT: Where did it come from? If -- Mr. Hall,
7 if you didn't get that until last night, where did you get it?
8 MR. HALL: I got it from counsel, Your Honor.
9 THE COURT: Ms. Rifkin?
10 MS. RIFKIN: Not from us.
11 MR. HALL: Not from plaintiff's counsel, Your Honor.
12 THE COURT: From who?
13 MR. HALL: Defense counsel, Mr. Eaton, Your Honor.
14 MS. RIFKIN: Who also had never provided it, even
15 though he's counsel in this case, to plaintiffs.
16 THE COURT: Mr. Eaton, where did this come from? And
17 why wasn't it disclosed until last night?
18 MR. EATON: Your Honor, it came from our expert,
19 Dr. Garvey, who is a member of WPATH. And when we deposed
20 Dr. Ettner and in the testimony today, this was the first time
21 it came up that she was denying that members were complaining
22 about --
23 THE COURT: No. That didn't answer my question. Why
24 didn't you turn it -- you just got it --
25 MR. EATON: I just got it this week, Your Honor, I

1 think a day or two ago. And I wasn't planning to use it until
2 the testimony.
3 MS. RIFKIN: Your Honor, we deposed Dr. Garvey. We
4 sent requests for production specifically to Dr. Garvey at her
5 deposition, which was only two weeks ago.
6 This document has never been brought up. I think, given
7 the beyond the scope objections by defendants' counsel -- they
8 didn't even make an effort to send it to us last night or this
9 week, whenever they got it.
10 And it's -- from all -- from all that's been represented
11 about it and testified to about it by counsel, it's hearsay.
12 THE COURT: All right. Let's lay the background.
13 Where did the letter -- who is the letter from? Who is it to?
14 What is the date on it?
15 MR. HALL: May 23, 2017, from the WPATH membership --
16 to the membership of WPATH signed by Gail Knudson, M.D.,
17 President WPATH.
18 And, Your Honor, we produced thousands of pages in
19 this -- throughout this case. I never -- I never thought that
20 this was -- even if I received it earlier, was responsive to any
21 issue in this case or request.
22 I think it only became relevant when the witness provided
23 testimony that was inconsistent with this. And that is
24 impeachment at that time, to be able to use this to show that
25 the witness testified inconsistently.

1 THE COURT: But it's impeaching questions you asked on
2 cross-examination.
3 MR. HALL: Well, no. It's directly impeaching a
4 question that plaintiff counsel asked the doctor on direct,
5 Your Honor, that she was not --
6 THE COURT: What question was that, and what response
7 was that?
8 MR. HALL: I believe the question was: Are you aware
9 that counsel -- me -- had represented that there was some
10 dispute or concern membership regarding whether or not the
11 standards of care were grounded in science-based research?
12 And that was asked in some way to Dr. Ettner, who testified
13 no. And yet, now, this letter, when she --
14 THE COURT: Ms. Rifkin asked that question?
15 MS. RIFKIN: I don't believe so, Your Honor.
16 THE COURT: I don't recall, but I thought it came up
17 just in your examination, but perhaps I'm mistaken.
18 MR. HALL: I thought she opened the door to that and
19 asked the question. I guess it's a matter for the court
20 reporter.
21 MS. RIFKIN: Your Honor, I never asked a question
22 about membership concerns about WPATH standards. That is simply
23 not accurate.
24 MR. HALL: Your Honor, I don't want to misrepresent
25 anything. I just remember that there was a question posed

1 regarding whether or not the WPATH standard --
2 THE COURT: Is Dr. Knudson going to be called?
3 MR. HALL: I'm sorry?
4 THE COURT: Is Dr. Knudson going to be a witness?
5 MR. HALL: No.
6 THE COURT: Are you aware of this letter? Have you
7 seen it?
8 THE WITNESS: No. Dr. Knudson and I -- I receive
9 emails from her every day because she's --
10 THE COURT: Well, my question is: Do you --
11 THE WITNESS: I don't have any memory of this email or
12 of this discussion.
13 THE COURT: Well, let's move on. Because she has no
14 memory of it, it isn't really impeaching if she didn't know of
15 it.
16 So I'll sustain the objection. Let's move on.
17 MR. HALL: I think, Your Honor, I got the testimony in
18 that -- and I can ask the question of the witness again, but I
19 believe the witness testified that she is now aware of that
20 dialogue. And I'll let her testimony regarding her knowledge of
21 the need for science-based research to stand.
22 THE COURT: Well, if that's the end, there was no
23 objection to that. Let's move on.
24 MR. HALL: With that, Your Honor, I don't have any
25 further questions. Thank you.

1 THE COURT: All right. Mr. Eaton.
2 CROSS-EXAMINATION
3 BY MR. EATON:
4 Q. Dr. Ettner, my name is Dylan Eaton.
5 Do you remember talking to me at your deposition?
6 A. I do.
7 Q. Mr. Hall did a good job, and he was thorough. So I only
8 have a few questions for you.
9 One thing I wanted to clarify is: Are you a
10 board-certified psychiatrist?
11 A. No.
12 Q. And are you a licensed psychiatrist?
13 A. No.
14 Q. And I know Mr. Hall was asking you, and I think generally
15 you indicated that providers -- you were not aware of the
16 providers you referred to in your declaration qualifications;
17 correct?
18 A. I didn't see their CVs, no.
19 Q. You also weren't aware of their qualifications; correct?
20 A. Correct.
21 Q. And specifically, you didn't know Dr. Eliason's
22 qualifications; correct?
23 A. No.
24 Q. Now, did I understand you to testify that SRS, sex
25 reassignment surgery, is not harmful? Did I understand that

1 testimony to be correct?
2 A. It's not harmful if it is done for medical purposes in --
3 in cases where it's indicated, yes.
4 Q. But you would acknowledge there is risks with that surgery;
5 correct?
6 A. As with any surgery, yes.
7 Q. Okay. So there is risks of infection, for instance?
8 A. Infection, dehiscence, urinary retention, yes -- and
9 other -- other complications, yes.
10 Q. Up to and including death; correct? That's a potential
11 risk of SRS?
12 A. Of any surgical operation where there is anesthesia used,
13 yes.
14 Q. So death is a risk of SRS?
15 A. Potentially, yes.
16 Q. I believe you indicated that SRS has low rates of
17 complications.
18 Did you testify to that?
19 A. Yes.
20 Q. And what did you mean by that?
21 A. Similar to the complication rate of genitourinary
22 reconstructive surgery for congenital or carcinogenic cancer
23 related vaginal procedures.
24 Q. Okay. But you're not a medical doctor; correct?
25 A. I am not.

1 Q. Okay. Are there -- you're not relying on any specific
2 study to make that statement, are you?
3 A. There are specific studies, yes.
4 Q. What study is that?
5 A. There are several studies. There is one recent one by an
6 author named Poh, P-O-H. And I can't remember the second
7 author.
8 There are several studies on the complications of
9 vaginoplasty, and they differ depending on the technique. So
10 there is more than one technique of doing vaginoplasty.
11 The simple inversion technique carries less rate of
12 complications. Most of the complications are easily managed.
13 Few, but occasionally, require surgical revision but not often.
14 Q. I believe you testified that you're aware of some concerns
15 by clinicians and/or medical providers regarding personality
16 disorder traits; is that right?
17 A. Would you say that again.
18 Q. I thought you had testified that you were aware that some
19 clinicians and/or medical providers for Ms. Edmo had indicated
20 there were personality disorder traits.
21 A. I recall seeing that in the medical records.
22 Q. But then I believe you testified you don't have -- you
23 haven't seen any diagnosis of a personality disorder; is that
24 correct?
25 A. I have not seen a specific diagnosis of borderline

1 personality disorder or another specific personality disorder.
2 Q. What is cyclothymia?
3 A. Cyclothymia is a disorder where a person has manic
4 behaviors.
5 Q. Is that a personality disorder?
6 A. It can be a personality disorder, or it can be an aspect of
7 a bipolar disorder.
8 Q. Have you seen that diagnosis in the medical records for
9 Ms. Edmo?
10 A. Not that I recall.
11 Q. It was a while ago, but if I remember your testimony, I
12 believe you indicated that you treated about 3,000 gender
13 dysphoria patients.
14 Is that correct?
15 A. That's correct.
16 Q. And if I understood you correctly, you've referred about
17 300 of them for surgery?
18 A. Not 300 of the patients that I have seen, that I followed
19 personally. In some cases, I have written a second opinion
20 referral letter for individuals, which is something that occurs
21 on a one-time basis.
22 If you refer to the standards of care, a person who
23 undergoes genital surgery requires two referral letters, one by
24 someone who has followed them and one which is a onetime
25 second-opinion letter.

1 So I have written second-opinion letters, and I have
2 written letters for my own patients that I follow.
3 Q. Well, I just want to be clear. If I understood, you said
4 the 300-patient number, which I thought I understood to be
5 related to referrals to surgery.
6 And if that's incorrect, what was that reference for?
7 A. I have written approximately 300 letters, referral letters,
8 for surgery for gender dysphoria individuals.
9 Q. Okay. So that's 10 percent?
10 A. That's 10 percent of my practice, but that's not what it
11 refers to.
12 300 is 10 percent of 3,000, but I'm not saying that 10
13 percent of my patients have gone on for surgery. I'm saying I
14 have written 300 referral letters.
15 Q. I understand.
16 A. Do you understand?
17 Q. Thank you for clarifying.
18 So would the percentage be less than of your own patients
19 that have gone on for surgery?
20 A. Yes. Likely, it would be. Yes.
21 Q. Okay. And what percentage would that be?
22 A. That I can't calculate because some of the clients that I
23 have seen are children who wouldn't be eligible for surgery or
24 young adolescents.
25 Q. But less than 10 percent?

1 A. Likely less than 10 percent, yes.
2 Q. Okay. Thank you.
3 I believe you talked with Mr. Hall about regret rates.
4 Do you recall that?
5 A. Yes.
6 Q. And you seem pretty certain about the 1 percent or less of
7 folks that have gender confirmation surgery have regrets; is
8 that correct?
9 A. That's according to the literature, yes.
10 Q. According to all literature?
11 A. According to, yes, the majority of the literature, yes.
12 Yes, including Anne Lawrence's articles. You referenced Anne
13 Lawrence earlier, and she has also documented those rates.
14 Q. But there is no studies about regret rates for incarcerated
15 gender dysphoria patients; correct?
16 A. Regret rates for incarcerated persons who have had surgery?
17 Q. Yes.
18 A. While they were incarcerated?
19 Q. Yes.
20 A. No, there are not.
21 Q. And haven't there been challenges to the studies for
22 regrets being not robust enough?
23 A. Not that I'm aware of.
24 MR. EATON: Your Honor, if I may, I just have to
25 toggle on my computer over here.

1 THE COURT: Yes.
2 Q. BY MR. EATON: I believe in our -- excuse me. I believe in
3 our deposition, we discussed the CMS decision.
4 Do you recall discussing that?
5 A. Yes.
6 Q. And what does "CMS" refer to? Do you know what that means?
7 A. Yes. It was the challenge to the Medicare decision of
8 2014.
9 Q. Okay. And it was a national-coverage decision that was
10 being made by CMS about gender reassignment surgery; correct?
11 A. Yes.
12 Q. I'm not sure if I hit the right button here. We'll see.
13 THE CLERK: Are you attempting to display from your
14 computer?
15 MR. EATON: I am, yes. Thank you.
16 THE CLERK: Are you using an HDMI or VGA connection?
17 MR. EATON: I believe it's an HDMI.
18 And is that Plaintiff 1 or 2?
19 THE CLERK: That's 1.
20 THE COURT: So you're trying to plug in at your table?
21 MR. EATON: Yes. I thought I was connected with an
22 HDMI over there and I could just pull it up on my computer, is
23 what I was trying -- it's already up on my computer, and I was
24 just trying to display it for the court.
25 THE COURT: Have you changed the input?

1 THE CLERK: I have. May I look?
2 THE COURT: Yes. Go ahead.
3 THE CLERK: Thank you.
4 So oftentimes they recommend connecting before you turn on
5 your computer, and that usually solves the problem. I don't
6 know if we have time to restart.
7 MR. EATON: I'll just try it through questions. I
8 apologize.
9 Q. BY MR. EATON: We looked at that document at the
10 deposition; correct?
11 A. Yes.
12 Q. Okay. And CMS did a thorough review of many studies.
13 Would you agree with that?
14 A. Yes. A review of the studies, yes.
15 Q. And these were reviews on regret rates after sex
16 reassignment surgery, among other things; correct?
17 A. Yes.
18 Q. All right. And the final decision was issued in 2016;
19 right? Is that your understanding?
20 A. Yes.
21 Q. And one thing they were considering, as well, is whether
22 they were going to recognize WPATH standards of care.
23 Do you understand that?
24 A. Yes.
25 Q. And they decided not to recognize the WPATH standards of

1 care as the exclusive standard.

2 You understand that; correct?

3 A. Yes.

4 Q. And since I'm not able to pull this up, I'm just going to

5 quote.

6 And for the court, it's Defendants' Exhibit 2034, 0065.

7 This is the summary at the end of this document. And it

8 says, quote:

9 "Based on extensive assessment of the clinical

10 evidence as described above, there is not enough

11 high-quality evidence to determine whether gender

12 reassignment surgery improves health outcomes for

13 Medicare beneficiaries with gender dysphoria and

14 whether patients most likely to benefit from these

15 types of surgical interventions can be identified

16 prospectively."

17 That's a quote from that. Do you recall that?

18 THE COURT: Just a moment.

19 MS. RIFKIN: Your Honor, may I provide a copy of this

20 exhibit to the witness?

21 THE COURT: Can we put it on the screen on the

22 evidence presenter so that she can see it?

23 MS. RIFKIN: I think defendants have a paper copy.

24 They quoted at length.

25 THE COURT: If you have a paper copy, you can show it

1 to the witness using the evidence presenter.

2 While Mr. Eaton is getting that, so I understand -- did I

3 understand this is some kind of a Medicare determination for

4 Medicare patients that these -- this treatment will not be

5 funded? Is that --

6 THE WITNESS: What it was, it was questioning the

7 efficacy of surgery for Medicare beneficiaries, which is a group

8 of individuals over age 65, as you well know.

9 THE COURT: That was going to be the point I was going

10 to ask.

11 THE WITNESS: And that was what the response was, that

12 that's not really an adequate control with the body of

13 literature that we typically look at.

14 THE COURT: You saved Ms. Rifkin 15 minutes of

15 redirect on that topic.

16 So go ahead, Mr. Eaton.

17 MR. EATON: Thank you. I apologize for the technical

18 difficulties. There we go.

19 Q. BY MR. EATON: Are you able to see this summary now?

20 A. Yes.

21 Q. Good deal.

22 And I was quoting that first paragraph. You see that

23 there?

24 A. Yes.

25 Q. Essentially what they decided is that -- is it your

1 understanding that CMS decided that there was not enough
2 high-quality evidence to determine whether gender reassignment
3 surgery improves health outcomes for Medicare beneficiaries with
4 gender dysphoria?
5 A. For Medicare beneficiaries, yes.
6 Q. That's your understanding.
7 And WPATH disagreed with that; correct?
8 A. WPATH offered a response to that.
9 And again, the studies of people over 65 have not been well
10 documented because it was only in 2014 -- it was actually
11 May 31st of 2014 -- that the Medicare began to provide surgeries
12 based on the evidence that they were not experimental, there
13 were few complications, and that they were efficacious.
14 MR. EATON: Your Honor, I would move to admit
15 Defendants' Exhibit 2034.
16 THE COURT: Any objection?
17 MS. RIFKIN: We object, Your Honor, based on both
18 relevancy and I believe this is a draft decision memo by
19 Medicare rather than their final decision memo that represents
20 the actual opinion of Medicare.
21 THE COURT: Mr. Eaton.
22 MR. EATON: Your Honor, this is on their website
23 currently. You can take judicial notice of it.
24 THE COURT: I can't take judicial notice of what's on
25 a website. That would open the door to lots of mischief.

1 MR. EATON: And it's a government entity.
2 MS. RIFKIN: As Your Honor has pointed out, Ms. Edmo
3 was not in the Medicare population, so we do not -- we object
4 based on relevancy.
5 THE COURT: Without more, I'm going to have to sustain
6 the objection. I mean, I don't know if it was based upon the
7 age of and the -- I mean, I think performing that surgery on
8 someone who is over 65 compared to someone who is in their 20s
9 or 30s is so radically different, that I just can't imagine it
10 really has much relevance.
11 Plus, there is hearsay issues, a number of other concerns.
12 So I'm going to sustain the objection.
13 MR. EATON: That's fine, Your Honor. We can address
14 it later.
15 Q. BY MR. EATON: And we also talked about in your deposition
16 about then Endocrine Society guidelines; correct?
17 A. Yes.
18 Q. And there is a 2009 version, and there's a 2017 version;
19 correct?
20 A. Yes.
21 Q. And you understand that the Endocrine Society in its 2017
22 version had indicated that there could be more robust studies
23 regarding regret rates.
24 We talked about that in the deposition; correct?
25 A. Yes.

1 We have just published a new study on regret rates,
2 actually, coming out of the University of Oregon.
3 MR. EATON: I'd move to strike. This is un -- not
4 responsive.
5 THE COURT: Sustained.
6 Yeah. Don't just volunteer statements. Just answer
7 counsel's questions.
8 Go ahead, Mr. Eaton.
9 MR. EATON: Your Honor, I don't believe I have any
10 further questions at this time.
11 THE COURT: All right. I am going to have just one or
12 two questions, Ms. Rifkin. This is the way I normally -- I wait
13 until counsel has all had one bite at the apple, and then...
14 EXAMINATION
15 BY THE COURT:
16 Q. You indicated that there was -- statistically, that studies
17 indicate that 1 percent or so of the individuals who have had
18 gender confirmation surgery later regretted that.
19 Has any analysis been done as to what the common features
20 were which led those individuals to regret the surgery?
21 A. Yes.
22 The most common cause is when the people went to
23 inexperienced surgeons and had poor surgical outcomes. So if
24 someone had surgery, Your Honor, and their urinary stream was
25 hitting the ceiling, they would be regretful. That was the most

1 typical reason for regret.
2 Q. But you've analyzed that. And is this something you work
3 with? I mean, it's not -- you're reporting to me --
4 A. What the studies have reported.
5 Q. Okay. All right. That's what I want to be clear about.
6 You indicated -- and I kind of got lost in the shuffle
7 there. But I understand that, although you have written
8 referrals for 300, a lot of those are kind of like second
9 opinions.
10 A. Correct.
11 Q. And so of the 3,000 patients with gender dysphoria that you
12 have either treated or evaluated, something less than 10 percent
13 you have recommended for gender confirmation surgery; is that
14 correct?
15 A. Yes.
16 Q. I mean, less than 10 percent, all the way from zero to 10
17 percent.
18 Can you pin it down a little more closely? Is 10 percent a
19 pretty good number, or is it something less than that?
20 A. I would say it's something more than that.
21 Q. More than 10 percent?
22 A. Yes.
23 Q. Okay.
24 A. 10 percent of -- I would say of the 300 referral letters I
25 have written, probably 200 were from patients that I, myself,

1 had followed preoperatively and was the primary provider.
2 Q. So 200 out of 3,000 patients, then, which is less than 10
3 percent?
4 A. Correct.
5 And then about 100 were people who came for a onetime
6 second opinion.
7 Q. All right. I'm really focusing more on the patients you
8 actually treated.
9 And so you're saying, roughly, 7 or 8 percent you
10 recommended for surgery. The remaining 92 or -3 percent, you
11 did not recommend, but they continued to receive some kind of
12 treatment, presumably hormone replacement or something of that
13 sort or --
14 A. Or sometimes they just are -- in the early days, they
15 couldn't afford surgery, before insurance covered it.
16 Q. Okay. What -- what I'm trying to get at is that
17 you -- there are some people who suffer from gender dysphoria
18 that you do not recommend surgery for; is that correct?
19 A. That's correct. There have been some cases where I have
20 actually refused surgery when people requested it or wanted it.
21 Q. Okay. I'm going to quit beating around the bush.
22 What I want to know is: Is it your opinion that
23 essentially every person who truly suffers from gender dysphoria
24 should be treated or at least be considered for treatment with
25 gender confirmation surgery?

1 A. No. For some people, hormones are sufficient treatment.
2 Q. Okay. And roughly, how do you break that group down?
3 I mean, just -- what I'm trying to get at is: What
4 percentage of the people you see should have been treated with
5 gender confirmation surgery?
6 A. A far smaller number than the people that are treated with
7 hormones.
8 Q. Okay. So less than half?
9 A. Yes.
10 Q. Okay. That's probably enough for my purposes.
11 And generally, is the distinguishing characteristics that
12 one or more of those criteria that we have discussed from the
13 WPATH organization were not met?
14 A. Typically, it's based on the severity of the gender
15 dysphoria.
16 Q. Okay. Now, you recommend here that Ms. Edmo should be
17 given gender confirmation surgery. So she is in that smaller
18 group that you feel that is the appropriate treatment.
19 And I assume, based on what you just said, primarily it's
20 because of the severity of the gender dysphoria that she suffers
21 from?
22 A. That's correct; that's my opinion.
23 Q. And that -- can you -- is there anything else you want to
24 elaborate as to what sets her case apart from the majority of
25 cases where you don't recommend gender confirmation surgery?

1 A. Yes. It's the inadequacy of the hormone therapy to
2 eliminate the gender dysphoria, and it's the desire to actually
3 perform the surgery herself, to remove the testicles.
4 So in the prisons, we see the natural progression of the
5 condition, and we see many people who attempt to remove their
6 own testicles to rid themself of the testosterone, because it is
7 the testosterone that causes the gender dysphoria. So if you
8 remove that target organ, you eliminate the gender dysphoria.
9 And taking pills is a different path of physiology. It
10 doesn't eliminate it entirely. But once you remove that organ
11 or, like, with a female, if you remove the uterus and the organs
12 that excrete estrogen in a person who is born female but wants
13 to be male, you have to actually remove the target organs to
14 eliminate the sex -- the nascent, the natural sex-circulating
15 hormones.
16 Q. Let me turn to one other question. I think it was the
17 fourth element on the -- maybe it was the third of the six
18 standards that you used.
19 As I recall -- and I don't have it in front of me. But as
20 I recall, it indicated that if there are serious mental health
21 concerns, then those need -- those must be -- what was the word?
22 A. Well controlled.
23 Q. -- well controlled.
24 While serious concerns almost pull a different direction.
25 "Serious" suggests something of significance, whereas a concern

1 suggests something short of a diagnosis.
2 So, as I thought about that, it struck me that perhaps
3 serious has to do with what the impact of that mental health
4 problem is on the individual.
5 In other words, everybody has some depression, everybody or
6 many of us do, I assume. Obviously, we all can suffer from
7 anxiety at times. But unless it is at a clinical level, it's
8 not something that would be -- that would trigger this
9 requirement or raise this concern that would require that it be
10 well regulated or well controlled; correct?
11 Can you --
12 A. I think that's correct.
13 What we're more concerned with are the thought disorders,
14 schizophrenia, the disorders that impair reality testing. So if
15 a person has, say, what we used to call multiple personality
16 disorder or bipolar disorder, those kinds of issues may impair
17 not only a person's ability to provide informed consent but to
18 comply with postoperative care or to even be reality based to
19 understand the risks involved with the surgery.
20 But depression and anxiety, if they are on medication and
21 their reality testing isn't impaired, as is the case with
22 Ms. Edmo, she can participate in decisions about her healthcare.
23 And what we find is that those issues actually decrease
24 after surgery. People are less depressed because they are not
25 feeling gender dysphoric any longer; they are cured of that.

1 Q. And there is no way to eliminate -- I mean, that's one of
2 the challenges. You assume, perhaps, as a clinician, that if
3 you remove stressors, you can resolve at least some of the more
4 minor, nonchemical-based mental issues. And so you're left
5 somewhat to guess.
6 But the thought would be if I -- again, I don't have the --
7 what Mr. Hall used during his closing *[sic]*, but those various
8 mental health concerns may -- perhaps all of those might well be
9 the result of gender dysphoria, so that the depression, the
10 anxiety, the self-medication through drugs and alcohol, sexual
11 acting out -- I can't recall the others -- but all of those may
12 be tied to the gender dysphoria, but there is no way to know;
13 correct?
14 A. There is no way to know.
15 But for certain individuals, particularly if they grow up
16 in a culture where they are not -- they don't have information
17 about gender dysphoria, they don't understand why they feel the
18 way they do, they may self-medicate as a way of suppressing
19 those feelings.
20 Many individuals join the army or do hypermasculine
21 activities to try to cure themself of the condition. They have
22 children, they marry, thinking that this will finally end this.
23 But it doesn't, and it does intensify with age.
24 Q. But my question is: There is no real way to know, in
25 advance of the surgery, whether that is going to have that

1 effect and resolve some of those mental health concerns.
2 A. If we can distinguish that the depression and anxiety are
3 largely or partially part and parcel of the gender dysphoria,
4 then we can determine that they will be attenuated or
5 eliminated.
6 Q. Okay.
7 A. Many clients give up antidepressants after surgery because
8 they no longer need them -- not all but many.
9 Q. Okay. Is the gender dysphoria more severe, typically,
10 among those who are in prison than those who are not for any
11 reason?
12 That's kind of an awkward question. But is incarceration,
13 itself, a factor that may actually make the gender dysphoria
14 more disruptive of your normal thought processes?
15 I guess what I'm getting at is: Is being confined in an
16 all-male environment and then suffering from this, whether that
17 actually may --
18 A. That's an excellent question. I would say no.
19 Q. Well, if you don't have an opinion, then you probably
20 haven't offered it. Let's move on.
21 A. My opinion is no because it's a medical condition.
22 Q. Okay.
23 A. And we believe that it's brain based. There are functional
24 magnetic resonance imagery shows differences in the brains of
25 people who have severe gender dysphoria and people who don't,

1 primarily in the right hemisphere of the brain. I won't get
2 into all of the nerdy --
3 Q. Well, we don't have that --
4 A. -- science. Right.
5 Q. We don't have that testing done in this case in any event.
6 A. No, we do not.
7 THE COURT: Counsel, I went on longer than I intended.
8 So let me -- we only have 20 minutes.
9 Ms. Rifkin.
10 MS. RIFKIN: Thank you, Your Honor.
11 REDIRECT EXAMINATION
12 BY MS. RIFKIN:
13 Q. Just to pick up on the court's question, Dr. Ettner. You
14 had referred before to the fact that your opinion that, in
15 prison, we see the natural progression of untreated gender
16 dysphoria.
17 What do you mean by that? Why in prison would we see --
18 or, in your opinion, do we see symptoms of gender dysphoria that
19 aren't as common to see on the outside?
20 A. Because people don't --
21 MR. HALL: Objection.
22 THE COURT: Just a moment.
23 MR. HALL: Objection. Foundation, Your Honor.
24 MR. EATON: Join.
25 THE COURT: Well, I opened the door to that. I don't

1 know -- counsel should have objected to my question, perhaps,
2 and see how far you get.
3 MR. HALL: Noted for the future, Judge.
4 THE COURT: Yeah. Let me --
5 MR. HALL: Judge, the objection is based on just a
6 lack of experience in a correctional institution and treating
7 anybody who has ever had gender dysphoria.
8 THE COURT: I think you noted on your CV that was on
9 the screen earlier that you had chaired sort of a subcommittee
10 of WPATH that focuses on incarceration of gender dysphoric
11 individuals.
12 THE WITNESS: I chaired the institutionalized
13 committee, yes.
14 THE COURT: And I have given you some leeway to talk
15 about that.
16 But is that more than just chairing a committee? Is that a
17 subpart or subfeature of your own expertise?
18 THE WITNESS: Yes. Yes.
19 THE COURT: You've worked specifically with inmates
20 suffering from gender dysphoria?
21 THE WITNESS: Not exclusively, but yes.
22 THE COURT: Well, I'm going to give some leeway here.
23 When we get into posttrial submissions, if it becomes important
24 to consider this, I'll kind of review whether or not there has
25 been enough foundation to establish expertise.

1 Go ahead and answer the question. I'm more concerned about
2 time right now than anything. Go ahead. Can you answer?
3 THE WITNESS: The question -- I think the answer is
4 that if people don't have access to healthcare treatments, to
5 medical treatments or surgical treatments, the disease will
6 unfold as would any disease.
7 So if a person had, for instance, pneumonia and they didn't
8 have access to the appropriate therapies, you would see the
9 disease progress. You would see damage to the lungs, possibly,
10 and possibly ultimate systemic bacterial infection.
11 Q. BY MS. RIFKIN: I would like to show you what has been
12 admitted Joint Exhibit 15, page 15 -- let's see -- I believe
13 that's page 22 of the exhibit that Mr. Hall showed you.
14 Mr. Hall asked you whether you had considered whether any
15 of Ms. Edmo's providers met these standards for WPATH mental
16 health professionals working with adults who present with gender
17 dysphoria.
18 Did you -- and you considered these standards; is that
19 right?
20 A. Yes. These are the WPATH criteria for competency for
21 qualified mental health professionals.
22 Q. And he asked you, when you rendered the opinion that her
23 providers did not -- are not competent under these standards --
24 -- whether you had been able to review their qualifications and
25 training.

1 Since you provided your report in this case, have you had
2 the opportunity to review the training provided to Ms. Edmo's
3 clinical providers?
4 A. Yes.
5 Q. I would like to show you what is Joint Exhibit 17.
6 This PDF, "Medical Necessity for Transgender Inmates in
7 Search of Clarity When Paradox, Complexity and Uncertainty
8 Abound" by Dr. Stephen Levine, is this one of the training
9 materials you reviewed that you understand was provided to
10 Ms. Edmo's treaters?
11 A. Yes.
12 Q. Are you familiar with Dr. Stephen Levine, Dr. Ettner?
13 A. Yes.
14 Q. What is Dr. Levine's reputation in the field of treating
15 gender dysphoria?
16 A. Dr. Levine is considered to be an outlier in the field. He
17 is anti WPATH. And Dr. Levine has his own personal theory about
18 gender dysphoria and its treatment and about the types of people
19 that complain about gender dysphoria in prisons.
20 Q. Is Dr. Levine part of WPATH?
21 A. No. He left WPATH after Standards of Care 5.
22 Q. And I would like to show you what is page 43 of this
23 exhibit and call your attention -- maybe we can blow it up to
24 the second main bullet point, "SRS is not conceived as
25 lifesaving." There we go.

1 Part of Dr. Levine's presentation to the -- Ms. Edmo's
2 providers, he said:
3 "SRS is not conceived as lifesaving, as is repairing a
4 potentially leaking aortic aneurysm, but is
5 life-enhancing, as is providing augmentation for women
6 distressed about their small breasts."
7 Is this an opinion about surgery to treat gender dysphoria
8 that's generally accepted in the field?
9 A. It is not.
10 Q. Let's show page 44 of this same exhibit. And let's blow up
11 the last bullet point here.
12 Dr. Levine's presentation training says:
13 "To date, most GD inmates in American prisons have not
14 had any major complications other than frustration and
15 the sense that the DOC does not care about their
16 suffering."
17 Do you -- is that statement consistent with your experience
18 and expertise, Dr. Ettner?
19 A. It is not.
20 Q. Are you aware of any literature, peer-reviewed studies,
21 data that supports this conclusion by Dr. Levine?
22 A. No.
23 Dr. Levine's personal theory about gender dysphoria doesn't
24 have any scientific documentation to accompany it. It appears
25 to be his own -- his own theory that is at odds with WPATH but

1 is not based in any scientific documentation.
2 Q. And turning to the next page, page 45 of this exhibit,
3 looking at the third bullet point down, Dr. Levine's training
4 stated that:
5 "Most preoperative trans females have learned to
6 ignore their penis most of the time even though its
7 functions remind them of their maleness."
8 Is this consistent with your experience and expertise,
9 Dr. Ettner?
10 A. No, it's not.
11 Q. Are you aware of any evidence, data, research, or
12 literature that supports this statement by Dr. Levine?
13 A. No.
14 I think one of the problems is that these statements paint
15 people all with the same brush rather than considering
16 individuals on case-by-case basis. And all of medicine, best
17 practice medicine, is based on an individualized basis.
18 Q. And if we can turn to page 58 of this exhibit. And go to
19 the last, No. 6.
20 Dr. Levine's training provided to Ms. Edmo's providers
21 under 6A states:
22 "This may explain their motivation to exaggerate their
23 distress, gender dysphoria."
24 Do you believe this statement is an accurate reflection of
25 all patients with gender dysphoria in prison?

1 A. I don't, no.
2 Q. So if we can return back to Joint Exhibit 15, page 22.
3 THE COURT: Counsel, what was the exhibit you were
4 just referencing here?
5 MS. RIFKIN: Joint Exhibit 17. And I'm sorry,
6 Your Honor. It's one of the ones already been admitted.
7 THE COURT: No. I'm not faulting you. I just didn't
8 catch the exhibit number. So thank you.
9 Q. BY MS. RIFKIN: All right. So if we can kind of blow up
10 the No. 6 under the WPATH standards here.
11 Based on your now opportunity to review the training
12 materials and the training that was provided to Ms. Edmo's IDOC
13 and Corizon treaters, do you believe that Dr. Levine's training
14 satisfies the requirement that they have continuing education in
15 the assessment and treatment of gender dysphoria such that they
16 become qualified providers?
17 MR. HALL: Objection. Foundation, relevance. This
18 goes beyond the scope of the report.
19 MR. EATON: Join.
20 THE COURT: Just a moment.
21 MS. RIFKIN: Your Honor, if I may?
22 THE COURT: Yes.
23 MS. RIFKIN: Your Honor, defense counsel, both of
24 them, actually asked Dr. Ettner about reviewing the
25 qualifications of the providers. And this is the exhibit that

1 Mr. Hall showed Dr. Ettner. So they opened the door.
2 MR. HALL: That's not my objection.
3 THE COURT: Just -- what is -- do you want to restate
4 the objection, Mr. Hall?
5 MR. HALL: Foundation, Your Honor, and relevance
6 talking about Levine. Levine is not here. He is not an expert
7 in this case.
8 THE COURT: And he is not going to testify?
9 MR. HALL: He is not going to testify.
10 THE COURT: But he did provide a presentation to at
11 least Corizon, if not IDOC as well, on this issue of what
12 policies should be followed in Ms. Edmo's case and other
13 inmates; is that accurate?
14 MR. HALL: Well, I think it's one training,
15 Your Honor. But she is drawing the conclusion -- she doesn't
16 even know who was at this training, let alone what provider --
17 THE COURT: I think counsel's question was whether or
18 not the training as reflected in those PowerPoint slides
19 satisfies this continuing education requirement.
20 What exhibit number is this?
21 MS. RIFKIN: This particular exhibit is Joint Exhibit
22 15, Your Honor.
23 THE COURT: All right. Thank you.
24 Whether or not -- in terms of compliance with the WPATH
25 standards; correct?

1 MS. RIFKIN: Correct.
2 THE COURT: I'll overrule the objection.
3 You may answer.
4 THE WITNESS: Dr. Levine's training does not align
5 with the WPATH standards, and it is not -- in my opinion, it
6 does not provide an appropriate knowledge base for providers to
7 learn about gender dysphoria, how to assess it, how to generate
8 treatment plans. And it is not considered relevant because he
9 is an outlier and has a different philosophical approach than
10 all of the organizations that I mentioned previously.
11 Q. BY MS. RIFKIN: And just a couple of more questions,
12 Dr. Ettner.
13 During Mr. Hall's cross-examination, he identified -- he
14 asked you about a number of traits that might be associated with
15 borderline personality disorder, such as impulsivity or a
16 history of abusive relationships.
17 In your experience and based on your expertise, are some of
18 these traits that Mr. Hall talked about -- are they uncommon in
19 individuals with untreated gender dysphoria?
20 A. No. And they are also not uncommon in other disorders.
21 Impulsivity is a characteristic of attention deficit disorder,
22 for example.
23 Q. In your opinion, are Ms. Edmo's current treatment providers
24 experienced and able to distinguish between symptoms of gender
25 dysphoria and other mental health conditions?

1 MR. HALL: Objection. Beyond the scope, foundation.
2 MR. EATON: Join.
3 THE COURT: I'm going to sustain the objection,
4 Counsel. I think we're getting beyond the scope of cross, and I
5 don't know whether or not there was any disclosure of these
6 opinions as well.
7 MS. RIFKIN: Your Honor, defense counsel asked
8 Dr. Ettner many questions representing that these traits had
9 been identified by Ms. Edmo's treating providers and -- as
10 borderline personality or personality traits. He didn't present
11 the records, but asked Dr. Ettner about this.
12 THE COURT: Has she evaluated -- I thought I
13 understood from her earlier testimony that she had not, at least
14 as of the time she prepared the report, reviewed the underlying
15 documents.
16 How can she offer an opinion as to the ability and
17 experience of the current treatment providers.
18 MS. RIFKIN: Your Honor, on July 10, 2018, the expert
19 disclosures in this case, Dr. Ettner offered a second
20 declaration that contained her first declaration and was largely
21 the same, but it states that she had then received the entire
22 medical file.
23 THE COURT: Okay. But was the opinion that you are
24 now asking her as to whether or not treatment providers were or
25 were not experienced and skilled enough to distinguish between

1 general mental health conditions and gender dysphoria?
2 MS. RIFKIN: Yes. I would like to --
3 THE COURT: You can ask the same question that's in
4 the disclosure, and then let's move on.
5 MS. RIFKIN: All right. Can we show the July 10,
6 2018, expert report, paragraph 11.
7 THE COURT: And I can see it as long as you stay
8 within the bounds of that report --
9 MS. RIFKIN: Our only copy is electronic.
10 I'm sorry. Paragraph 12.
11 Q. BY MS. RIFKIN: Was it your opinion, Dr. Ettner, that
12 Ms. Edmo's medical providers demonstrate -- that their notes
13 demonstrate that they do not have the training or expertise to
14 understand gender dysphoria as a serious medical condition
15 requiring treatment?
16 A. That wasn't, is my opinion.
17 MS. RIFKIN: Thank you. No further questions.
18 THE COURT: Mr. Hall.
19 Counsel, I can stay five minutes. It's almost 2:30, but I
20 have a class coming in fairly soon. And so I don't know -- do
21 you have just a few questions, or are we -- how much time do you
22 need?
23 I'm not saying I'm going to cut you off. We'll come back
24 tomorrow morning if we need to, but I hate to hold Dr. Ettner
25 here.

1 MR. HALL: I agree, Your Honor. Can we have three
2 minutes just to confer?
3 THE COURT: Well, if I take a recess, three minutes
4 will become ten. So why don't you just -- we'll stay in the
5 courtroom, and you can visit.
6 MR. EATON: I just have one follow-up question,
7 Your Honor.
8 THE COURT: Yes.
9 RECROSS-EXAMINATION
10 BY MR. EATON:
11 Q. Dr. Ettner, you don't purport to know all of the trainings
12 that the medical providers at the Idaho Department of
13 Corrections and Corizon have received; correct -- on gender
14 dysphoria?
15 A. Only what I read in their declarations and in their
16 depositions when questioned about their training in gender
17 dysphoria.
18 Q. Have you seen any other PowerPoint slides that have been
19 presented to Corizon or IDOC other than the Levine slides that
20 you have seen?
21 A. I believe I saw some slides by Mr. Clark.
22 Q. Any others that you're aware of?
23 A. Not that I recall.
24 MR. EATON: Nothing further, Your Honor.
25 THE COURT: Anything else?

1 MR. HALL: No further questions.

2 THE COURT: Anything else, Ms. Rifkin?

3 MS. RIFKIN: No, Your Honor.

4 THE COURT: All right. We'll get you off the stand.

5 Counsel, we'll reconvene at 8:30 again tomorrow morning.

6 Same -- we will probably go until 3:00, just to catch up on the

7 time that we lost this morning.

8 Is there anything else we need to take up this afternoon?

9 MS. RIFKIN: Not from plaintiff, Your Honor.

10 MS. FERGUSON: Thank you, Your Honor.

11 Just our concern was Ms. Edmo did not -- she left the

12 prison this morning at 6:30; it was called out for

13 transportation. She wasn't given any breakfast. She arrived

14 here at almost 9:00 and without -- you know, in a rush to

15 change. So we're just hoping that the prison could please

16 remedy that.

17 THE COURT: Mr. Hall, I'm sure can make sure that

18 doesn't happen tomorrow morning. And that was both a question

19 and kind of a suggestion.

20 MR. HALL: Your Honor, I will not be driving the van

21 or doing the call-out, but I will do my best to talk to my

22 client and make sure that she is here earlier.

23 THE COURT: All right.

24 MR. HALL: Your Honor, I do believe there was a little

25 bit of confusion because the initial transport order was for

1 7:30; that was moved to 8:30.
2 What time can Ms. Edmo be here in the morning in regards to
3 the marshals? Are they able to accept her at 7:30?
4 THE COURT: Why don't I let you work -- Mr. Severson
5 will perhaps put you in touch with the marshal, if need be, so
6 you can work that out.
7 MR. HALL: Thank you.
8 THE COURT: Maybe all three parties -- three attorneys
9 can get together with Mr. Severson and work out the details.
10 And I think perhaps allowing her to change clothes before she
11 comes might be an answer, as well, just to make it easier on
12 everyone. But however you work that out is fine with me.
13 Okay. Mr. Eaton, anything else?
14 MR. EATON: Not at this time, Your Honor. Thank you.
15 THE COURT: We will be in recess until 8:30 tomorrow
16 morning.
17 Sorry. I would like to see Exhibits -- either hard or
18 electronic copies of Exhibits 15 and 19 so I can look at them.
19 If you can submit them by email if they are electronic. If you
20 have hard copies and they are not terribly long, give them to
21 Mr. Severson.
22 All right. We will be in recess.
23 (Court recessed at 2:35 p.m.)
24
25

1 CERTIFICATE OF OFFICIAL REPORTER

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6 I, Tamara Hohenleitner, Federal Official Realtime

7 Court Reporter, in and for the United States District Court for

8 the District of Idaho, do hereby certify that pursuant to

9 Section 753, Title 28, United States Code, that the foregoing

10 is a true and correct transcript of the stenographically

11 reported proceedings held in the above-entitled matter and that

12 the transcript page format is in conformance with the

13 regulations of the Judicial Conference of the United States.

14

15 Dated this 19th day of October, 2018.

16

17

18 /S/ TAMARA I. HOHENLEITNER

19 TAMARA I. HOHENLEITNER, CSR NO. 619, CRR
FEDERAL OFFICIAL COURT REPORTER

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