

UNITED STATES DISTRICT COURT

DISTRICT OF IDAHO

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

**TRANSCRIPT OF PROCEEDINGS - VOLUME 1
 BEFORE THE HONORABLE B. LYNN WINMILL
 WEDNESDAY, OCTOBER 10, 2018, 8:53 A.M.
 BOISE, IDAHO**

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 produced by computer.

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P R O C E E D I N G S

October 10, 2018

THE CLERK: The court will now hear Civil Case 17-151, Adree Edmo vs. Corizon, Incorporated, regarding a motion for preliminary injunction.

THE COURT: Good morning, Counsel.

Before we start, first, I will be taking a moment to log in. But while I'm doing that, I wanted to let you know a couple things.

One is Ms. Hohenleitner had agreed that she should be able to prepare the transcript within a week, I think, after the trial is completed. The challenge is that we had not anticipated a case set for trial next week which we thought had been resolved but was not. So we will be in trial next week. And I'm in trial the two weeks after that as well. So I have got back-to-back trials going from now through the next four weeks.

And Ms. Hohenleitner, that puts quite a burden on her. And I think she was anticipating that she would be able to take care of the transcript next week when we were not in trial. And, of course, that has now changed.

So I can't put undue pressure on her, and so this may affect her ability to get the briefing -- the transcript to you in preparation for the final briefing and submission of findings 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 *Frye* 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 themselves 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.

CROSS-EXAMINATION

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BY MR. HALL:

Q. Dr. Ettner, nice to see you again.

We had an opportunity to spend a few hours out in Chicago recently, didn't we?

A. Yes.

Q. And I told you I wasn't wearing a tie then, but I would wear a tie today. And I did wear a tie, as I promised.

A. Yes. I recall your making that promise.

Q. I keep my promises.

Doctor, I don't have a lot of time with you today. So in the interest of time, I'm going to ask some very pointed questions. It's really going to call for just a yes, no, correct, incorrect. And I would appreciate if you could answer that way.

A lot of these you have already answered in your deposition, but I have to get them on the record here today.

Is that fair?

A. Yes.

Q. Okay. Thank you.

Now, Doctor, you are not a certified correctional health professional, also known as CCHP, which is a designation from the National Commission of Correctional Health; correct?

A. That's correct.

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 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 themselves 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 themselves 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 RECCROSS-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.)
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CERTIFICATE OF OFFICIAL REPORTER

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I, Tamara Hohenleitner, Federal Official Realtime Court Reporter, in and for the United States District Court for the District of Idaho, do hereby certify that pursuant to Section 753, Title 28, United States Code, that the foregoing is a true and correct transcript of the stenographically reported proceedings held in the above-entitled matter and that the transcript page format is in conformance with the regulations of the Judicial Conference of the United States.

Dated this 19th day of October, 2018.

/S/ TAMARA I. HOHENLEITNER

TAMARA I. HOHENLEITNER, CSR NO. 619, CRR
FEDERAL OFFICIAL COURT REPORTER

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