

1 UNITED STATES DISTRICT COURT

2 DISTRICT OF IDAHO

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

14

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16 **TRANSCRIPT OF PROCEEDINGS - VOLUME 2**
BEFORE THE HONORABLE B. LYNN WINMILL
17 **THURSDAY, OCTOBER 11, 2018, 8:33 A.M.**
18 **BOISE, IDAHO**

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22 produced by computer.

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P R O C E E D I N G S

October 11, 2018

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

THE COURT: Good morning. I believe we were ready for the plaintiffs to call their next witness.

With that, Ms. Rifkin.

MS. RIFKIN: Yes, Your Honor. We would like to call plaintiff, Adree Edmo, Your Honor.

THE COURT: Ms. Edmo, would you please step before the clerk and be sworn.

ADREE EDMO, PLAINTIFF, SWORN

THE COURT: We got started off on the wrong -- typically you walk in front of the clerk's space. But that's all right. We started that yesterday with Dr. Ettner.

THE CLERK: Please state your complete name and spell your name for the record.

THE WITNESS: My name is Adree Edmo. My first name is Adree, A-D-R-E-E. My last name is Edmo, E-D-M-O.

THE COURT: You may inquire.

MS. RIFKIN: Thank you.

DIRECT EXAMINATION

BY MS. RIFKIN:

Q. Good morning, Ms. Edmo.

1 A. Good morning.

2 Q. Is Adree Edmo your legal name?

3 A. Yes, it is.

4 Q. And has it always been your legal name?

5 A. No, it has not.

6 Q. When did you start using the name "Adree"?

7 A. Approximately in 2013.

8 Q. And when did you legally change your name?

9 A. In September of 2013.

10 Q. How did you pick the name "Adree"?

11 A. My older brother was having a daughter, his first daughter,
12 and he had been asking a name for his daughter. And I proposed
13 the name "Adriana."

14 Shortly after she was born, I found out that he had
15 actually chosen Adriana, and I really enjoyed the name Adriana.
16 So I shortened it to "Adree," which is my legal name now.

17 Q. And how old are you, Ms. Edmo?

18 A. 30 years old.

19 Q. How long have you been incarcerated?

20 A. Since 2012.

21 Q. What is your education?

22 A. I have some college education. I completed a paralegal
23 certificate program through Adams State University of Colorado.
24 It's an extended college program specifically for prisoners.

25 Q. And prior to incarceration, where did you primarily live?

1 A. In Fort Hall, Idaho, on the Fort Hall Indian Reservation.

2 Q. What tribe are you enrolled with?

3 A. I am enrolled into the Shoshone-Bannock tribes.

4 Q. Ms. Edmo, what is your gender identity?

5 A. Female.

6 Q. And how do you know that you are female?

7 A. The best way to explain it is my brain typically operates
8 female, even though my body hasn't corresponded with my brain.
9 My brain operates, I guess, in a way similar to as a female, is
10 the best way I can explain it.

11 Q. When do you first remember feeling that way?

12 A. About the age of around 5 or 6.

13 Q. Did you have a name at that time for what you were feeling?

14 A. No, I did not.

15 Q. And what is your sexual orientation?

16 A. I'm attracted to heterosexual men. So I guess my sexual
17 orientation would be heterosexual.

18 Q. Was there a time that you identified as any other sexual
19 orientation?

20 A. Before learning about gender identity and transgender, a
21 lot of people around me had identified me as being gay, even
22 though, to me, that wasn't necessarily the right word that I
23 would choose, but I accepted it.

24 Q. And what is your understanding of what gender dysphoria
25 means?

1 A. My understanding of gender dysphoria is it means it's an
2 incongruence between a person's -- a feeling of who they are,
3 whether they are male or female. And it's a difference between
4 a person's innate sense of female or male as compared to what
5 they were assigned at birth.

6 Q. When did you learn what gender dysphoria or gender identity
7 disorder is?

8 A. Approximately, I would say for sure in 2012.

9 Q. And was that while you were incarcerated or prior?

10 A. While I was incarcerated.

11 Q. What is the experience of having gender dysphoria like for
12 you?

13 A. The typical feelings that I feel with gender dysphoria are
14 I feel depressed; I feel -- sometimes, when it's extreme, I feel
15 disgusting; I feel tormented; I feel hopeless; and I feel like,
16 with no hope, I have no, like, reason to keep on going. It's
17 pretty extreme.

18 Q. Are there times that it gets better, times that it gets
19 worse?

20 A. I would have to say it's there all the time, but there are
21 times where it is worse, like extremely worse. And there are
22 times where it's not as bad, but it's still there in the
23 foreground.

24 Q. And you said that you identify as female.

25 How do you express yourself as female?

1 A. So, with me, I have always identified as female, I guess,
2 in a sense. I do wear makeup. I have grown my hair out. I
3 have similar gestures as females. I walk, my voice is feminine.
4 I just have, I guess, general mannerisms that you would see in a
5 typical female.

6 Q. And why -- why is wearing makeup something that's important
7 to you?

8 A. It helps create, like, an egosyntonic state of mind. It
9 helps me express on the outside about what I feel on the inside.
10 It helps me give people an idea of who I truly am on the inside.

11 Q. Have you been disciplined for presenting as feminine in
12 prison?

13 A. Yes, I have.

14 Q. Why keep presenting as feminine even though you have been
15 punished for it?

16 A. It's -- it's -- honestly, it's all I ever know. I mean, I
17 don't know what it means to have male or to be a man, as they
18 say. I don't know -- that doesn't -- I can't comprehend that.
19 I just act this way that I am now. It's the only way that I
20 know.

21 Q. Do you think it would be easier to stop presenting
22 outwardly as feminine, to cut your hair and not wear makeup?

23 A. It would not be easy.

24 Q. And why?

25 A. Because it would be -- it would be making me feel like I

1 had to conform to something or somebody that I'm not. And that
2 is not who I am. I mean, it would -- it's embarrassing. It's
3 difficult and it's depressing.

4 Q. Besides gender dysphoria, do you have any other mental
5 health diagnoses that you're aware of?

6 A. The only one that I am sure that I'm aware of is major
7 depressive disorder.

8 Q. Have you received treatment for gender dysphoria?

9 A. I have received hormonal therapy. I received some pretty
10 much process groups of gender dysphoria, and that's about the
11 extent of what I have received.

12 Q. How long have you been receiving hormones for gender
13 dysphoria?

14 A. Since 2012.

15 Q. And how have these hormones affected you?

16 A. Mentally, they have -- I guess a better word is they
17 cleared my mind; whereas before, it was like a -- I guess a
18 cloud over my mental state. It felt like a blurriness. And
19 when I finally started taking hormones, it kind of felt like all
20 that fogginess and kind of -- became clear.

21 Physically, I have grown breasts. I have had body fat
22 redistribution from my waist to more so my hips. It's allowed
23 my skin consistency to change, meaning I have, like, softer
24 skin. I don't produce as much oil in my skin, so my skin is a
25 lot smoother.

1 Q. What kind of treatment are you seeking for gender dysphoria
2 in this lawsuit?

3 A. Sex reassignment surgery or gender confirmation surgery.

4 Q. Why are you seeking surgery?

5 A. Ultimately, I feel the gender confirmation surgery will
6 help me affirm my gender identity as female.

7 Q. Do you continue to experience distress related to gender
8 incongruence?

9 A. Yes.

10 Q. How do you feel about your genitals now?

11 A. They are disgusting. They feel like it's alien to my body.
12 It's embarrassing. Sometimes it's hard to comprehend that I
13 still have male genitalia. And it's even more so embarrassing
14 because I know that other people know that, especially being in
15 prison, and they capitalize on that. And it makes me feel even
16 more depressed, embarrassed, disgusted.

17 I feel -- I don't feel appreciated as who I feel I am, and
18 I feel just like a complete outcast.

19 Q. How often do you think about the kinds of things you just
20 described?

21 A. Every day. It's an everyday reoccurring thought. Every
22 day I wake up, and I have to remind myself that some day, at
23 some point, I will be okay enough, and I will have surgery, and
24 I can continue on in life.

25 Q. Have you taken any steps to try to treat yourself on your

1 own?

2 A. Yes. In 2015, I attempted to castrate my testicles. I
3 used a razor blade that we get at the prison. And I broke open
4 the disposable razor blade, and I attempted to cut the testicle
5 sac open.

6 I did leave a note before I did it, letting the officers
7 know that I in no way -- I was not trying to commit suicide. I
8 was only trying to help myself.

9 And in December of 2016, again, I tried to castrate my
10 testicles; this time I got further. I used a disposable blade
11 again. I broke it out of the razor. And this time, I actually
12 got into the testicle sac and got out the testicle.

13 But I wasn't able to actually sever the testicle because
14 there was too much blood. I didn't know there would be that
15 much blood in that area, and I couldn't see anymore what I was
16 cutting. So I abandoned it and got medical help.

17 Q. Can you describe how you were feeling at the time that you
18 attempted to cut your testicle off?

19 A. I can remember right before it, I had a sense of urgency.
20 I felt like this was -- this was -- like I had to do this. I
21 felt like it was going to benefit me in the long run, and I felt
22 like it was a decision that I had to make. I felt ready. I had
23 adrenaline pumping through my body, and I felt like it
24 was -- like it was going to happen.

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

1 you sought medical help.

2 What happened?

3 A. The emergency personnel that we have at the prison arrived.
4 They assessed me as best they could right there and took me to
5 the medical building at the prison. And then from there, they
6 called the ambulance, and I went to Saint Alphonsus hospital.

7 Q. And what happened at the hospital?

8 A. They gave me some more pain medication, and they -- I
9 waited for a while for a urologist, I think it is. And once the
10 urologist arrived, she kind of assessed the situation.

11 But due to, like, the adrenaline wearing off, I was in so
12 much pain that she had said I would need anesthesia to go under,
13 and then she repaired my testicle.

14 Q. Were you offered a choice as to whether your testicle would
15 be repaired?

16 A. No.

17 Q. And how did you feel after -- after it was repaired and you
18 came out of the anesthesia?

19 A. After I came to and they brought me back to the prison, I
20 was pretty disappointed in myself. Because I felt like I made
21 it that far, and I was kind of upset because I was, like, I was
22 so close, and I should have finished it. I was just pretty
23 disappointed in myself, ultimately.

24 Q. Do you worry that you will try to castrate yourself again?

25 A. Given the extreme episodes that I go through in gender

1 dysphoria, I -- I don't doubt that I would actually try it
2 again. I don't -- I can't tell you when I will have another
3 extreme episode of gender dysphoria. I don't know when it's
4 going to happen. I just know that it's always there, and
5 sometimes it's worse than others.

6 Q. And what do you do when -- at the times when it's worse
7 than others now?

8 A. Well, I have been self-medicating by using a razor to cut
9 my arm. Because while I'm in a gender dysphoric episode, the
10 mental anguish and torment I go through about who I feel I am
11 versus my physical body, I need to feel actual pain to actually
12 bring me out of that episode, to realize, you know, I need to
13 keep as much tissue down there for surgery to be successful.
14 But at the time, cutting my arm and feeling that physical pain
15 releases that emotional torment that I feel at that time.

16 Q. What do you expect the results of gender confirmation
17 surgery to be for you?

18 A. Ultimately, I expect to have the complete production of
19 testosterone stopped and ultimately my genitals turned into a
20 vagina.

21 Q. What kinds of challenges in your life do you think you
22 might have after gender confirmation surgery?

23 A. I know that gender confirmation surgery is not a fix-all.
24 It's not a magic operation. It's not going to make my life
25 completely fantastic or blissful afterwards.

1 I'm still going to face the same stressors that we all face
2 in everyday life, you know, medical, family, relationship
3 issues. I just know that after having gotten the surgery, it's
4 going to put me at a level a lot better to handle those types of
5 situations than I am now.

6 Q. Do you expect gender confirmation surgery to affect your
7 mental health condition of depression one way or the other?

8 A. Definitely. I feel like I won't have as much depression
9 about myself and about my physical body. I don't think I will
10 be so anxious that people are always knowing that I'm different,
11 and I feel like in -- you know, not only that, I feel like I can
12 actually express who I truly am more visibly and just more
13 adequately.

14 Q. When do you expect to be released from prison?

15 A. In 2021.

16 Q. Do you feel prepared to live in the community as a woman?

17 A. I don't think that there is a major difference to whether
18 or not you step outside the prison and automatically it's like a
19 dramatic change. I mean, I have been living myself since 2012
20 and even before that. So it's not a major difference.

21 I'm about as ready as any person getting out of prison. I
22 will continue to wear makeup. I will continue to wear female
23 clothing.

24 Q. Have you had a job while you have been in prison?

25 A. Yes, I have. I have had two, actually.

1 Q. And at the jobs, have you presented feminine in terms of
2 hair and makeup, as you've described?

3 A. Yes, I have. I've -- actually, as of yesterday, I just
4 barely got my employment back at the Idaho Correctional
5 Industries, which they call "CI." I work out there.

6 Before -- before yesterday, I was working as a production
7 clerk in the production office at Correctional Industries. I
8 went to an interview yesterday, and I was able to get my
9 position back. And I will continue to work as a -- basically an
10 office clerk.

11 Q. If you were in the community right now and had the freedom
12 to dress however you chose and present yourself however you
13 wanted, do you think you would still seek gender confirmation
14 surgery?

15 A. Absolutely.

16 Q. How do correctional officers in the prison address you?

17 A. They address me as "him" or "Mr. Edmo." There are very few
18 and far between that actually address me as just "Edmo." But a
19 lot of them use the pronoun of "he," "him," "his."

20 Q. And what about medical and mental health staff? What
21 pronouns do they use?

22 A. The same. They are mostly -- they use "him," "his."
23 Multiple occasions, they use "Mr. Edmo." Very few medical
24 providers ever call me "Edmo." Very rarely do I ever hear any
25 of them call me "Ms. Edmo."

1 Q. How does that make you feel?

2 A. Since it's been happening since 2012, it irritates me, it
3 embarrasses me. But at the same time, I just kind of have to go
4 with it besides trying to argue with them. I mean, it's really
5 frustrating.

6 Q. And I would like to show you what's been marked as
7 Plaintiff's Exhibit 2.

8 THE COURT: Is that a joint exhibit?

9 MS. RIFKIN: No, Your Honor.

10 THE COURT: Then it's 1002?

11 MS. RIFKIN: I'm sorry. Yes. I'm sorry. Plaintiff's
12 Exhibit 1002.

13 Q. BY MS. RIFKIN: Do you recognize this document, Ms. Edmo?

14 A. Yes. It's my birth certificate.

15 Q. And what sex does it list?

16 A. Female.

17 Q. Has your birth certificate always listed female?

18 A. No, it has not.

19 Q. Did you have it changed?

20 A. Yes.

21 Q. Why did you want it changed?

22 A. Because it helps affirm my identity as a female.

23 MS. RIFKIN: I would like to move Plaintiff's Exhibit
24 1002 into evidence.

25 THE COURT: Any objection?

1 MR. HALL: No objection.

2 MR. EATON: No objection.

3 THE COURT: 1002 will be admitted.

4 (Plaintiff's Exhibit 1002 admitted.)

5 MS. RIFKIN: I have no further questions at this time.

6 THE COURT: Cross.

7 MR. HALL: Yes, Your Honor.

8 THE COURT: Mr. Hall.

9 CROSS-EXAMINATION

10 BY MR. HALL:

11 Q. Good morning, Ms. Edmo.

12 A. Good morning.

13 Q. It's nice to see you again. If you don't remember me, I'm
14 one of the attorneys for the Department of Corrections. We had
15 an opportunity to spend a good seven hours together this summer
16 at a deposition.

17 Do you recall that?

18 A. Yes, I do.

19 Q. And I asked you a number of questions that certainly we're
20 not going to go through today.

21 But were you truthful in the responses you gave at the
22 time?

23 A. Yes, I was.

24 Q. Okay. And you also had a clinical interview with a
25 Dr. Andrade.

1 Do you recall that --

2 A. Yes.

3 Q. -- this summer?

4 And he asked you a number of questions about your history.

5 Were you truthful with that?

6 A. Yes.

7 Q. Is it your habit to be truthful when talking with medical
8 providers?

9 A. Yes. To the best of my ability, yes.

10 Q. And is it your habit to be truthful when talking to mental
11 health providers?

12 A. Yes.

13 Q. Thank you.

14 Ms. Edmo, can you see the record that has been marked as
15 Defendant's Exhibit 2007?

16 A. Yes, I see it.

17 Q. Okay. Did you have an opportunity to receive treatment
18 from the Shoshone-Bannock Tribes Counseling and Family Services
19 in 2011?

20 A. I believe so.

21 Q. And do you recall that this followed a suicide attempt that
22 you had made on yourself in that time?

23 A. I don't remember the -- I don't remember having an intake
24 assessment, but --

25 Q. Do you recall --

1 A. -- I remember a suicide attempt in that year, yes.

2 Q. Do you recall -- and you had treatment with a Dr. Palmer in
3 this time period; correct?

4 A. I don't remember his name.

5 Q. I think you referenced it earlier.

6 MR. HALL: I would like to move to admit Exhibit
7 No. 2007, Your Honor. It's been stipulated.

8 THE COURT: Any objection?

9 MS. RIFKIN: No objection.

10 THE COURT: 2007 will be admitted.

11 (Defendants' Exhibit 2007 admitted.)

12 Q. BY MR. HALL: Ms. Edmo, I have had placed here Exhibit
13 No. 2009.

14 Isn't it true that you received emergency medical treatment
15 in 2011 as well as in 2010 for two separate suicide attempts?

16 A. Yeah, I believe so.

17 MR. HALL: Okay. I would like to move to admit
18 Exhibit No. 2009.

19 THE COURT: Any objection?

20 MS. RIFKIN: No, Your Honor.

21 THE COURT: 2009 will be admitted.

22 (Defendants' Exhibit 2009 admitted.)

23 Q. BY MR. HALL: While we're on this housekeeping, do you
24 recognize the document that's been marked as 2016?

25 A. I -- yes, I can roughly remember it. I don't absolutely

1 remember the absolute context of it.

2 Q. Right. Do you recall having a gender dysphoria group with
3 a Clinician Watson?

4 A. Yes. That would have to be in 2012, 2013.

5 Q. Okay. And this is a document that you produced as part of
6 a homework assignment; correct?

7 A. I believe so. I can't really exactly remember.

8 Q. On the third page of Exhibit No. 2016, there is a signature
9 down there.

10 Is that your signature, Ms. Edmo?

11 A. Yes.

12 MR. HALL: I would like to move to admit Exhibit
13 No. 2016.

14 THE COURT: Any objection?

15 MS. RIFKIN: No.

16 THE COURT: 2016 is admitted.

17 (Defendants' Exhibit 2016 admitted.)

18 Q. BY MR. HALL: And we had talked about your preincarceration
19 history of suicide attempts. There were a couple in the
20 2010-2011 time frame; correct?

21 A. Yes.

22 Q. Okay. And in this document, you discuss living in
23 Washington and dating a man named Casey, sometime prior to
24 moving to Idaho in 2009.

25 Do you recall that?

1 A. Yes, in 20- -- prior, yes.

2 Q. Okay. You had a fight with Casey. And as a result of
3 that, you took it hard, and you attempted suicide; is that
4 correct?

5 A. I believe so.

6 Q. Okay. And then you moved back to Idaho; correct?

7 A. I don't think I ever moved to Washington, but I was in
8 Washington, and I came back to Idaho.

9 Q. Okay. This suicide that's referenced here, that occurred
10 in Washington; correct?

11 A. No, it did not.

12 Q. Okay. So you're saying that suicide that's referenced here
13 occurred in Idaho?

14 A. Yes.

15 Q. Do you recall either way?

16 A. I have never committed -- tried to commit suicide in
17 Washington.

18 Q. Okay. Do you recall trying to commit suicide when you were
19 16 years old?

20 A. No.

21 Q. Before you is Defendant's Exhibit 2007. Let's see if we
22 can zoom in on this a little bit more. And this is the record
23 from Shoshone-Bannock Tribes Counseling & Family Services.

24 Isn't it true that in November of 2003, you were
25 transported to Portneuf via ambulance after an apparent

1 overdose? Do you recall that?

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

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

4 A. No.

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

7 Prior to the incarceration in 2012, there has been multiple
8 suicide attempts that you've taken directly on your own life;
9 correct?

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

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

12 A. No, there hasn't.

13 Q. In your deposition, you recall there were two serious
14 suicide attempts, but there may have been more? Do you recall
15 that?

16 A. I recall letting you know that, yeah, there were two
17 serious ones that I actually had the intent to commit suicide.

18 Q. Okay. There were others that you did not have the intent
19 to commit suicide; is that your testimony?

20 A. Yes.

21 Q. Okay. And during those time period where you were
22 attempting suicide, you were heavily abusing alcohol; correct?

23 A. Yes.

24 Q. And in the three, four years prior to incarceration, you
25 were using alcohol and other drugs at a very high rate; correct?

1 A. Yes.

2 Q. Okay. And I believe that you agreed that your substance
3 abuse was its most extreme in the years -- three or four years
4 prior to your incarceration in 2012; correct?

5 A. Yes.

6 Q. Okay. And isn't it true that your more serious suicide
7 attempts followed relationship problems with one of your
8 partners; correct?

9 A. Yes.

10 Q. And at this time, you were also unemployed; correct?

11 A. Yes.

12 Q. You were -- that was a big stressor for you, was it not?

13 A. It was a stressor.

14 Q. Okay. And you were having self-worth problems, were you
15 not?

16 A. Yes.

17 Q. You didn't feel like your life was worth much at that time;
18 correct?

19 A. I felt worthless, yes.

20 Q. And you had a lot of legal problems at that time with some
21 felony check fraud charges; correct?

22 A. In 2010, yes.

23 Q. And in '11 and '12, you were still dealing with probation
24 and probation violations; correct?

25 A. Yes.

1 Q. Now, in your declaration that you provided, on page 7, you
2 stated that:

3 "I began living full time as a woman around the age of
4 20 or 21. I wore makeup, women's outerwear, underwear
5 and bras, and styled my long hair."

6 Isn't that correct?

7 A. Yes.

8 Q. That's what you stated --

9 A. Yes.

10 Q. -- correct?

11 A. I did.

12 Q. And isn't it true that prior to your incarceration, you
13 never had hair longer than your ears; correct -- about longer
14 than the top of your ears?

15 A. It's been about in the middle.

16 Q. About in the middle?

17 A. Yeah, or about the bottom to the middle of my ears.

18 Q. Okay. So the longest your hair was ever prior to your
19 incarceration was about the middle of your ear; correct?

20 A. Bottom or middle. I don't know the exact, if it was middle
21 or bottom, but I would say to the bottom of my ear.

22 Q. Right. So after your incarceration, you grew your -- in
23 2012, you grew your hair out longer than it's ever been in your
24 life; correct?

25 A. Yes.

1 Q. And you've had, let's say, counseling or verbal warnings
2 from correctional staff about your hair from time to time;
3 correct?

4 A. Yes.

5 Q. And a lot of those have been directed at when you have a
6 ponytail or a bun; correct?

7 A. Yes.

8 Q. And you have a high ponytail; right? Which I imagine is a
9 ponytail up on top, coming off the top of the head; correct?

10 A. No.

11 Q. No? Describe for me a high ponytail, then.

12 A. If I were to wear my hair in a ponytail, it would be about
13 this length (indicating).

14 Q. And you have been counseled by correctional officers since
15 2012 on multiple occasions, about maybe toning down your
16 feminine hairstyle; correct?

17 A. Yes.

18 Q. And the rationale that was given to you on multiple times
19 is along the lines of: "Ms. Edmo, we need to protect you from
20 sexual assault. And we can't have you appearing in a feminine
21 matter that may cause a, quote, 'sexually charged environment.'"

22 Isn't that correct?

23 A. No, that's not correct.

24 Q. No officer has ever told that to you?

25 A. No. Actually, they have told me to take my hair down.

1 Q. You have never been told by a correctional officer that
2 your hair creates a sexually charged environment?

3 A. Only after if I have been given a disciplinary offense
4 report was it explained that it -- the reason why.

5 Q. Right. And isn't it true, Ms. Edmo, that you have never
6 actually been given a disciplinary offense report for wearing
7 makeup or wearing your hair in a feminine style? The
8 disciplinary offense reports have been for disobedience to a
9 direct order; isn't that correct?

10 A. Yes.

11 Q. There is a difference there; right? And you do recognize
12 that?

13 A. I think -- I believe it's covert. The disciplinary process
14 has the officer pick the best offense that describes the
15 behavior. So they would use disobedience to orders.

16 Q. Right. And on all of those disobedience to orders DORs
17 relating to your makeup or your hair, you were warned in
18 advance, like, "Ms. Edmo, you need to take down your hair," or
19 "You need to remove your makeup"; correct?

20 A. Yes.

21 Q. Okay. And your response was no; correct?

22 A. On multiple occasions, yes.

23 Q. Right. You refused that direct order; correct?

24 A. At the time, I didn't think it was a direct order. But
25 they gave me instructions to remove my makeup or take my hair

1 down.

2 Q. Okay. So then after you refused to follow direct order, it
3 was then that you were given a DOR; correct?

4 A. Yes.

5 Q. Okay. And you've understood since your incarceration that,
6 as a transgender female, that you feel that you're at a higher
7 risk of sexual assault in a male facility; isn't that correct?

8 A. No prison is safe.

9 Q. No prison is safe. But you have actually written in your
10 declaration that, because you are a transgender female in a male
11 prison, you feel like you are at a higher risk of sexual assault
12 from the male population; correct?

13 A. Yes.

14 Q. And isn't it true that there are individuals incarcerated
15 with you that are in jail on convictions for sexual assault?

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

18 Q. Right. Do you understand that the Department of Correction
19 has an obligation to protect you from sexual assault?

20 A. Yes.

21 Q. And isn't it true that in this lawsuit, which is not a real
22 claim on this motion, that you are making a claim that one of
23 the defendants -- namely, Defendant Keith Yordy -- failed to
24 protect you from sexual assault due to your transgender status
25 and femininity?

1 A. Yes.

2 Q. Do you see there that there is kind of this conflict? You
3 want to feminize in prison, and the IDOC has allowed you to do
4 that in a number of ways. But there are limits to that placed
5 by security, and it's due to the goal of protecting you from
6 sexual assault.

7 Do you understand that?

8 MS. RIFKIN: I'm going to move to strike the testimony
9 of counsel prior to the question.

10 THE COURT: Just a moment.

11 Counsel, I think -- let's rephrase the question.

12 MR. HALL: That's fine.

13 THE COURT: There was a lot of testimony in the
14 question that's probably not necessary.

15 Q. BY MR. HALL: You understand that one of the rationales for
16 limiting your ability to wear your hair pre today in a feminine
17 fashion was to protect you from sexual assault; correct?

18 A. I don't know what their reasons are.

19 Q. But those were the justifications that were provided to
20 you?

21 A. In the DORs, yes.

22 Q. Okay. And, Ms. Edmo, you're aware that there has been some
23 recent policy changes; correct?

24 A. I think so.

25 Q. As of last Friday, the policy has been changed regarding

1 gender dysphoria treatment; correct?

2 A. I received a memo from Ashley Dowell.

3 Q. Okay. That memo said that now all GD offenders, including
4 yourself, will have access to female commissary items that are
5 available to female offenders at other institutions; correct?

6 A. Yes.

7 Q. So makeup?

8 A. Yes.

9 Q. And even female underwear?

10 A. Yes.

11 Q. Now, it's true you've had female underwear from time to
12 time since your incarceration in 2012; correct?

13 A. Yes.

14 Q. And you're also -- it's your understanding of this new
15 policy that IDOC has mandated that its mental health and medical
16 staff are to refer to you and other gender dysphoric inmates by
17 your preferred gender?

18 A. That's what it states.

19 Q. Okay. Are you happy with that? Does that -- does that
20 please you in any way?

21 A. It's a very slight relief.

22 Q. You understand that since 2011, IDOC has had a policy to
23 provide gender dysphoric inmates with treatment for GD?

24 A. I think so.

25 Q. Okay. And that included sex reassignment surgery or gender

1 confirming surgery if it was determined to be medically
2 necessary by a qualified GD evaluator; correct?

3 A. Yes. That's what the policy states.

4 Q. Okay. The policy did not have a prohibition against sex
5 reassignment surgery, per se; correct?

6 A. Per se.

7 Q. Yes, though; correct?

8 A. Yes, per se.

9 Q. Okay. And isn't it true that prior to June 1 of this year,
10 when this motion for preliminary injunction was filed, no
11 medical provider or mental health provider had determined that
12 sexual reassignment was medically necessary for you?

13 A. Yes, that's correct.

14 Q. And those that have determined it purportedly are the
15 experts that have been retained by your counsel; correct?

16 MS. RIFKIN: I would like to move to strike
17 "purportedly."

18 MR. HALL: It's in debate, Your Honor. I think the
19 record will show what Dr. Ettner had testified.

20 THE COURT: Overruled.

21 Q. BY MR. HALL: Would you answer the question, please.

22 A. What was the question again?

23 MR. HALL: Would you read the question back, Madam
24 Court Reporter.

25 (Question read by reporter.)

1 THE WITNESS: Yes.

2 Q. BY MR. HALL: Now, you understand that as part of some
3 procedures for sex reassignment surgery, including a
4 vaginoplasty, that your male anatomy would be used to create a
5 vagina?

6 A. I think that's correct.

7 Q. So you understand that it's important to preserve your male
8 anatomy so that in the future, if it's appropriate for you to
9 have sex reassignment surgery, that tissue is available to
10 create female anatomy; correct?

11 A. As what I have been told, yes.

12 Q. Okay. And you're committed to preserving your male anatomy
13 to be used in the future; correct?

14 A. Yes.

15 Q. Now, you've had -- you've had a number of contacts
16 throughout your incarceration with clinical staff; correct?

17 A. Yes.

18 Q. Including Clinician Watson; correct?

19 A. Yes.

20 Q. And Clinician Stewart; correct?

21 A. Yes.

22 Q. Okay. And throughout those years, both Clinician Watson
23 and Clinician Stewart have repeatedly referred you to and
24 recommended that you undergo a number of different group
25 therapies; correct?

1 A. I wouldn't say "group therapy," but groups.

2 Q. Mood management would be one; correct?

3 A. Yeah. Mood management class, yes.

4 Q. Social skills?

5 A. Social skills class, yes.

6 Q. Healthy relationships; yes?

7 A. Yes.

8 Q. And you've also been recommended and required to complete
9 the sex offender treatment programming; correct?

10 A. Yes.

11 Q. And despite multiple recommendations to undergo those
12 classes, you have repeatedly refused to take those classes;
13 correct?

14 A. Yes.

15 Q. Okay. And however, though, I have noticed throughout the
16 records that there have been periods of time where you expressed
17 to the clinicians, whether it's Watson or Stewart, that you have
18 a moment of clarity that maybe you should take those classes.

19 Do you agree with that?

20 A. I think at some point, yes.

21 Q. Yeah. Where you stated, "You know, I do need to take those
22 classes because it will help me work on my other issues, not
23 just GD."

24 Do you agree with that?

25 A. I would say yes.

1 Q. And as recently as May or April of this year, you told
2 Clinician Watson in a concern form that you were ready to get on
3 top of your mental health issues and take these classes.

4 Do you remember that?

5 A. Because she had recommended them.

6 Q. Right. But you had agreed, which was something rare for
7 you. You had agreed that: Yes, I do need to do that. I need
8 to focus on these other mental health issues. I'm ready to take
9 those classes.

10 Correct?

11 MS. RIFKIN: I'm going to move to object to counsel's
12 characterization as "something rare for you" and move to strike
13 that part of the question. Also lacks foundation.

14 THE COURT: Counsel, I'm going to sustain the
15 objection. It assumes a fact not in evidence. And because of
16 that, it becomes compound and confusing.

17 Q. BY MR. HALL: You agree that you've repeatedly -- and you
18 testified earlier that you repeatedly refused to take these
19 classes; correct?

20 A. Yes.

21 Q. Okay. Yet you have, on only a couple of occasions, had a
22 moment of clarity where you have agreed that, yes, I do need to
23 work on these mental health issues; correct?

24 MS. RIFKIN: I'm objecting as lacks foundation,
25 misstates the evidence as to "only a couple of occasions."

1 Assumes facts not in evidence.

2 THE COURT: Overruled. The witness can respond if she
3 feels she has done it on more than on a couple of occasions, if
4 she wishes.

5 Q. BY MR. HALL: Go ahead. And If I'm mischaracterizing
6 anything, please let me know.

7 THE COURT: Typically -- don't be reluctant to explain
8 a response if you disagree with counsel's characterization.

9 Go ahead.

10 THE WITNESS: Can you repeat the question, please.

11 MR. HALL: Madam Court Reporter, would you read the
12 question back for the witness, please.

13 (Question read by reporter.)

14 THE WITNESS: I'm not sure what you mean by "moment of
15 clarity," but I have agreed to it on a couple of occasions.

16 Q. BY MR. HALL: But as of today, you have not completed mood
17 management, social skills, healthy relationships, or the sex
18 offender treatment program; correct?

19 A. Correct.

20 MR. HALL: I have no further questions. Thank you.

21 THE COURT: Mr. Eaton.

22 CROSS-EXAMINATION

23 BY MR. EATON:

24 Q. Hello, Ms. Edmo.

25 As you probably recall, my name is Dylan Eaton. I

1 represent the Corizon providers.

2 Do you remember me?

3 A. Yes, I do.

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

5 First of all, I believe you indicated that you acknowledge
6 you were diagnosed with gender identity disorder in 2012; is
7 that correct?

8 A. Yes.

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

10 A. I don't know exactly who diagnosed me initially. I know
11 that I had an evaluation by Dr. Lake.

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

13 You recall that?

14 A. Yes.

15 Q. And did the -- and you understand that you actually
16 received that diagnosis in 2012; right?

17 A. Yes, I did.

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

19 A. It was exciting.

20 Q. And why is that?

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

23 Q. And you were seeking a GID, gender identity disorder,
24 designation at that time because you wanted to be put on
25 hormones; isn't that right?

1 A. I didn't really know necessarily what the treatment was,
2 but I did ask for an evaluation of a gender identity disorder.

3 Q. And after you received that designation, did you want to be
4 put on hormones?

5 A. They had asked me if that was my -- if I would be willing
6 to go on hormone replacement therapy.

7 Q. And you agreed to that?

8 A. Yes.

9 Q. Okay. And I believe you testified that once you started
10 taking the hormones, that a cloud was lifted, and you started
11 feeling better; is that correct?

12 A. Yes.

13 Q. Okay. So the hormones helped you; right?

14 A. In the beginning, yes.

15 Q. Okay. And you acknowledge that you've been on hormones
16 since 2012; right?

17 A. Yes.

18 Q. And you have been managed by medical providers, including a
19 Dr. Whinnery, on those hormones?

20 A. I have seen Dr. Whinnery for hormones.

21 Q. And you understand that your medications, your hormones
22 have been adjusted periodically, sometimes because of your
23 requests over the years?

24 A. Yes.

25 Q. When we talked at your deposition, I brought up a record by

1 Dr. Stoddart, who had indicated that -- in that record that you
2 had been sad because Dr. Whinnery had left, and she was an
3 advocate for you.

4 Do you remember discussing that with me?

5 A. I remember you referring to that conversation.

6 Q. And I believe you -- we got into a discussion as to you're
7 not sure what "advocate" means, but you indicated that you
8 believed Dr. Whinnery was helping you; correct?

9 A. She was the doctor that initially prescribed me hormones.

10 Q. But she was helping you; right?

11 A. She prescribed the hormones that was helping me, yeah.

12 Q. I'm not just asking about the hormones.

13 But she was helping you with your gender identity disorder
14 and your gender dysphoria treatment; correct?

15 A. Yes.

16 Q. She helped you, for instance, with the prescription to get
17 a bra -- a memo to get a bra; correct?

18 A. Yeah. She wrote the medical memo.

19 Q. Okay. And she tried to work with you to help you get some
20 type of underwear that would work for you; correct?

21 A. On multiple occasions, I asked her, and she attempted to, I
22 believe. I'm not sure if she did actually, but she had told me
23 that she had tried.

24 Q. And she tried to work with you and helped you, for
25 instance, get a jockstrap and pads to help you try to tuck;

1 correct?

2 A. I had asked her for a medical memo for panties, actually.
3 And she said the best she can give me is a jockstrap with some
4 medical pads.

5 Q. So you understand she gave you that and was trying to help
6 you there; correct?

7 A. That's what she prescribed me, yes.

8 Q. And you acknowledge that you have been seeing a
9 psychiatrist, Dr. Eliason, since 2012; correct?

10 A. I have seen him, yes.

11 Q. Okay. And you saw him initially when you were diagnosed
12 for GID; correct?

13 A. I don't know if he was the initial person. I seen him one
14 time prior to seeing Dr. Lake.

15 Q. Okay. So you do recall seeing -- an appointment at least
16 with Dr. Eliason prior to seeing Dr. Lake?

17 A. Yes.

18 Q. And then afterwards, you would acknowledge that you have
19 seen him periodically for mental health conditions --

20 A. Yes.

21 Q. -- since 2012?

22 A. Excuse me. Yes.

23 Q. At some of those appointments, you have received
24 medications, such as Zoloft; correct?

25 A. I believe so.

1 Q. Okay. But you acknowledge that Dr. Eliason and other
2 medical providers have given you medications to help you with
3 your depression, for instance; correct?

4 A. Dr. Eliason has. Yes, Dr. Eliason has.

5 Q. Okay. And you have been in chronic care and seen a medical
6 provider every approximately 90 days; is that correct?

7 A. I don't know if I'm in that program or not. They don't
8 give me that information.

9 Q. So you're not aware of whether you're in chronic care?

10 A. Like I said, I don't know if that's what they designated me
11 into the program. They don't let me know that information.

12 Q. Okay.

13 A. But I assume that I am in chronic care, I think. I can't
14 give you an answer as to if that's absolutely sure or not.

15 Q. And you continue to see a psychiatrist at the ISCI today;
16 correct?

17 A. Yes.

18 Q. And sometimes you will see a mental health nurse
19 practitioner?

20 A. I have seen a mental health nurse practitioner, yes.

21 Q. This year?

22 A. Not this year.

23 Q. Okay. But you do see a psychiatrist? You have seen a
24 psychiatrist this year?

25 A. Yes.

1 Q. On more than one occasion; correct?

2 A. Yes.

3 MR. EATON: I don't believe I have any further
4 questions. Thank you.

5 THE COURT: Before redirect, I'm going to ask just one
6 or two questions.

7 EXAMINATION

8 BY THE COURT:

9 Q. Ms. Edmo, I'm a little confused about the extent of the
10 hormone treatment you've had since you have been incarcerated.

11 Has that been an on-again, off-again? I mean, have you
12 generally had access to hormone treatment while incarcerated or
13 not?

14 A. Yes. As to the dosages, they have been never consistent.

15 Q. Okay. But I assume the doctors have tried to work with you
16 in terms of adjusting that, or they just unilaterally make
17 changes?

18 A. They just unilaterally make changes.

19 Q. I had understood that there was some -- something cropped
20 up in your blood work which suggested that they either
21 substantially reduce or even eliminate the hormone treatment.

22 Did I understand that correctly?

23 A. Yes, you did.

24 So part of my hormone therapy, I receive estrogen and
25 spironolactone, which is a testosterone suppressant. Just as of

1 recently, beginning in December of last year into February of
2 this year, they gave me a blood test, and my liver enzymes had
3 elevated.

4 And they didn't know -- we didn't know exactly what that
5 was attributed to. So they kind of did a, you know, elimination
6 process. And they determined or felt that it was probably due
7 to the spironolactone.

8 So they took me off of it completely. And as a result, I
9 started getting more testosterone in my body. And I can feel
10 that because it's -- prior to hormone therapy, I know what it
11 feels like to be hormonally just testosterone.

12 So I felt that testosterone building up, and I sent in
13 concern forms to the providers asking: Please, is there any
14 other testosterone suppressant that you can find for me or
15 anything, because I can feel it building, and it's not good for
16 me. It feels disgusting. It's gross.

17 So just recently, as of I believe June of this year, they
18 put me back on spironolactone after I continually and repeatedly
19 requested it.

20 Q. All right. I'm going to ask another question. It's a
21 little sensitive, but I think I need to ask.

22 Were you -- I assume, then, that you were on hormone
23 therapy at the time you attempted to self-castrate on both
24 occasions; is that correct?

25 A. Yes, it is.

1 THE COURT: All right. Questions, Ms. Rifkin?

2 REDIRECT EXAMINATION

3 BY MS. RIFKIN:

4 Q. Ms. Edmo, at the time that you stopped sex offender
5 programming, was it your understanding that you were required to
6 attend?

7 A. Before I stopped?

8 Q. At the time that you stopped the programming.

9 A. No. I didn't -- they didn't say it was required that I had
10 to -- I had to finish -- I was required to finish it in order to
11 have a chance at parole.

12 Q. And at what point did you stop attending sex offender
13 programming?

14 A. Right after the Commission had decided that I needed to
15 complete my full sentence. And right after that, they -- my
16 case manager had told me: Since you don't have a date for
17 parole anymore, you're going to full-term release, there is no
18 need for you to be in this program. We need to give that slot
19 to somebody who has parole.

20 MS. RIFKIN: No further questions.

21 THE COURT: Mr. Hall.

22 MR. HALL: No recross, Your Honor.

23 THE COURT: Mr. Eaton.

24 MR. EATON: Nothing further, Your Honor.

25 FURTHER EXAMINATION

1 BY THE COURT:

2 Q. I can find this out in some other form.

3 What is your parole status, then? Based on what you have
4 just said, are you indicating that the parole commission has
5 said that you will not be considered for parole?

6 A. Yes, that's correct.

7 Q. That's your understanding?

8 A. Yes.

9 Q. What is your top-out date?

10 A. 2021.

11 THE COURT: Okay. All right. I assume that was --
12 any follow-up to that?

13 MS. RIFKIN: No, Your Honor.

14 MR. HALL: No follow-up, Your Honor.

15 MR. EATON: No, Your Honor.

16 THE COURT: All right. Ms. Edmo, you may step down.
17 Thank you.

18 Call your next witness.

19 MS. WHELAN: Good morning, Your Honor. I'm Amy
20 Whelan, one of Ms. Edmo's counsel. And we're going to call
21 Dr. Nick Gorton.

22 THE COURT: Dr. Gorton, please step before the clerk
23 and be sworn.

24 RYAN NICHOLAS GORTON, M.D., PLAINTIFF'S WITNESS, SWORN

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

1 MR. HALL: No objection, Your Honor.

2 MR. EATON: No objection.

3 THE COURT: 1004 will be admitted.

4 (Plaintiff's Exhibit 1004 admitted.)

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

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

7 A. I do.

8 Q. And what is it?

9 A. It's my curriculum vitae.

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

12 A. It does.

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

15 A. Yes. I got a bachelor of science in biochemistry at
16 North Carolina State University. And I got my M.D. at the
17 University of North Carolina Chapel Hill. And then I did a
18 residency and chief residency in emergency medicine at Kings
19 County Hospital in Brooklyn.

20 THE COURT: Dr. Gorton, you are a little soft-spoken.
21 If you could bring the microphone just a little closer and don't
22 wander too much from that. Some of us are blessed with a
23 booming voice and some don't, such as myself. So please keep
24 the microphone close so that we can hear you.

25 Go ahead, Ms. Whelan.

1 Q. BY MS. WHELAN: And during your residency and your chief
2 residency, can you explain what you were doing at that time.

3 A. So I had finished medical school. And so, as a physician,
4 I was doing specialty training in emergency medicine.

5 Q. And from 2008 to the present, you have also worked with
6 Project Health.

7 Can you explain what that organization is and what you do
8 for them.

9 A. So Project Health was a collaboration between Lyon-Martin
10 Health Services, which is the clinic where I work, and the
11 Transgender Law Center.

12 And the initial goal of the project was that in California
13 at the time, if you were transgender, there were really only two
14 places you could get care, which is San Francisco and
15 Los Angeles, which is not an ideal situation.

16 So the project was to identify community clinics throughout
17 California and provide them some intensive clinic technical
18 assistance so that they would be able to provide that care in a
19 clinically appropriate way.

20 And the -- we probably trained about eight or nine clinics
21 throughout California.

22 Q. You have also been a consultant with TransLine since
23 January 2011.

24 Can you explain what that organization is and what you do
25 for them.

1 A. So TransLine was actually a project that came out of
2 Project Health in that we would go out to these clinics, and
3 we'd provide them with a bunch of educational training. But
4 then as they started practicing and seeing patients, things came
5 up, and they weren't necessarily sure what to do in all
6 circumstances. So they needed sort of this consultation that
7 was ongoing.

8 And so it was very successful, and the clinics that we
9 worked with said it was absolutely probably one of the most
10 important things we did. So we actually opened it up, and it
11 became a national consultation line.

12 So that if you're healthcare provider and taking care of a
13 transgender patient, and you might not have the experience you
14 need or you might just have a very unusual question, you submit
15 it to TransLine, and one of a number of providers who are
16 experienced in transgender care from Lyon-Martin Clinic but also
17 from some other LGBT clinics throughout the U.S. will answer the
18 question.

19 Q. And are there any restrictions on who can use that hotline?

20 A. Well, it's for healthcare providers. And most of the
21 questions are from physicians or nurse practitioners or P.A.s,
22 but we occasionally get a nurse or mental health provider who
23 has a question.

24 Q. And where are you currently employed?

25 A. I'm employed as an emergency physician at Sutter Davis

1 Hospital in Davis, California. And I also practice pro bono at
2 Lyon-Martin Health Services in San Francisco.

3 Q. Can you explain what Lyon-Martin Health Services is.

4 A. Yes. It was originally a sort of for-us, by-us clinic for
5 lesbian and bisexual women started in the 1980s. And then in
6 the 1990s, the clinic expanded its treatment model to include
7 transgender patients.

8 And it's a -- it's a -- like a safety-net clinic. It's a
9 federally qualified healthcare center.

10 Q. Can you explain what a federally qualified healthcare
11 center is.

12 A. So FQHCs are clinics that enter into an agreement with the
13 government that they will treat anybody who shows up, whether
14 they are insured or not insured. So if you're uninsured, you
15 have a sliding scale payment system. And in return for that,
16 the government reimburses you more for those patients that do
17 have government-sponsored insurance, particularly Medicaid and
18 Medicare.

19 Q. And are the patients you treat at a federally qualified
20 healthcare center different from patients at other primary care
21 clinics?

22 A. Yes. In that, you know, because the majority of our
23 patients are uninsured -- or if they are insured, they have
24 Medicare or Medicaid -- they tend to be a lot more
25 disenfranchised.

1 So, for example, in my clinic, about 20 percent of our
2 patients are homeless or marginally housed. We have higher
3 rates of substance abuse, higher rates of cooccurring mental
4 health conditions. They are people who aren't doing quite as
5 good as you would see in a regular primary care clinic.

6 And we also have a significant portion of our patients who
7 are involved in the criminal justice system. Either they were
8 in prison or they're on parole or some of my patients have gone
9 to prison.

10 Q. You described it as a primary care clinic.

11 Can you describe what your duties and responsibilities are
12 at Lyon-Martin as a primary care doctor.

13 A. So I carry my own panel of patients that I see, and I'm
14 their regular doctor. But I also supervise midlevel providers,
15 like nurse practitioners and physician assistants.

16 I do a lot of training with the clinic. So we have medical
17 students, nurse practitioners, P.A. students, residents, fellows
18 who come and will spend a month or so with us to get training in
19 transgender healthcare.

20 Q. And where do those students come from who you train?

21 A. The majority is, you know, just because of location, they
22 are from the Bay Area and California area, but we have had
23 students from across the country and even a couple of
24 international students.

25 Q. How many students would you estimate that you have trained

1 since 2005, when you began working there?

2 A. That's a hard number, but probably about 10 a year or so.
3 At least 100.

4 Q. How many people with gender dysphoria have you treated in
5 the course of your career?

6 A. That have been my primary patients? About 400 or more than
7 400.

8 Q. And how many people with gender dysphoria are you currently
9 treating?

10 A. Again, that are my primary care patients, about 100.

11 Q. I'm sorry. Did you say 100?

12 A. Yeah, 100.

13 Q. Thank you.

14 Are you familiar with the World Professional Association
15 for Transgender Health, or WPATH?

16 A. I am.

17 Q. And what is that organization?

18 A. It's a professional organization for those who provide care
19 to transgender patients.

20 Q. And what activities does WPATH engage in?

21 A. They release the standards of care and revise it
22 periodically, which is guidance on who should be treated with
23 what particular types of treatments, medical, surgical.

24 They hold a conference every two years that's sort of a
25 research and education conference. So people will present their

1 data from more recent research.

2 They, you know, will periodically make statements or
3 address things that are relating to transgender health.

4 Q. And do you have a role in the association of WPATH?

5 A. I'm a member of WPATH. I'm also on the Medicine Research
6 and the Incarcerated Persons committees.

7 Q. Your CV also lists several publications related to
8 transgender healthcare. We don't need to go over those
9 individually.

10 But does your -- if you could pull up his CV again. Sorry.
11 Does your CV accurately list those publications?

12 A. Can I scroll through it?

13 Q. There is a way. I don't know that you can.

14 A. Like one more page.

15 Yeah, it does.

16 Q. Are there any newer publications that are not listed?

17 A. Could you back up one page?

18 Oh, that are not listed? No. I mean, I have one project
19 I'm working on but not in publication.

20 Q. Your CV also lists numerous presentations related to
21 transgender healthcare. Again, we don't need to go over those
22 individually.

23 But does your CV accurately list those presentations?

24 A. The most important ones. I don't put every presentation
25 that I do on my CV. It would be 30 pages long. So these are

1 the most important ones.

2 Q. Okay. We often hear about peer-reviewed journals.

3 Can you explain what that means.

4 A. Those are medical or, more broadly, scientific journals
5 where you submit a paper, and then peers of yours -- so people
6 who are knowledgeable in that field of study -- will review the
7 paper.

8 And you then have the opportunity to make corrections or
9 they might suggest, you know, you should expand on this or
10 explain this or maybe include this data that you didn't include.
11 And then you make corrections, and you resubmit it.

12 It's published. And then there is a process afterwards and
13 the sometimes vigorous discussion in the editorial pages in
14 subsequent months where people discuss the paper if it's --
15 especially if it's something controversial.

16 Q. And do you have peer-reviewed journal publications listed
17 on your CV?

18 A. I do.

19 Q. Have you ever been retained as an expert in other cases
20 involving transgender healthcare?

21 A. Yes.

22 Q. Can you give some examples of those cases in the past five
23 years.

24 A. Yes. So I was an expert in a case in New York State that
25 was *Cruz v. Zucker*, where the question was whether or not the

1 state Medicaid agency would cover certain treatments for
2 transgender recipients of New York State Medicaid. And that
3 was -- the plaintiffs won, and so New York State now provides
4 that.

5 There was a case in Florida. Reilyn Keohana was the
6 plaintiff. I don't know what the -- it was the prison system
7 was the defendant. And the issue was whether or not she would
8 have female grooming requirements. And ultimately, they agreed
9 to give her those.

10 I was an expert in Michelle Norsworthy's case in
11 California. And at issue was whether or not she needed sex
12 reassignment surgery. And she won, but then they paroled her
13 very soon afterwards, so she didn't get surgery while she was in
14 prison.

15 And I had two similar cases to that in California that were
16 the same issue, a trans woman in prison who was wanting to get
17 sex reassignment surgery. They are not completed yet, but I
18 actually found out one of them yesterday was -- we're not doing
19 it anymore because the state decided to parole that person.

20 Q. You testified earlier about the WPATH standards of care.

21 Do you use those when you treat patients who have gender
22 dysphoria?

23 A. I do.

24 Q. Can we bring up the WPATH standards, which is Joint Exhibit
25 15, please.

1 Dr. Gorton, do these look like the standards of care that
2 we're talking about?

3 A. Yes.

4 Q. During your deposition in this case, defense counsel asked
5 you about your understanding of the standards of care as,
6 quote/unquote, "flexible guidelines."

7 Do you recall that?

8 A. I believe so.

9 Q. Can we go to page 2 of this document -- sorry. Page 2 of
10 the actual document, not the 15-2.

11 Do you see the heading here called "The Standards of Care
12 are Flexible Clinical Guidelines"?

13 A. I do.

14 Q. What is your understanding of what that means?

15 A. What that means is that for most patients in most
16 situations, the guidelines that WPATH sets forth to determine
17 who should be given certain types of treatment are appropriate
18 to follow; but that in some situations, experienced providers
19 can provide treatment even to a patient who hasn't completely
20 met all those criteria, if there is a good reason.

21 And so, like, the examples they give are unique anatomic,
22 social, or psychological situations. So, like, I have a patient
23 who is a transgender woman whose mother has dementia, and her
24 mother was actually accepting her transition but now doesn't
25 remember that her child transitioned.

1 And so when my -- if my patient shows up to provide care
2 for her, she doesn't recognize her. And so when she provides
3 care for her mother, she dresses in men's clothes, and she
4 presents as a man, you know, to make it -- to make her
5 essentially able to care for her mother.

6 And this patient was wanting to be referred for surgery.
7 And typically, you would say: Well, gee, you have to have 12
8 months of living full time in the target gender role.

9 And, you know, if somebody, say, at work, they don't, you
10 know, present as that gender, you would say: Well, gee, maybe I
11 haven't met the 12-month requirement.

12 And in her case, there is a situation where she presents as
13 male, but it has nothing to do with her gender dysphoria, and it
14 wouldn't be appropriate for me to say, well, since you have to
15 provide care for your mother, we are not going to give you this
16 treatment that you otherwise need.

17 Q. And the standards of care give another example of that on
18 page 35.

19 Can we switch to that page, please. The second part.
20 There you go.

21 Do you see the heading on this page that says, quote,
22 "Relationship between the standards of care and informed consent
23 models," end quote?

24 A. I do.

25 Q. Can you explain what informed consent models are.

1 A. So that's something that came out of the United States,
2 historically LGBT community health centers who treated a lot of
3 trans patients in that the criteria for starting hormone therapy
4 was that you had to be diagnosed by a mental health provider
5 before you could start hormone therapy.

6 And in many cases, patients weren't able to access that
7 psychological care because their insurance wouldn't cover it and
8 because they couldn't afford to pay out of pocket.

9 So providers in those clinics said, you know, we have to
10 provide care to this person. You know, not providing care
11 because they don't have the resources to see a psychologist for
12 10 visits is not appropriate.

13 And so they, you know, essentially went -- you know, used
14 the concept that the standards are flexible and made sure that
15 patients understood that we're not -- we're not doing the thing
16 that WPATH says, but there is a good reason we are not doing it
17 and made sure they were okay with that departure from the
18 standard.

19 And you know, that's what the informed consent part of it
20 is about, that the patient understands you are departing from
21 the standard, and they consent to treatment.

22 Q. And those health centers that are listed here -- Callen
23 Lorde Community Health Center, Fenway Community Health
24 Transgender Health Program, and the Tom Waddell Health Center --
25 what are those centers?

1 A. They are all community health centers. Tom Waddell is
2 actually a San Francisco Department of Public Health Clinic, but
3 they are historically clinics that treat and care for the LGBT
4 community.

5 Q. So the first part of that first paragraph references what
6 you just described, the informed consent model. And then the
7 last sentence of that first paragraph says:

8 "The SOC are flexible clinical guidelines; they allow
9 for tailoring of interventions to the needs of the
10 individual receiving services and for tailoring of
11 protocols to the approach and setting in which these
12 services are provided."

13 And then there is a cite to a study there by Ehrbar and
14 Gorton from 2010.

15 Is that right?

16 A. Yes.

17 Q. And that's a cite to a study that you did; correct?

18 A. To a paper that I did, yes.

19 Q. Can you explain how that paper addresses the topic of
20 tailoring the standards of care to particular patients.

21 A. Yes. So, basically, the idea was -- it was a discussion
22 paper for providers of care for transgender patients to sort of
23 examine their own model for providing care; that is, how much
24 and when is appropriate for them to deviate from the standard of
25 care.

1 So, for example, one of the examples we used in that was a
2 patient who also is wanting to get surgery and so needs to meet
3 the requirement of living in the target gender for 12 months.
4 And that's usually expected to be in either school or work or a
5 volunteer context, so something you do in the community. And,
6 say, you had a patient who had such a profound disability that
7 they couldn't participate in schoolwork or volunteer activity.
8 It wouldn't be appropriate to say for this patient that, well,
9 because you can't do those things, we're not going to treat your
10 other condition.

11 So it was just sort of a way for providers to examine their
12 own model and their own comfort level in providing that care.

13 Q. So it sounds like this concept of flexibility is intended
14 to address situations where experienced providers may need to
15 loosen the criteria due to individual patient circumstances; is
16 that fair?

17 MR. EATON: Objection. She is testifying.

18 THE COURT: I'm sorry.

19 MR. EATON: And leading.

20 THE COURT: Well, I -- I think counsel is trying to
21 just paraphrase what the witness has already said. I generally
22 give a fair amount of leeway as long as counsel is not putting
23 words in the witness's mouth, particularly in a court trial.

24 So I'll overrule the objection. But, Counsel, be careful
25 not to testify from the lectern.

1 Go ahead. You may answer.

2 THE WITNESS: Can you ask the question again.

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

5 (Question read by reporter.)

6 THE WITNESS: Yes, that's correct.

7 Q. BY MS. WHELAN: Yesterday the parties heard testimony about
8 hormone treatments for transgender women.

9 Can you describe the physical effects a transgender woman
10 would experience from hormone medication.

11 A. Sure. So she will develop breasts. Her facial hair is not
12 going to stop growing in, but it -- it will grow slower, and the
13 hairs might be a little thinner.

14 There is some changes in the skin. You know, you produce
15 less sweat. Sometimes people find they smell different.

16 Your distribution of fat and muscle in your body changes,
17 so you have a more feminine figure.

18 Those are some of the physical changes. Also, to your --
19 in some patients -- not in all, but in some patients, the sex
20 drive diminishes, and also there's shrinkage of the testicles.

21 Q. Typically, how long would it take for those physical
22 changes that you described to occur?

23 A. You might notice the first beginnings of those changes
24 within the first month of treatment. But it usually takes two
25 to three years to get the maximum effect that you're going to

1 get.

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

4 A. The most typical surgery is the vaginoplasty, which is the
5 construction of a vagina. And there is some different
6 techniques that you can use to do that, but probably the lion's
7 share of it is what's called a penile inversion vaginoplasty.

8 And what you do is you take the head of the penis and its
9 neurovascular pedicle that the nerves and the blood vessels that
10 run to it, and you preserve those, and that actually becomes the
11 clitoris.

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

14 THE COURT: In what respect?

15 MR. EATON: Well, I don't think he has been qualified
16 or has been established that he is able to testify as to SRS
17 surgeries and how those go.

18 THE COURT: Overruled. The witness clearly was
19 treating as a primary care physician transgender individuals.
20 And I think that's sufficient to -- since he would be making
21 referrals, presumably, for that surgery, I think that's
22 sufficient to establish that he would know what's involved in
23 the process.

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

1 THE WITNESS: So I think I was saying you preserve the
2 head of the penis. The head of the penis is the clitoris. And
3 then the shaft of the penis, essentially the tissue inside of
4 it, is removed; and it's inverted, and that's used to create the
5 vagina. A space is created in the perineum, and that's
6 inserted. The testicles are removed, and the scrotum is used to
7 create the labia majora.

8 Q. And what are the goals of genital surgery for transgender
9 women?

10 A. Well, the primary goal is to treat their gender dysphoria.
11 I mean, you know, when you treat gender dysphoria, it also will
12 sometimes diminish other mental health diagnoses.

13 You also get the benefit of removing the testicles, so
14 there is no more testosterone production. And so it simplifies
15 hormone treatments in that you don't usually have to be on any
16 antiandrogen. So if somebody is on --

17 THE REPORTER: Could you slow down.

18 THE WITNESS: Sorry.

19 It simplifies hormone treatment in that if people are on
20 any antiandrogen, that can be stopped usually.

21 And, for example, spironolactone, which is the antiandrogen
22 we use in the vast majority of transgender women, you can
23 discontinue that.

24 Q. BY MS. WHELAN: In your clinical experience, have you had
25 patients who had trouble accessing surgeries to treat their

1 gender dysphoria?

2 A. Yes.

3 Q. And what consequences have you observed in patients who had
4 trouble accessing that surgical care?

5 A. So in -- so I started practicing with trans patients in
6 about 2005. And in 2011 -- around 2011, things changed pretty
7 dramatically in that instead of most of my patients not having
8 access to surgery, most of them did.

9 Private insurers were covering it a lot more, and the state
10 Medicaid agency started covering it.

11 So in comparing those two times, I mean, before we were
12 able to get patient surgery, their dysphoria was inadequately
13 controlled, oftentimes causing severe suffering, sometimes with
14 disastrous consequences.

15 I have had patients -- I haven't had a patient since 2011
16 who committed suicide, but I had some patients who committed
17 suicide. And I think that was a big contributing factor.

18 It's just -- there is a tremendous amount of suffering that
19 people experience if they can't get the surgery that they need.

20 Q. Have you also provided follow-up care to patients who have
21 had genital surgery?

22 A. I provide follow-up care to all my patients who have
23 genital surgery.

24 Q. Approximately how many patients are you currently treating
25 who have had vaginoplasty?

1 A. So I have about 100 trans patients on my panel. So about
2 50 trans women, say. And I would say probably 30 of them have
3 had vaginoplasty.

4 Q. What therapeutic effects have you seen for patients who
5 have had genital surgery?

6 A. The biggest one is that their dysphoria diminishes. You
7 know, like I said, that's -- that's a huge thing, and that's
8 what we are treating with this.

9 But, I mean, there is secondary effects. Like I said,
10 depression, anxiety can get better. I have had patients who no
11 longer needed to take antidepressants.

12 The other thing, too, is when people are able to sort of
13 take care of this huge issue that they have, they can often then
14 focus on other things in life -- going back to school, getting a
15 job, you know, focusing on their relationships.

16 And certainly not in every situation, but, like, I had a
17 patient who was at times homeless, at times marginally housed
18 and had a really bad substance abuse problem who wanted surgery
19 and had to get clean for surgery; so he did and then stayed
20 clean after surgery.

21 And he has been clean and sober for several years, and he
22 actually works as a peer, a substance abuse counselor. And he
23 does that, but then he is also going to school to get therapy
24 credentials to be an MSW.

25 Q. Let's talk about Ms. Edmo in particular.

1 Can you explain what you were retained to do in this case.

2 A. I was retained to evaluate whether or not she was getting
3 appropriate medical treatment for her gender dysphoria and, in
4 specific, whether or not she needed genital sex reassignment
5 surgery.

6 Q. Can you explain what you did prior to writing your first
7 report in this case to form those opinions.

8 A. So I reviewed some of her medical records from prison, and
9 I went to see her and evaluated her.

10 Q. And when you say you reviewed some of her prison medical
11 records, did you later receive a full set?

12 A. I did.

13 Q. And the first set that you reviewed, what percentage would
14 you say is that of her full set that you later received?

15 A. Maybe 80 to 90 percent.

16 Q. Can you say a little bit more about the clinical interview
17 that you did of her at prison. Can you describe that.

18 A. So we were in a visiting room, and I essentially got her
19 history with regards to her gender dysphoria but also with
20 regards to other mental health issues she has, medical issues,
21 how she had been living as a woman in prison, what treatment she
22 had received, what benefits she'd received from those.

23 Q. And after that evaluation and your review of her medical
24 records, did you come to a conclusion as to whether or not
25 Ms. Edmo has gender dysphoria?

1 A. Yes.

2 Q. And what was that conclusion?

3 A. That, yes, she does have gender dysphoria.

4 Q. Did you also determine whether Ms. Edmo needs surgery?

5 A. Yes, she does.

6 Q. When you assessed her need for surgery, did you use the
7 standards of care?

8 A. I did.

9 Q. Can we bring up again Joint Exhibit 15 at page -- I believe
10 it's 15-66.

11 Do you see that on the screen, Dr. Gorton?

12 A. I do.

13 Q. You used these criteria to assess surgery for Ms. -- the
14 need for surgery for Ms. Edmo; is that correct?

15 A. Correct.

16 Q. Can you go through those six factors and describe what you
17 found with respect to Ms. Edmo.

18 A. Sure. So the first one is a persistent well-documented
19 gender dysphoria. And, you know, in my interview with her, this
20 has been a persistent symptom for her, and also her records that
21 I reviewed from prison, document that. So I think she meets
22 that criteria.

23 The capacity to make a fully informed decision and to
24 consent for treatment, she didn't seem at all impaired in her
25 decision-making capacity. So I think that's met.

1 She is obviously over the age of 18, so she meets criteria
2 3.

3 4 is if significant medical or mental health concerns are
4 present, they must be well controlled. So from the medical
5 perspective, there is nothing that is a contraindication for her
6 to have surgery. From the mental health perspective, other than
7 her gender dysphoria, she has depression, anxiety. And those
8 are present, but they are not to a level that would preclude her
9 getting sex reassignment surgery.

10 MR. HALL: Objection. Foundation, move to strike.

11 MR. EATON: Join.

12 MR. HALL: The doctor is not a mental health provider.

13 THE COURT: Well, the question, I think, is not --
14 well, I will overrule the objection.

15 The question is phrased in a way as to characterize the
16 extent or how the mental health problems would impact the
17 decision as to gender confirmation surgery. Even though there
18 is a mental health component, it's primarily driven by the
19 doctor's expertise in this other area.

20 So I'll overrule the objection. Go ahead and answer --
21 well, your answer stands. Let's go ahead and put another
22 question before the witness.

23 MS. WHELAN: Sure.

24 Q. BY MS. WHELAN: Could you just continue with the next two
25 prongs, Dr. Gorton.

1 A. Sure. So No. 5 is 12 continuous months of hormone therapy
2 appropriate to the patient's gender goals. And she has that, as
3 documented in her medical record.

4 And then the final is 12 continuous months of living in a
5 gender role that is congruent with her gender identity. I think
6 she exceeds this; right? Because the idea is that you have to
7 live in the -- your target gender role, and she had been doing
8 that despite an environment that's very hostile to that and some
9 negative consequences that she has experienced because of that.
10 So, I mean, she is doing it despite that. So she more than
11 meets that criteria.

12 Q. Are you also aware that Ms. Edmo has attempted
13 self-surgeries?

14 A. Yes.

15 Q. What is the clinical significance of her self-surgery
16 attempts?

17 A. Primarily that she has severe genital-focused gender
18 dysphoria and that she is not getting the medically necessary
19 treatment to alleviate that.

20 Q. Do you think that Ms. Edmo engaged in self-surgery because
21 her depression or her anxiety are not well controlled?

22 MR. EATON: Objection. Speculation.

23 MR. HALL: Join.

24 THE COURT: Overruled.

25 THE WITNESS: Even if she had no anxiety and no

1 depression, she still might have done this because it's -- the
2 depression and anxiety aren't driving it. I mean, there is a
3 lot of people with depression and anxiety who don't remove their
4 testicles. The dysphoria was driving this.

5 And the -- you know, essentially, it's a function of not
6 having access to medically necessary care. And this isn't
7 unique to her situation or even unique to people with gender
8 dysphoria.

9 I mean, there is a case reported in the literature of a
10 Russian surgeon who was Antarctica and got appendicitis, and
11 there was nobody else to do it, so he took his own appendix out.

12 There was a woman, completely untrained, a Mexican woman
13 who performed a Cesarean section on herself, and she and her
14 child both survived -- in her kitchen.

15 And it's because these people are presented with extreme
16 circumstances where that's the only option. And the only
17 difference between those is the diagnosis. So in the Russian
18 surgeon, it was appendicitis; and in the Mexican woman, it was
19 failure to progress in labor. And in Ms. Edmo's case, it's
20 gender dysphoria.

21 Q. After you wrote your report in this case, you reviewed
22 additional documents; is that correct?

23 A. Yes.

24 Q. Do you recall what those documents were?

25 A. Yes. There were a lot of them.

1 So I got a more complete set of her medical records from
2 prison. I got some -- not very much but some records from
3 before she was in prison, some medical records. I got more
4 information about the DORs that were mentioned in the original
5 set that I got. So I got more complete information about that.

6 There was a slide deck for a lecture that I think providers
7 had received about transgender care. There were multiple
8 depositions. There was Dr. Garvey and Dr. Andrade's reports.

9 I don't know if I'm missing anything, but that's what I can
10 think of now.

11 Q. Have you seen anything in the documents you reviewed after
12 writing your report, that would change your opinion as to
13 whether Ms. Edmo's mental health issues are well controlled?

14 A. No.

15 Q. Have you seen anything in the documents you reviewed that
16 would change your opinion that Ms. Edmo needs genital surgery?

17 A. No.

18 Q. Do you think that a prisoner should be discipline-free for
19 some period of time before receiving surgery?

20 A. Not at all.

21 MR. HALL: Objection. Foundation.

22 MR. EATON: Join.

23 MR. HALL: There has been no testimony that he has any
24 experience in prison or corrections.

25 THE COURT: Rephrase the question as to whether that

1 would be an indicator that she would not be a good candidate.
2 It's roughly the same question, but I think rephrased, it would
3 probably resolve the objection of counsel.

4 Q. BY MS. WHELAN: Dr. Gorton, in your professional opinion,
5 would you ever consider disciplinary actions or even criminal
6 actions of a patient as precluding their medical need for
7 surgery?

8 MR. HALL: Objection. Foundation and it goes
9 towards -- well, Your Honor, it is compound.

10 THE COURT: I'm going to overrule the objection. Go
11 ahead.

12 THE WITNESS: No. And I couldn't do my job as an ER
13 doctor if I thought that, because we get a lot of prisoners that
14 are brought in for care. And there have even been a few cases
15 where I was assaulted by somebody and pressed charges against
16 them, but I still had to treat them because I was the only
17 doctor there.

18 And in those cases, you have to make a bright line between,
19 you know, what the person did -- even if what the person did was
20 punch you in the face -- and the care that you treat. You know,
21 somebody's medical care shouldn't be dependent on whether or not
22 they have committed a crime, and it would be supremely unethical
23 to even consider that.

24 Q. BY MS. WHELAN: Are you familiar with the term
25 "evidence-based medicine"?

1 A. Yes.

2 Q. Can you describe what that term means.

3 A. So, basically, it's taking the sum of all medical
4 literature, all the evidence that we have about treating
5 patients and taking that data and applying it to the individual
6 patient that's in front of you to try and optimize the treatment
7 that you provide to optimize their ultimate outcome.

8 Q. Do you believe that the WPATH standards of care are
9 supported by evidence-based medicine?

10 A. I do.

11 Q. Are you aware that some people have suggested that genital
12 surgery should not be provided because there is insufficient
13 high-quality evidence to support those surgeries?

14 A. Yes.

15 Q. How are you aware of that?

16 A. I have come up with that argument -- or come up against
17 that argument before. That was in the New York State Medicaid
18 case that I worked with. I mean, that was their whole
19 contention, that this isn't supported by the medical literature.

20 And I mean, in this particular case, I think Dr. Garvey's
21 report says that.

22 Q. Can you explain what high-quality evidence is in this
23 context.

24 A. Well, the highest quality evidence is, you know,
25 meta-analysis. So we bring a bunch of studies together, and

1 then each of those studies is a large, well-performed
2 double-blinded randomized controlled clinical trial that runs
3 for a very long period of follow-up.

4 Q. And are those types of studies that you just described --
5 sorry. Strike that.

6 Does that quality of evidence that you just described exist
7 for genital surgeries for transgender people?

8 A. No.

9 Q. Why doesn't that evidence exist?

10 A. There is a lot of reasons. You know, just going through
11 the type of studies, so it's not going to be a large study
12 because it's a rare disease. So, I mean, nobody expects of that
13 a rare disease.

14 You can't do a double-blinded study, because in a
15 double-blinded study, neither the patient nor the provider knows
16 what treatment they received. And this is, obviously, apparent
17 surgery, so patients are going to know what procedure they had.

18 You can't do a placebo-controlled trial because if you have
19 a treatment that you know is effective -- and we do; I mean, we
20 have been doing this for decades, and there is an adequate
21 evidence base to realize that this is effective -- you can't
22 say, well, I'm going to take 100 people, and 50 I'm going to
23 provide them the care that we know that works, and these other
24 50, I'm just going to watch them and see what happens, because
25 that's not ethical, you know. Especially in a disease where

1 suicide is a significant complication, that's not okay.

2 I mean, we even do that -- like, if you're doing a study or
3 if you're in the middle of a study, like, if you're studying a
4 new cancer drug and you give -- half the people get the drug and
5 half get placebo, and then partway through the study, you
6 realize, wow, the patients that are getting the drug have a much
7 greater survival and their cancer is shrinking, you stop the
8 study. You don't say, well, let's keep going with the study so
9 that we get good data and, in doing so, endanger the lives of
10 the people who got the placebo.

11 I mean, that's not medically ethical. I mean, there is no
12 way you could get a placebo-controlled trial of trans surgery
13 study past an IRB. You can't do it.

14 Q. And what is an IRB?

15 A. It's an institutional review board. So if you're doing
16 research, you make a proposal and say, hey, this is the study
17 that I want to do this, and this is how I want to treat the
18 human subjects. And they decide whether or not that's okay.

19 Q. Your report in this case discusses a surgical evaluation
20 for Ms. Edmo that was done by Dr. Eliason.

21 Do you recall that?

22 A. I do.

23 Q. Can we bring up the Eliason assessment, which is Joint
24 Exhibit 1-538.

25 THE COURT: Counsel, so we're clear, we have been

1 referring to this as, I think, 1-538. That's really Exhibit 1,
2 page 538; is that correct?

3 MS. WHELAN: That's correct. I'm sorry.

4 THE COURT: That's fine. I just need to make sure the
5 record is clear for any appellate review.

6 MS. WHELAN: Yes. Thank you, Your Honor.

7 THE COURT: I always have to cover my bets. So go
8 ahead.

9 Q. BY MS. WHELAN: Dr. Gorton, is that up on your screen?

10 A. Yes, it is.

11 Q. Is this the assessment that you reviewed?

12 A. Yes, it is.

13 Q. Did you agree with this assessment?

14 A. No.

15 Q. Can you explain why you didn't agree with this assessment.

16 A. Well, one, I didn't agree with the conclusion that he made
17 that she doesn't need surgery. But, two, his reasoning I also
18 didn't agree with.

19 Q. Can you explain why you didn't agree with his reasoning.

20 A. So if you look at the thing that starts "A" with a colon
21 after it, that stands for "assessment," he talks about
22 situations where sex reassignment surgery might be medically
23 necessary, and he gives three examples.

24 And the first example isn't even germane to transgender
25 people. That talks about people with intersex conditions. I

1 mean, you can have coexisting intersex conditions and gender
2 dysphoria, but that's -- that's actually referring to problems
3 that intersex people have.

4 The third one is -- it says, "Some type of medical problem
5 in which endogenous sexual hormones were causing severe
6 physiologic damage." And so that's the hormones that your body
7 makes itself, not ones that we give you.

8 So, I mean, I can't even -- that's -- it's almost kind of
9 bizarre. I can't even think of a clinical circumstance where
10 that would be the case that your hormones that your body
11 produces are attacking you, so we have to give you sex
12 reassignment surgery. I just don't understand what he is
13 talking about there.

14 And then the second one is it was -- he is talking about
15 how severe the dysphoria is, and that's legitimate. But he
16 says, "Severe and devastating dysphoria that is primarily due to
17 genitals could potentially meet criteria."

18 And the criteria isn't severe and devastating dysphoria;
19 it's clear and significant dysphoria. And that's the criteria
20 that I use and my colleagues use for assessing patients; right?
21 If I required my patients to have severe and devastating
22 dysphoria, over two-thirds of the people I refer for surgery
23 wouldn't get it.

24 You know, and the thing is even if you use his extremely
25 high bar, I think Ms. Edmo meets it. Because, I mean, she tried

1 to cut her testicles off, twice. If that's not something that
2 speaks to severe genital-focused dysphoria, I'm not sure what
3 is.

4 Q. Do you agree with Dr. Eliason's statement that, quote,
5 "Medical necessity for sex reassignment surgery is not very well
6 defined and is constantly shifting"?

7 A. Not at all.

8 Q. Why don't you agree with that statement?

9 A. I mean, this is something that we have been doing this for
10 decades. You know, the first sex reassignment surgery that we
11 know of happened 101 years ago at the University of Oregon. And
12 so we have been doing this for a long time.

13 We know it's effective. And medical necessity is the
14 patient has a disease, and you have a treatment that we know to
15 be effective. And that disease is to a clinically significant
16 level; that's medically necessary. There is no argument about
17 the medical necessity of it.

18 Q. What is your opinion about what might happen to Ms. Edmo if
19 she isn't provided surgery?

20 MR. EATON: Objection. Speculation.

21 MR. HALL: Join.

22 MS. WHELAN: May I, Your Honor?

23 THE COURT: Just a moment. I'm going to overrule the
24 objection. I think this question goes to the very heart of the
25 issue before the court.

1 There, undoubtedly, is some measure of speculation. But on
2 the other hand, the doctor has been involved in treating
3 hundreds of individuals suffering from gender dysphoria. And I
4 think based on that, clearly, there would have to be an
5 understanding of what the consequences are if certain treatment
6 is or is not provided.

7 So I'm going to overrule the objection. Counsel will be
8 allowed to explore the speculative nature, if there is one, of
9 the doctor's testimony during cross.

10 You may go ahead and answer.

11 THE WITNESS: Can I have the question again.

12 THE COURT: I was afraid of that. Go ahead.

13 Q. BY MS. WHELAN: What is your opinion about what might
14 happen to Ms. Edmo if she isn't provided surgery?

15 A. If she is not provided surgery, there is a very substantial
16 chance that she will try to attempt self-surgery again. And
17 that's especially worrisome given her attempts have been
18 progressive. Like her first attempt, she didn't make as much
19 progress as the second attempt. So I think she might be
20 successful if she repeats that.

21 There is also a real chance that she will attempt or commit
22 suicide.

23 Q. Why did you say in your report that surgery should be
24 provided to Ms. Edmo within six months?

25 A. In my -- in the patients that I have treated, there is

1 something that I just kind of noticed that when people who have
2 been needing surgery for a long time finally realize they are
3 going to get it, even before they have surgery, their gender
4 dysphoria improves.

5 They -- you know, it's sort of like there is this -- you
6 know, a relief that comes that's, you know, they know they are
7 going to get the treatment that they want.

8 And so what happens is if there is a delay -- and that
9 could be because the patient gets appendicitis and can't have
10 surgery for a number of months, or, you know, there is a longer
11 wait for the surgeon to be able to get them in -- if it goes
12 more than about six months, that sort of anticipatory benefit
13 that you get with regards to their gender dysphoria starts to
14 fade away.

15 And so if I have patients who, for some reason, there is
16 going to be a delay past that, I actually bring them in and talk
17 with them about it and make sure things aren't getting worse.

18 THE COURT: Counsel, we are past where we would take
19 the break, but I'll let you go for a few more minutes. I don't
20 want to interrupt your line of questioning, either.

21 MS. WHELAN: I'm about done, so I think that will work
22 if it works for you.

23 THE COURT: Just a few more minutes?

24 MS. WHELAN: Just a couple more minutes.

25 THE COURT: All right.

1 Q. BY MS. WHELAN: How likely do you think that it is that
2 Ms. Edmo will regret surgery?

3 A. Very, very low.

4 Q. And on what do you base that opinion?

5 A. One, my evaluation of her. She has -- her gender dysphoria
6 is very genital-focused. And so that makes her less likely to
7 regret it.

8 Also, if you look in the medical literature, regret rates
9 sort of overall generically for transgender patients are on the
10 order of 1 to 2 percent, which sounds like that's a big amount,
11 but it's actually -- like, if you compare it to, say, you know,
12 like prostate surgery or gastric bypass surgery, those have
13 regret rates in the 10 to 20 percent range.

14 And by "regret," I mean you're asking the patient
15 afterwards, "If you could go back in time and make this decision
16 again, would you still choose to do it?" And that's -- you
17 know, so 1 to 2 percent for surgical procedures is actually not
18 bad.

19 And the other thing, too, is there is -- there have been a
20 few studies that have looked at predictors for which patients
21 are more likely to regret. And the one that probably has the
22 strongest effect -- and I could not tell you why this is the
23 case -- but it's the sexual orientation of the transgender woman
24 in that trans women who are straight -- so their sexual
25 preference is for men -- tend to have much lower regret rates

1 than transgender women who are lesbians.

2 Q. Are you also familiar with complications that can result
3 from genital surgeries for transgender women?

4 A. Yes.

5 Q. What are some of those complications?

6 A. I mean, it's a major genitourinary surgery. So you can
7 have infections; you can have complications with urine flow; you
8 can have dehiscence, where the wound doesn't perfectly heal.

9 You -- if patients don't, subsequent to surgery, dilate
10 their vaginas as they are supposed to, you can actually have the
11 vaginal depth decrease and the width decrease. Those are things
12 that you can treat if they come up.

13 I mean, there is the -- in order to have surgery, you have
14 to have anesthesia, and anesthesia carries its own risks, which,
15 you know, you have a one-in-a-million shot that you're going to
16 die under anesthesia. So there is that.

17 Though it's not -- the risks aren't particularly greater
18 than other similar genitourinary surgeries.

19 Q. Based on your clinical experience, what is the likelihood
20 that Ms. Edmo's severe gender dysphoria will significantly
21 improve without surgery?

22 A. Very low to none.

23 MS. WHELAN: Thank you, Dr. Gorton. I have no further
24 questions at this time.

25 THE COURT: Counsel, let's just start cross after we

1 take a 15-minute break. Try to hold it to 15 minutes, Counsel.

2 So, again, try to reconvene at 20 minutes to the hour.

3 Court will be in recess.

4 (Recess at 10:28 a.m. until 10:44 a.m.)

5 THE COURT: I'll remind the witness that you're still
6 under oath.

7 I think we were ready for cross-examination, Mr. Hall -- or
8 Mr. Eaton. Yes, Mr. Eaton.

9 CROSS-EXAMINATION

10 BY MR. EATON:

11 Q. Good morning, Dr. Gorton. How are you today?

12 A. Good.

13 Q. Good. As you know, my name is Dylan Eaton. I represent
14 Corizon as providers in this lawsuit. I talked with you at your
15 deposition.

16 Do you remember that?

17 A. Yes.

18 Q. That deposition was on September 25th?

19 A. That sounds about right.

20 Q. Sounds about right?

21 And so I have the privilege of asking you a few more
22 questions today.

23 First, have you -- you have never worked in a prison;
24 right?

25 A. No, I haven't.

1 Q. Okay. And you have never been a part of a treatment group
2 or committee at a prison; correct?

3 A. No.

4 Q. And you have never provided treatment and care to an inmate
5 who had gender dysphoria or gender identity disorder while they
6 were incarcerated; correct?

7 A. My patients have become incarcerated, but I was their
8 provider before but not during. And I have treated patients
9 after prison if they are on parole, but not while they were in
10 prison.

11 Q. Right. And I understand when we talked at your deposition
12 that you told me you had some pre and post experience with
13 people that have been in prison. But that wasn't my question.

14 My question is: Have you -- you have never provided
15 treatment and care to an inmate who has gender dysphoria or
16 gender identity disorder while they were incarcerated; correct?

17 A. Yeah, I haven't.

18 Q. So that's a correct?

19 A. Yes; correct. Sorry.

20 Q. And you are not a board-certified psychiatrist; correct?

21 A. No, I'm not.

22 Q. Correct?

23 A. Correct. Sorry.

24 Q. Sorry. I just need to watch the double negatives.

25 You are not a licensed psychiatrist; right?

1 A. Correct.

2 Q. And you're not a licensed clinician; right -- mental health
3 clinician?

4 A. Correct.

5 Q. All right. And you are not a licensed therapist; correct?

6 A. Correct.

7 Q. And you are not a psychologist; correct?

8 A. Correct.

9 Q. Do you know what a certified correctional
10 healthcare -- health professional is?

11 A. You mentioned it at the deposition, so that's about it.

12 Q. So you don't know about that term?

13 A. No.

14 Q. Okay. So safe to say that you're not a certified
15 correctional health professional?

16 A. Correct.

17 Q. And you do not perform gender confirmation surgery;
18 correct?

19 A. No, I don't. Correct. Sorry.

20 Q. Correct? That's okay.

21 And just so I understand -- there has been confusion
22 sometimes about terminology -- is "sex reassignment surgery" an
23 okay term as well?

24 A. Yes, that's fine.

25 Q. And I just used the term "gender confirmation surgery."

1 Is that an appropriate term?

2 A. They are used interchangeably.

3 Q. Is that a newer term?

4 A. Yes, it's more new.

5 Q. What about "gender affirming surgery"?

6 A. Those -- "gender affirming surgery" is a newer term as
7 well.

8 Q. Is "gender affirming surgery" even newer than "gender
9 confirmation surgery"?

10 A. They are both relatively new. I don't know which one was
11 first, so...

12 Q. Okay. And you're not licensed to practice medicine in any
13 state other than California; right?

14 A. Correct.

15 Q. If there is a patient with complex mental health problems,
16 say, with several mental health comorbidities, you would refer
17 such a patient to a psychiatrist; correct?

18 A. There is different contexts to answer that question. Are
19 you talking about overall? Are you talking about gender
20 dysphoria patients' referral for surgery?

21 Q. No. I'm talking about if a gender dysphoria patient has
22 complex mental health problems, you would refer them to a
23 psychiatrist, right, to address their mental health issues?

24 A. It depends. I mean, I have patients who come to me, who
25 have complex mental health problems who have previously seen a

1 psychiatrist, and they are very stable on their medicines. And
2 so if they are stable, I just continue those medicines.

3 Certainly, if they became symptomatic or had problems, I
4 refer them back to psychiatry.

5 Q. So you utilize psychiatrists in your practice, correct,
6 even for gender dysphoria patients?

7 A. I do. My clinic actually has psychiatrists there.

8 Q. Okay. You will refer your gender dysphoria patients often
9 to psychiatrists?

10 A. My practice at my clinic is that -- so we have access to
11 psychiatrists; we also have access to therapists. And so the
12 most common thing is I would refer a patient to a therapist.
13 Really, for psychiatry, it's more there is some meds management
14 issue that needs to be addressed.

15 Q. So bottom line, at your Lyon-Martins clinic, you have
16 mental health professionals that you utilize; correct?

17 A. Yes, absolutely.

18 Q. And that includes clinicians? Yes?

19 A. Yes.

20 Q. And that includes therapists?

21 A. I think of those as the same things. But, yes.

22 Q. Okay. And you utilize psychiatrists sometimes?

23 A. Yes.

24 Q. And that situation could be when there is complex mental
25 health issues and comorbidities, that would be an example of

1 when you might refer somebody to a psychiatrist; correct?

2 A. As I answered before, sometimes, yes.

3 Q. Now, you did not charge an expert fee for this case;
4 correct?

5 A. That's correct. They paid my expenses but no expert fee.

6 Q. I think this is the first time I've had an expert not ask
7 for a fee at a deposition. So thank you.

8 So you don't charge at all for fees for being here today or
9 for your testimony at deposition or any of the work you have
10 done on this case; correct?

11 A. Correct.

12 Q. And you don't charge a fee because it's a transgender case;
13 correct?

14 A. No. I actually did have one transgender case that I
15 charged a fee for.

16 Q. Have you had transgender cases where you didn't charge a
17 fee other than this one?

18 A. Correct, yes.

19 Q. Most of them; right?

20 A. Yes.

21 Q. And then I believe you told me that you have charged a fee
22 when you were an expert witness in a Florida licensing case
23 involving a gynecologist; right?

24 A. That's correct.

25 Q. Okay. There was some discussion with Ms. Whelan about some

1 of your involvement with groups when we were looking at your CV.

2 So you do legal -- you're a legal consultant and do
3 specific projects for the Sylvia Rivera Law Project, which is an
4 organization to assist transgender people, especially who are
5 poor or people of color; right?

6 A. That's correct.

7 Q. Right. And you do legal consulting and projects for Lambda
8 Legal Defense and Education Fund, which handles LGBT cases?

9 A. I mean, I think of it as medical consulting because I'm not
10 a lawyer, so -- I mean, to legal organizations, yeah.

11 Q. So you do medical consulting for them?

12 A. Yes.

13 Q. Okay. And Transgender Law Center, which works on
14 transgender precedent-setting cases, I believe is what you told
15 me?

16 A. They do -- they do now. They were a more direct service
17 organization years ago.

18 Q. And you provided consulting and specific projects for them
19 as well; correct?

20 A. Yes.

21 Q. All right. And National Center for Lesbian Rights, which
22 focuses on lesbian rights and, more broadly, LGBT issues, such
23 as transgender issues, you provide consulting and do specific
24 projects for them; right?

25 A. That's correct.

1 Q. And then the National Center for Transgender Equality,
2 you're involved with them as well; correct?

3 A. To a small extent.

4 Q. And you donate to some of these groups; correct?

5 A. Yes.

6 Q. Okay. And I believe you mentioned you also get quite a few
7 calls from attorneys at the National Center for Lesbian Rights,
8 such as Ms. Whelan, who is one of Ms. Edmo's attorneys,
9 regarding various issues and questions on other matters; right?

10 MS. WHELAN: Objection. Misstates the evidence.

11 THE COURT: Well, if you disagree, you can. I'll
12 overrule the objection.

13 THE WITNESS: I mean, I have worked on a handful of
14 projects with them, maybe less than six over 8 to 10 years.
15 But, you know, I'll get questions from people, you know, "Can
16 you work on this project?" And if I have the bandwidth at that
17 time, I do.

18 Q. BY MR. EATON: So I remember discussing this at your
19 deposition. And you indicated that you get calls fairly
20 frequently from Ms. Whelan or other attorneys, right, for other
21 projects?

22 A. Are you speaking --

23 MS. WHELAN: Objection.

24 THE COURT: Just a moment. What is the objection,
25 Ms. Whelan?

1 MS. WHELAN: I'm sorry. It just misstates the
2 deposition testimony, Your Honor.

3 THE COURT: Well, let's put a question --

4 MS. WHELAN: I mean, if he wants to show it to him --

5 THE COURT: I'm going to sustain the objection and ask
6 counsel to put a question before the witness rather than just
7 make an observation.

8 Go ahead and proceed.

9 Q. BY MR. EATON: Do you remember discussing -- do you recall
10 when we were discussing that you would get phone calls from
11 Ms. Whelan on other cases during the deposition?

12 A. I believe what I said is that, overall, I will not
13 infrequently get calls from the organizations you just
14 mentioned; there is a big list of them.

15 And so, overall, yeah. But from Ms. Whelan, I think we
16 worked on two things, this and one other.

17 Q. So she has contacted you occasionally, then, on other
18 matters?

19 A. These two times, yes -- or this time and one other time.

20 Q. All right. Now, you mentioned in your deposition that you
21 realize that getting documentation of a person's prior mental
22 health treatment is important in assessing that person for SRS;
23 correct?

24 A. Ideally, yes.

25 Q. I'm sorry. I didn't hear the first word.

1 A. Ideally, yes.

2 Q. You indicated that that is important; correct?

3 A. You can't always get that information, but you should try,
4 yes.

5 Q. Okay. And after your clinical interview with Ms. Edmo, did
6 you request to receive or obtain any of her prior mental health
7 treatment records?

8 A. I actually got more of her treatment records while she was
9 in prison, from the attorneys. And like I said, I got some more
10 records from -- like, a very little bit -- from her previous
11 treatment before prison.

12 Q. But did you ask for her preincarceration mental health
13 records at the time of your declaration in May of 2018?

14 A. Honestly, I didn't know I could. I mean, usually people
15 just hand you the stuff and say, "This is the data that you
16 have." So, no, I didn't.

17 Q. Did you ask Ms. Edmo if you could obtain any of her
18 preincarceration records?

19 A. The thing is I didn't establish a physician-patient
20 relationship with her, and I made that very clear at the
21 beginning. That's part of my boilerplate I explain to people.

22 So, you know, if I was seeing somebody and they are my
23 patient and I'm providing them care, I -- that's something I
24 typically do; I request their old medical records, if there
25 are -- if they exist and if they are germane. But I didn't

1 think that that was something that I was supposed to do,
2 honestly.

3 Q. So you did not ask Ms. Edmo --

4 A. No.

5 Q. -- for her preincarceration records; is that correct?

6 A. No, I didn't.

7 Q. Correct?

8 A. Correct. Sorry.

9 Q. You did not obtain or review plaintiff's presentence
10 investigation or related documents regarding her convictions
11 prior to your declaration in May of 2018; correct?

12 A. Correct.

13 Q. So I want to be clear. At the time of your May 29, 2018,
14 declaration in this case, you only reviewed medical
15 records -- the prison chart notes that you said you received
16 were about 80 or 90 percent of those records -- and had a
17 clinical interview with Ms. Edmo; correct?

18 A. Correct.

19 Q. And at the time you executed your declaration in May 2018,
20 you hadn't reviewed incident reports regarding Ms. Edmo;
21 correct?

22 A. In her -- are you talking about DORs?

23 Q. No. Incident reports.

24 Do you know what those are?

25 A. Can you give me a description.

1 Q. I'm just wondering: Do you know what they are?

2 A. Well, I'll tell you what I saw in her chart, and you can
3 tell me if this is correct.

4 So there were notes that were written by clinicians in
5 regarding -- or in regards to disciplinary problems that she had
6 that, you know, answer questions like was her mental health a
7 mitigating factor or involved in this.

8 So that's what I had. I don't know if that's what you're
9 talking about.

10 Q. So you saw in the chart some references by clinicians
11 related to DORs that she had received?

12 A. That's correct; yes.

13 Q. But you hadn't actually seen the actual DORs at the time of
14 your May 2018 declaration; correct?

15 A. That's correct.

16 Q. When I say "DORs," you understand I'm talking about
17 disciplinary offense reports?

18 A. Yes.

19 Q. Okay. At the time of your declaration in May of 2018, you
20 hadn't reviewed any of the Management and Treatment Committee
21 meeting minutes regarding Ms. Edmo; correct?

22 A. That's correct.

23 Q. At the time of your May 2018 declaration, you hadn't
24 reviewed sex offender treatment program records regarding
25 Ms. Edmo; correct?

1 A. Correct.

2 Q. At the time of your May 2018 declaration, you hadn't
3 reviewed preincarceration Sho-Ban Tribe medical records
4 regarding Ms. Edmo; correct?

5 A. Correct.

6 Q. At the time of your May 2018 declaration, you hadn't
7 reviewed any preincarceration records from Indian Health
8 Services regarding Ms. Edmo; correct?

9 A. Correct.

10 Q. At the time of your May 2018 declaration, you hadn't
11 reviewed any preincarceration records from Portneuf Hospital
12 regarding Ms. Edmo; correct?

13 A. Correct.

14 Q. At the time of your May 2018 declaration, you hadn't
15 reviewed any presentencing investigation; correct -- documents?

16 A. Correct.

17 Q. And at the time of your May 2018 declaration, you hadn't
18 reviewed any Bannock County Jail records; correct?

19 A. I'm pretty sure not.

20 Q. And at the time of your May 2018 declaration, you hadn't
21 reviewed any Idaho Department of Corrections gender dysphoria
22 policies or procedures; correct?

23 A. Correct.

24 Q. And at the time of your May 2018 declaration, you hadn't
25 reviewed any prior versions of the Idaho Department of

1 Corrections PREA policy; correct?

2 A. Correct.

3 Q. And just so we're clear, then, you executed another shorter
4 declaration again in this case on June 11th of 2018; right?

5 A. I did. And I believe that date is correct.

6 Q. Okay. And for that declaration, the only additional
7 information you reviewed was the complete prison medical chart;
8 correct?

9 A. Partially correct.

10 There was -- what happened was I got a new set of records.
11 And I mean, she has massively long records. So the attorneys
12 that I was working with actually gave me a one-page document
13 that said: These are the pages that you didn't have. So it
14 sort of highlighted the pages that I didn't have.

15 And so I read through those pages. But, as it turned out
16 subsequently, there was -- I mean, they made an error in writing
17 down which pages were -- that hadn't been reviewed yet. So
18 there was actually a small portion of her mental health records
19 that I didn't realize was added to that. And then subsequent to
20 that second declaration, I became aware of that.

21 Sorry. That's complex.

22 Q. So if I understand you correctly, you received the complete
23 medical chart by the time you executed your declaration in June
24 of 2018?

25 A. Yes.

1 Q. Okay. But you're saying that there were a few mental
2 health records that you didn't realize that were in that new
3 packet that were new; correct?

4 A. Correct.

5 Q. But other than that, all of the list of other documents I
6 just went through that you did not review for your May 2018
7 declaration, you also had not reviewed those for your June 2018
8 declaration; correct?

9 A. I'm actually not entirely sure. I mean, I -- what I recall
10 is that I got the subsequent set of records that were her
11 medical records. And then after that, things kind of dribbled
12 in. Like I would get, "Here is a report to read," "Here is a
13 deposition to read."

14 And I can't tell you for certain that none of those came
15 before the second declaration. I just don't know the exact
16 dates.

17 Q. Okay.

18 A. I don't think it was the majority -- I mean, it certainly
19 was not the majority.

20 Q. Well, at your deposition, we went through all of those, and
21 you indicated that all those that we just discussed, had come in
22 within the last few weeks of the deposition, at the end of
23 September; right?

24 A. That certainly may be the case. I mean, it was a little
25 bit fresher in my mind then. So if I said that, that's probably

1 true.

2 Q. And you certainly didn't have her preincarceration medical
3 and mental health records at the time of your June 2018
4 declaration; right?

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

6 Q. Now, in your deposition, we discussed paragraph 32 of your
7 May declaration. And I can pull it up if you want me to, but we
8 discussed that the -- that Ms. Edmo reported that she saw a
9 psychiatrist through Indian Health Services who mentioned the
10 possibility of getting a diagnosis related to gender dysphoria;
11 and that if she wanted treatment, they would have to send her to
12 a specialist.

13 Do you recall discussing that with me?

14 A. I recall discussing it, not the exact discussion. But,
15 yeah, we talked about it.

16 Q. Why don't we pull up that declaration, the May declaration,
17 paragraph 32.

18 So are you seeing this on your screen?

19 THE COURT: Counsel, just for the record, is this part
20 of the court record? And if so, can you give us a docket
21 number? Or is it an exhibit?

22 MR. EATON: This is a docket number. It was filed
23 with the court. So I believe the parties indicated they would
24 refer to the docket number for purposes of --

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

1 MR. EATON: Correct, Your Honor.

2 THE COURT: Paragraph 32; is that what you said?

3 MR. EATON: Yes, Your Honor.

4 THE COURT: All right.

5 Q. BY MR. EATON: Are you seeing that, Doctor?

6 A. Yes. Sorry. Yes.

7 Q. And here, this is part of your declaration where you are
8 summarizing what she reported to you; is that correct?

9 A. Correct.

10 Q. And the last sentence says:

11 "She does report that a psychiatrist she had seen
12 through the Indian Health Service mentioned the
13 possibility of getting a diagnosis related to gender
14 dysphoria and said that if she wanted treatment, she
15 would have to send her to a specialist."

16 Do you see that there?

17 A. I do.

18 Q. I read that correctly?

19 A. Yes.

20 Q. And that was per Ms. Edmo's report; correct?

21 A. That's correct.

22 Q. And did you ever confirm this statement with any documents
23 or records?

24 A. Again, all I had were the records from her -- the
25 incomplete prison records.

1 Q. Well, you did not confirm that this statement with any
2 documents in this case; correct?

3 A. No.

4 Q. Correct?

5 A. I'm sorry. Correct.

6 Q. And you mentioned that you interviewed Ms. Edmo for this
7 case; correct?

8 A. Correct.

9 Q. All right. And you did not record that interview, either
10 audio or video; correct?

11 A. Correct.

12 Q. All right. So the only documentation we have regarding
13 your clinical interview with Ms. Edmo is what you put in your
14 declaration; right?

15 A. Correct.

16 Q. And that lasted about two hours?

17 A. Two, two-and-a-half hours, something like that.

18 Q. And you -- the purpose of that was pretty much to get her
19 subjective history; correct?

20 A. It was to get her subjective history, but I also did a
21 limited examination.

22 Q. That was a no-touch medical examination; is that right?

23 A. Correct.

24 Q. So just observation?

25 A. Observation and assessing her -- you know, like, it's part

1 of the physical exam, the psychiatry portion of a physical exam,
2 to assess level of depression.

3 So it would be in the objective section, but it's an
4 objective thing that you ask the patient about and your
5 observations.

6 Q. You didn't ask the patient to disrobe; right?

7 A. No, I did not.

8 Q. And you didn't examine her breasts or her anatomy or
9 anything; correct?

10 A. Not beyond what I could see through her clothes, like her
11 body habitus.

12 Q. Now, your counsel talked to you about the WPATH standards
13 of care.

14 You're a member of WPATH; correct?

15 A. Correct.

16 Q. And I believe you mentioned you served on the
17 Institutionalized Persons Committee for WPATH; is that right?

18 A. Correct.

19 Q. And do you recall telling me in your deposition that you
20 could not recall any person on that committee that worked in a
21 prison; right?

22 A. Correct.

23 Q. All right. So could you pull up Plaintiff's Joint
24 Exhibit 15. That's the WPATH standards. Let's go to the next
25 page. One more. One more. Keep going. I'm trying to get to

1 the first page. Let's go to the second page.

2 You see this is the document you were talking with your
3 counsel about, "The standards of care are flexible clinical
4 guidelines"; right?

5 A. Correct.

6 Q. So you admit that one of the main -- first of all -- sorry.
7 Could we go back one page.

8 If you could look at the second paragraph, this is purposes
9 and use of standards of care just generally; right, Doctor?

10 THE COURT: Can you zoom in on that.

11 MR. EATON: Can we zoom in on the -- there we go.
12 Second paragraph.

13 Q. BY MR. EATON: So you can see the start of this first --
14 second paragraph, it says:

15 "One of the main functions of WPATH is to promote the
16 highest standards of healthcare for individuals
17 through the articulation of standards of care for
18 health of transsexual, transgender, and gender
19 nonconforming people."

20 Do you see that?

21 A. I do.

22 Q. You agree with that; right?

23 A. Yes.

24 Q. Isn't it the purpose of WPATH to set a higher standard of
25 care than the bare minimum?

1 A. I don't know what you're specifically talking about.

2 Q. Well, it's trying to set a high bar for treatment and care
3 of gender dysphoria cases; correct?

4 A. As far as the quality of care, yes.

5 Q. Let's go to the next page, please. Zoom out and go to the
6 next page. We went one too far. Page 2. Go back up one.

7 And again, now we're on the section, "The standards of care
8 are flexible clinical guidelines," that you were talking with
9 your counsel about; correct?

10 A. Yes.

11 Q. And so you admit that WPATH standards of care are intended
12 to be flexible in order to meet the diverse healthcare needs of
13 transsexual, transgender, and gender nonconforming people;
14 right?

15 A. Yes.

16 Q. Indeed, the section says its standards of care are flexible
17 guidelines; correct?

18 A. Correct.

19 Q. Clinical guidelines.

20 And you admit that the WPATH criteria put forth in this
21 document for hormone therapy and surgical treatments for gender
22 dysphoria are clinical guidelines; right?

23 A. Yes.

24 Q. And that's what it says right there on the first
25 paragraph -- or the second paragraph, first sentence; right?

1 Second paragraph, first sentence:

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

6 Right?

7 A. Yes.

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

10 A. Yes.

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

13 A. Correct.

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

15 A. Yeah, they are examples.

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

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

23 Q. Where are you looking?

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

1 examples were much more specific, you know. But they are giving
2 the broad sort of groups of departures. They are not giving
3 specific examples like this patient with this clinical
4 situation. They are saying social situations and anatomic
5 situations and an experienced provider's evolving method of
6 treating patients.

7 So these are kind of global groups, not really so much
8 examples.

9 Q. But it says "may come about."

10 So these are examples; right? Examples of categories?

11 A. Yeah, categories.

12 Q. Now, you would agree that treatment and care of gender
13 dysphoria patients has been evolving over the last 10 years;
14 right?

15 A. Yes.

16 Q. We discussed some of those. But terminology has changed,
17 for instance, SRS versus gender confirmation surgery?

18 A. Correct.

19 Q. And the diagnosis of gender identity disorder was changed
20 to gender dysphoria; right?

21 A. That's correct.

22 Q. All right. And over the last 10 years, hormone dose range
23 recommendations have changed over the years, too; right?

24 A. Not a lot but some, yes.

25 Q. Now, I believe in our -- in your deposition, you indicated

1 that you liberally refer your gender dysphoria patients to
2 mental health therapy; right?

3 A. If they need specific issues addressed, yeah.

4 Q. But you do that often with your patients; right?

5 A. Always with patients who are being referred to surgery.

6 And not always -- I would say not in the majority of the
7 patients who it's not specifically related to surgery.

8 Q. Well, it's a helpful tool that you utilize with your
9 patients; right?

10 A. Absolutely, in some patients, yes.

11 Q. All right. And you believe, don't you, that psychotherapy
12 is important for Ms. Edmo; right?

13 A. I do.

14 Q. You believe that it's important that she goes to mental
15 health groups; correct?

16 A. If they are good-quality mental health groups, yes.

17 Q. Now, you acknowledge that Ms. Edmo was properly diagnosed
18 with gender identity disorder in 2012 by Dr. Eliason; correct?

19 A. Correct.

20 Q. And you also acknowledge that Ms. Edmo was properly
21 diagnosed with gender identity disorder in 2012 by Dr. Lake;
22 correct?

23 A. Correct.

24 Q. Now, I wanted to talk to you briefly about elevated liver
25 enzymes.

1 You mentioned that that's a concern in your declaration in
2 this case; correct?

3 A. Correct.

4 Q. All right. So now, another issue you mention in your May
5 2018 declaration relates to management of medications or
6 hormones when plaintiff had elevated liver enzymes in 2018;
7 right?

8 A. It was the end of 2017, like late December into 2018.

9 Q. And into January of 2018?

10 A. Correct.

11 Q. Now, as I understand it, you take issue with plaintiff
12 being taken off spironolactone hormone in late February 2018
13 when she likely still had elevated liver enzymes; right?

14 A. I think she may have been taken off in January. But, yes,
15 I do.

16 Q. Well, let's pull up the June declaration. Let's go to the
17 last paragraph in this declaration. Actually, it's the last
18 page, top there.

19 So on page 3, we're looking at your June declaration;
20 correct, Doctor?

21 A. Correct.

22 Q. All right. At the very bottom of page 3, it starts with
23 the word "it." Do you see that?

24 Like a sentence start with "it" and then carries onto
25 page 4.

1 A. Yes, I see that.

2 Q. All right. That says:

3 "It appears from the records that Ms. Edmo has not
4 been taking any spironolactone or any other adequate
5 antiandrogen since February 19, 2018."

6 Correct?

7 A. It does.

8 Though she was taken off in January, I think they restarted
9 it. That's probably why I remember January.

10 Q. What I'm getting at is that then she was stopped for a
11 while on February 19, 2018; correct?

12 A. Well, I think she was briefly started and then stopped
13 again on the 19th.

14 Q. Right. It was stopped for sure on the 19th?

15 A. Correct.

16 Q. And in your May 2018 declaration, you opine that the
17 spironolactone is likely not causing elevated enzyme -- liver
18 enzymes; right?

19 A. Correct.

20 Q. In fact, you go so far as to say that there was virtually
21 no chance that spironolactone caused Ms. Edmo's elevated liver
22 function tests; correct?

23 A. I don't know if those are the exact words. But, yes.

24 Q. Would you please pull up the June 11th declaration,
25 paragraph 14. I'm sorry. I have been saying "June." I think

1 it's July.

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

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

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

6 "As I opined in my May 2018 declaration, there is
7 virtually no chance that spironolactone caused
8 Ms. Edmo's elevated liver function tests."

9 Right?

10 A. Correct.

11 Q. And you also opine that the Effexor, also called
12 venlafaxine, is the most likely cause of her elevated liver
13 enzymes; correct?

14 A. No. What I said is, of the medicines she is on, if one of
15 those medicines caused it, venlafaxine is the most likely
16 culprit.

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

19 So in this declaration paragraph, last line at the top of
20 page 24 of your declaration, page 72 of document 62-1, it says:

21 "The medication change is extremely concerning since
22 venlafaxine is the most likely medication prescribed
23 to Ms. Edmo that would cause elevations in LFTs."

24 Correct?

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

1 taking, that's the most likely culprit. But that's not my
2 opinion that that was the most likely cause of the elevated
3 liver function test; just that if you're going to blame the
4 medicine, the venlafaxine is the more likely culprit.

5 Q. Okay. But you don't disagree with that sentence in your
6 declaration?

7 A. No. Because I was talking about the most likely medicine
8 prescribed to her.

9 THE COURT REPORTER: Would you -- "No, because"?

10 THE WITNESS: No. Because -- I totally lost what I
11 said.

12 Q. BY MR. EATON: I was just asking if you agreed with that
13 sentence. I wasn't really asking for anything more.

14 A. Sorry. Yes.

15 Q. Okay. And you take issue with her being left on a high
16 dose of Effexor during this time frame in February and March
17 2018; right?

18 A. I believe what I was saying in paragraph 59 was that she
19 was on a high dose of Effexor, and then they increased her
20 Effexor, and the mental health provider hadn't looked at her RA
21 result of liver function tests.

22 And we know that in about 1 percent of people who take
23 Effexor -- at the max dose, about 1 percent will have elevated
24 liver function tests.

25 So if you're going to go over that max dose, and she

1 recently had LFTs that were elevated, I would not do that.

2 Q. Right. In fact, you said you would cut the Effexor in half
3 if you were her provider; right?

4 A. I would cut the dose by some. I probably said "half"
5 there. That sounds reasonable.

6 Q. Okay. So her spironolactone was discontinued in February
7 19 of 2018, and she was still on the Effexor going into March;
8 correct?

9 A. Correct.

10 Q. All right. And so could we pull up the lab from March. If
11 you would scroll down a little bit.

12 So this is a lab from March 6 of 2018. And we have been
13 talking about elevated liver enzymes.

14 What in the lab do you look at to make those
15 determinations?

16 A. So there is several tests that look at liver inflammation,
17 liver function. So the two that are highlighted there, AST and
18 ALT, those are proteins that are found in liver cells. And so
19 if the cells get damaged, those get released in the circulation
20 and will go out. So that's a marker for inflammation or damage
21 to liver. But there is also markers of the function of the
22 liver.

23 For example, the two top tests, albumin and bilirubin -- so
24 albumin is a protein made by the liver. So if your liver is not
25 functioning well, that may go down.

1 Bilirubin is actually a waste product of red blood cells
2 being destroyed eventually, and that can go up if your liver's
3 metabolic function is not able to break down all the waste
4 products your body is -- your body is producing.

5 Q. So, in any event, the March 6th, 2018, lab here for
6 Ms. Edmo shows that her liver function was normal; correct?

7 A. Correct.

8 Q. After being taken off spironolactone; correct?

9 A. Yes, but I don't think those are related.

10 Q. And she is still on Effexor at this point?

11 A. I believe so, yes.

12 Q. Let's pull up the May declaration, paragraph 84. I'm not
13 sure if it's paragraph or page 37. I think it's paragraph 37.

14 Let's try page 37 -- oh, I'm sorry. Paragraph 84.

15 So just to help the doctor, why don't you scroll up to the
16 prior page.

17 Just to orient you, Doctor, this is your section where you
18 are talking about surgery, in your opinion, is medically
19 necessary to treat Ms. Edmo's gender dysphoria; right?

20 A. Correct.

21 Q. All right. And then let's scroll down.

22 And you list the criteria in WPATH there; right?

23 A. Correct.

24 Q. And then scroll down to page 48.

25 And you're talking about in part -- you're going through

1 the criteria in this section, correct, for Ms. Edmo?

2 A. My computer screen didn't move. Did you move to a
3 different place?

4 Q. I'm still on page 84.

5 A. I'm on page 37.

6 Q. I'm sorry. It's paragraph 84.

7 A. Oh, sorry. Okay. Yes.

8 Q. Are we on the same page now?

9 A. Yes.

10 Q. Are we on the same paragraph now?

11 A. Yes. Got it.

12 Q. So in this paragraph, you are going through the WPATH
13 criteria as you believe they apply to Ms. Edmo; right?

14 A. Yes.

15 Q. Okay. And where I highlighted there, you are talking about
16 the criteria for whether her mental health issues are well
17 controlled; right?

18 A. Yes.

19 Q. You say her mental health issues are also reasonably well
20 controlled; right?

21 A. Correct.

22 Q. You don't analyze any of her mental health issues in this
23 declaration; right?

24 A. In this particular paragraph, no. I mean, but I think I
25 mentioned them elsewhere.

1 This is my bigger declaration; right? The first one?

2 Q. This is your -- yes, your longer declaration.

3 A. I mentioned her anxiety and depression and assessed those.

4 Q. But you don't address those here when you're talking about
5 the criteria for SRS; correct?

6 A. In this paragraph 84, no. I just am talking about what I
7 have already seen or what I have already stated.

8 Q. Now, WPATH, the final standard for SRS is 12 continuous
9 months living in a gender role that is congruent with their
10 gender identity; right?

11 A. Correct.

12 Q. All right. And you determined that she has fulfilled that?

13 A. I did.

14 Q. The WPATH doesn't further elaborate on how to apply this
15 criteria in a prison setting; right?

16 A. Correct. I mean, they say it's applicable in a prison
17 setting, but they don't give specific guidance.

18 Q. Well, that's in the one-and-a-half-page section that in
19 WPATH that just applies to institutions generally that includes
20 prisons but other institutions as well; correct?

21 A. Correct.

22 Q. Right. And that's not -- the prison setting is not
23 addressed in the specific criteria in WPATH for SRS; right?

24 A. Well, it's like the -- you know, the Institutionalized
25 Persons Committee. Yes, it's applicable to people in nursing

1 homes, but 95 percent of the issues are about prisons. And the
2 same thing with the institutionalized persons comment in WPATH.
3 Yes, it's about all the circumstances, because you shouldn't
4 ignore those. But the vast majority of times this comes up,
5 it's related to prisons.

6 Q. But the section on SRS criteria in the WPATH, that section
7 doesn't address prison settings and how it applies; correct --
8 how the criteria applies?

9 A. Well, those criteria apply broadly across the board to
10 anybody who is transgender.

11 Q. Well, again, it doesn't elaborate on how to apply the 12
12 months living in gender role as a congruent person with their
13 gender identity in a prison setting? It doesn't address that
14 any further, correct, in a prison setting?

15 A. It doesn't do it in any setting. So, no. I mean, they are
16 not specific about where they are applied. They are just
17 applicable to the disease.

18 Q. That might be where the flexibility comes in in the
19 guidelines; right?

20 A. I don't understand what you're asking.

21 Q. It doesn't define where the -- how to apply the section in
22 different settings.

23 So there could be some flexibility there; correct?

24 A. Yes.

25 Q. Now, you did not recommend SRS be performed immediately at

1 the time of your declarations in this case; correct?

2 A. Well, I said within six months, but immediately would have
3 been great, too. I gave a range because I didn't think the day
4 after I evaluated her that they were going to come in and give
5 her surgery, so...

6 Q. Well, if you thought there was a medical need for her to
7 get it immediately and within a month, you would have said that;
8 right?

9 A. I would have specifically -- I mean, I set the range based
10 on my clinical experience with patients. So I think within six
11 months is a reasonable range.

12 MR. EATON: Okay. Could you read my question back to
13 the witness, please.

14 (Question read by reporter.)

15 THE WITNESS: I mean, it's not like your appendix is
16 going to rupture and you have to get surgery tonight. So all
17 patients who are treated for this, they are seen, they are
18 evaluated, there is a process you have to go through. It's not
19 something that happens overnight. So that's not -- I mean,
20 that's not what you do clinically.

21 So, I mean, I would never say this person needs emergency
22 sex reassignment surgery. Let's send them in an ambulance to
23 the hospital. That's kind of absurd.

24 Q. So it's a process for dealing with when SRS is appropriate;
25 right?

1 A. That's correct.

2 Q. And you thought -- it was a guesstimate that within six
3 months, SRS would be appropriate; right?

4 A. Well, it's based on my clinical experience with my
5 patients, what I have observed.

6 Q. So you tell them, your patients, that you should get SRS
7 within six months?

8 A. No. I tell my patients that we're going to refer you for
9 SRS. And in most cases, that actually happens within six
10 months. From the time that I see them, we pretty quickly get
11 them in to see a mental health provider and get them referred.

12 But occasionally there are things that come up that make
13 that process longer. And so I don't tell patients, "Hey, we're
14 going to get this by six months." I'm like, "We are referring
15 you for this. Most of them go in under those windows." And the
16 ones that don't, there ends up being an issue.

17 Q. And I believe in your deposition, you indicated that it's
18 not uncommon for a surgeon to schedule a vaginoplasty out five
19 months or more; right?

20 A. It depends on the surgeon. You know, there are some
21 surgeons that are backed up. And if a patient wants a specific
22 surgeon, like I want Dr. Marci Bowers, she is going to have to
23 wait for it. But if she is willing to go to another surgeon,
24 she can get it sooner.

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

1 that's approximately -- it takes a surgeon approximately
2 five -- excuse me -- five months to get the sex reassignment
3 surgery scheduled?

4 A. I may. I mean, you know, it's a range. It depends on the
5 surgeon.

6 But, sure. If you can point me to what I said, I can tell
7 you if it's accurate. But I don't know -- this is a better way
8 of saying it: I don't know if I said specifically five months.
9 But there is a range that providers do; and some of the more
10 popular ones, you have to wait longer.

11 Q. Five months wouldn't be unreasonable, for instance, to wait
12 for an SRS; right?

13 A. No. Five months wouldn't be unreasonable.

14 Q. And you're critical of Dr. Eliason's SRS assessment; right?

15 A. Correct.

16 Q. Now, you understand that Dr. Eliason had mostly been Edmo's
17 treating psychiatrist since 2012; right?

18 A. I saw a couple of notes from Dr. Eliason, but most of the
19 mental health notes that I saw in her chart weren't from him.

20 Q. You didn't see periodic treatment notes from Dr. Eliason
21 over the years?

22 A. I did, but there were a lot of other mental health notes,
23 so I didn't know if he was her primary.

24 Q. Okay. But you understand he was one of her treaters, her
25 treating psychiatrists, over the years since 2012; right?

1 A. Sure. On the mental health treatment team, that's
2 legitimate to say.

3 Q. And you realize that Dr. Eliason diagnosed Ms. Edmo with
4 GID in 2012; right?

5 A. Correct.

6 Q. And you understand that Dr. Eliason had been seeing
7 Ms. Edmo periodically to discuss her mental health care issues
8 and manage her medications, such as Zoloft, over the years since
9 2012; right?

10 A. I remember there were at least a couple of notes.

11 Q. Where he was managing her mental health care; correct?

12 A. Correct.

13 Q. And you acknowledge that Dr. Eliason spoke with Ms. Edmo at
14 the time of the April 2016 SRS evaluation and documented her
15 subjective reporting in that note; right?

16 A. Correct.

17 Q. All right. And you acknowledge that Dr. Eliason documented
18 his objective observations at the time; correct?

19 A. Correct.

20 Q. And you acknowledge that Dr. Eliason did an assessment on
21 plaintiff; right?

22 A. Correct.

23 Q. And you acknowledge that Dr. Eliason's plan was that a
24 combination of hormonal treatment and supportive counseling was
25 sufficient at that time for her gender dysphoria; right?

1 A. That he -- that he said that, yes.

2 Q. And you acknowledge that he says that he will -- would
3 continue to monitor and assess the inmate throughout her stay at
4 the facility where he worked?

5 A. Correct.

6 Q. Do you know where he worked?

7 A. The same facility where she was at, possibly others.

8 Q. Do you have an understanding of whether there is a
9 behavioral health unit at that facility that's separate from the
10 general population? Do you understand that?

11 A. Do you mean are prisoners at a behavioral health level at
12 that institution? Yeah.

13 Q. Do you have an understanding of whether there is a separate
14 behavioral health facility or section separate from general
15 population?

16 A. Like, to house the prisoners? Yes.

17 Q. Okay. And you acknowledge that Dr. Eliason staffed the
18 SR -- his note says he staffed the SRS decision with other
19 medical and mental health providers; right?

20 A. Other mental health providers, yes. But I don't remember
21 their exact credentials, so I'm not sure if one of them was a
22 medical provider other than Dr. Eliason.

23 Q. Okay. Why don't we pull up that note. It's probably in
24 the Dr. Eliason folder, Corizon records.

25 So this is the document you were talking with your counsel

1 about, the SRS assessment by Dr. Eliason?

2 A. Correct.

3 Q. All right. If you scroll down or if we could highlight the
4 first paragraph where it says, "A," there is -- "27-year-old
5 male," is what that paragraph starts with --

6 A. Correct.

7 Q. -- in the middle.

8 A. I see that.

9 Q. I'm just asking her if she can zoom in on that a little
10 bit.

11 So the note indicates, in the middle there:

12 "I staffed this case with Dr. Jeremy Stoddart,
13 Dr. Murray Young, Jeremy Clark, LCPC, clinical
14 supervisor and WPATH member, and they agreed with my
15 assessment."

16 Do you see that there?

17 A. I do.

18 Q. So he staffed this with others; right?

19 A. Yeah. But, like I said, I still didn't know if
20 Dr. Stoddart or Dr. Young are psychologists or other medical
21 providers, so...

22 Q. Well, you see the reference to Jeremy Clark, a clinician
23 who indicates has WPATH training; right?

24 A. Well, it says he is a WPATH member. There is no training
25 required to be a member.

1 Q. Well, you would agree that it's appropriate for Dr. Eliason
2 to staff the SRS decision with other providers, including a
3 clinician who was associated with WPATH; right?

4 A. You can be a member of WPATH by sending them a check and
5 filling out a form. So, I mean, I don't know Dr. Clark's
6 credentials.

7 I mean, it should be staffed with people who are
8 experienced in taking care of transgender individuals because
9 that's the issue at question.

10 Q. You wouldn't fault someone for consulting with someone that
11 has an understanding of WPATH standards; right?

12 A. No, but I don't know if Mr. Clark has that.

13 Q. And you acknowledge that his note states he considered
14 criteria and determined he did not meet the criteria for SRS;
15 right?

16 He mentioned --

17 A. He said -- yeah. He says "does not meet criteria for
18 medical necessity for sex reassignment surgery."

19 Q. Okay. And if we could scroll down just a little bit.

20 And Dr. Eliason documented Ms. Edmo's other mental health
21 disorders, including major depressive disorder and alcohol use
22 disorder, on the bottom there; correct?

23 A. Correct.

24 Q. Now, I want to switch gears a little bit and talk to you
25 about regret and suicide.

1 At least one of your --

2 We can clear out of that and maybe pull up another one here
3 in a second.

4 So you told me at your deposition at least one of your
5 patients who had SRS -- and I'm talking about sex reassignment
6 surgery -- was successful at committing suicide after the
7 surgery; correct?

8 A. I had a patient -- I think we talked about a patient of
9 mine who tried to do self-surgery who committed suicide after
10 surgery.

11 Q. You don't recall telling me that one of your patients who
12 had SRS was successful at committing suicide after surgery?

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

15 Q. Right.

16 A. -- not a patient?

17 Q. Right.

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

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

21 So you see at the bottom there, it says, question: "And of
22 those that have had SRS, there was one that was successful at
23 committing suicide; correct?"

24 And you responded "yes"?

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

1 SRS -- like, I didn't refer them for it; they got that back in
2 the day.

3 Q. I'm sorry. I'm not following you.

4 A. So it was somebody who had SRS, but it was not my referral
5 for SRS. They came to me having -- being status postsurgery.

6 Q. So it wasn't your patient, but you're aware of somebody
7 that had SRS that then committed suicide after; is that what
8 you're telling me?

9 A. Yeah, it was my patient. But, like, it wasn't like they
10 came to me, I diagnosed them with gender dysphoria, and then
11 they had surgery and then --

12 THE REPORTER: Would you slow down.

13 THE WITNESS: I'm sorry. It wasn't a patient that I
14 saw diagnosed, referred for, and they had surgery and then
15 committed suicide. It is somebody who previously had had
16 surgery before I saw them, before they became my patient; and
17 then, subsequently, they committed suicide.

18 Q. BY MR. EATON: Okay. And at your deposition, we talked
19 about three other of your patients have attempted suicide after
20 a vaginoplasty; correct?

21 A. Yes, but not completed.

22 Q. And you estimated a handful of your patients have attempted
23 suicide after their surgeries; right?

24 A. We're talking about the three and the one. So four, "a
25 handful"?

1 Q. Well, of all the patients that have had SRS to some degree,
2 you estimate that a handful of your patients have attempted
3 suicide after those surgeries; right?

4 A. I'm sure that's correct. That's fair.

5 Q. And you had one patient who expressed regret after an
6 orchiectomy --

7 Am I saying that right?

8 A. Correct.

9 Q. -- an orchiectomy, which is surgery to remove the
10 testicles, and then sued you and your clinic; correct?

11 A. Sued several people in my clinic, yes.

12 Q. Including you?

13 A. Yes.

14 Q. Could we please pull up the Defendants' Exhibit 2038, page
15 27. Let's look at this first page.

16 Doctor, do you remember discussing the Endocrine Society
17 guidelines with me?

18 A. Correct, yes.

19 Q. And if you scroll down just to the bottom of that page, it
20 will show that that's the 2017 guidelines; correct?

21 A. Correct.

22 Q. All right. Let's go to page 27.

23 Is the Endocrine Society -- that's a good guide; correct?

24 It's a helpful guide and resource for you and other doctors?

25 A. This particular guideline? Yes.

1 Q. Yes.

2 A. Yes.

3 Q. Okay. So I put a little highlight there next to the
4 paragraph. There is a sentence that says:

5 "Further insight into the characteristics of persons
6 who regret their decision postoperatively would
7 facilitate better future selection of applicants
8 eligible for sexual reassignment surgery."

9 Do you see that?

10 A. I do.

11 Q. You agree with that?

12 A. Yes.

13 Q. And then the next sentence says:

14 "We need more studies with appropriate controls that
15 examine long-term quality of life, psychosocial
16 outcomes, and psychiatric outcomes to determine the
17 long-term benefits of surgical treatment." And it's
18 referring to SRS.

19 Do you see that?

20 A. I do.

21 Q. And you agree with that?

22 A. Yes.

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

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

1 THE COURT: What was the exhibit number again?

2 MR. EATON: Sorry. The exhibit is Defendant's Exhibit
3 2038. It's the Endocrine Society guidelines.

4 THE COURT: Any objection?

5 MS. WHELAN: No objection.

6 THE COURT: 2038 will be admitted.

7 (Defendants' Exhibit 2038 admitted.)

8 Q. BY MR. EATON: Do you know that she -- Ms. Edmo
9 received a bra at the prison from early on, soon after she
10 received her hormones; correct?

11 A. I don't know the exact timing, but yes.

12 Q. She has had it for a long time, since soon after --

13 A. For years, yeah.

14 Q. -- sex -- or soon after the hormone therapy, correct,
15 started?

16 A. For years. I mean, soon -- I don't know what you mean by
17 "soon." So -- but, yes, she has it for quite some time.

18 Q. Sorry. We were talking over one another there. Let me try
19 it again.

20 So since 2012, Ms. Edmo has had access to a bra; correct?

21 A. I don't know if it was 2012, but that certainly sounds
22 reasonable.

23 Q. You're aware that she currently has access to panties;
24 correct?

25 A. Currently, yes.

1 Q. And she has had panties in the past at times; correct?

2 A. She has had panties that she has obtained or created for
3 herself but not that were given to her to treat her gender
4 dysphoria.

5 Q. And what is a gaff?

6 A. A gaff is an undergarment that is used by transgender women
7 to tuck the penis and the testicles against the perineum so
8 that, one, they don't sort of feel the penis and the testicles
9 as much and, two, so it makes it so that they don't appear to
10 have a penis and testicles.

11 Q. Are you aware of any record showing that Ms. Edmo requested
12 a gaff?

13 A. I think she may have. I'm not entirely sure, but that
14 sounds familiar. There were a lot of records.

15 Q. You don't know?

16 A. I'm not sure, yeah.

17 Q. Now, in your declaration, you indicated Ms. Edmo reports
18 wearing women's underwear almost exclusively and wearing either
19 women's clothes and feminine men clothes; she would dress
20 feminine and go out with her friends to parties. And that was
21 referring to preincarceration.

22 Do you recall that?

23 A. I do.

24 Q. Okay. That's accurate, from what she told you?

25 A. Correct.

1 Q. And she reported to you that she used extensive -- she
2 had -- she used makeup extensively before prison; correct?

3 A. Yes.

4 Q. Let's pull up the May 2018 declaration, paragraph 47. Can
5 you scroll up just a tiny bit.

6 Are you seeing this paragraph 47, Doctor?

7 A. Yes.

8 Q. Okay. That's your paragraph in one of your declarations;
9 right?

10 A. The first declaration, yes.

11 Q. Okay. And this first sentence says, quote:

12 "Prior to Ms. Edmo's first appointment with Dr. Alviso
13 in 2016, her medical records contain no real
14 transgender history," end quote.

15 Right?

16 A. That's correct.

17 Q. Is that a correct statement, Doctor?

18 A. No. As we talked about in my deposition, I didn't have the
19 Dr. Alviso and Dr. Lake records when I initially saw her. And
20 then I got the complete set of her medical records before the
21 second declaration I made, but the pages that were indicated
22 that these are the records that you didn't get initially,
23 actually didn't include Dr. Eliason's and Dr. Lake's notes.

24 So when I wrote this, I hadn't read those. So that's not
25 correct.

1 Q. Nevertheless, you made conclusions about Corizon and
2 IDOC --

3 Actually, scroll down, please, a little bit more.

4 You made assumptions, nevertheless, that -- this is the
5 last sentence:

6 "It is also possible, however, that the prison
7 officials failed to access this history because even
8 if they had it, they are precluded by prison policy
9 from providing adequate care, such as surgery and
10 access to female commissary items."

11 You came to that conclusion; right?

12 A. I said it was possible, yes.

13 Q. And that was -- and that sentence is referring to her not
14 having a transgender history; right?

15 A. Well, it is also true that even with those histories done,
16 the -- that statement actually still stands that it's possible
17 that you could change it to "Even though they assessed her
18 history, they were precluded by prison policy from providing
19 adequate care."

20 Q. So you are wanting to change your declaration; is that
21 right?

22 A. This particular -- well, what I'm saying is the first part
23 of that paragraph was incorrect because I didn't have those
24 records at the time.

25 The second part of the paragraph, that it's possible that

1 she was not -- that she was not provided that care because it
2 was precluded by prison policy.

3 Q. But that sentence is based on her not having a transgender
4 history; correct?

5 A. That -- yeah, I was particularly talking about it there,
6 but, yes.

7 Q. And again, you hadn't reviewed any prison policies at the
8 time of this declaration; right?

9 A. Well, what I read were responses in her medical record that
10 said, "No, you can't have this; that's against policy."

11 You know, so did I read the policy? No, when she was told,
12 you can't have this because of the policy.

13 So I assume the people who were responding to her -- I
14 don't even know what they are called -- the requests for
15 treatment that she puts in -- know the policy enough to be able
16 to state it.

17 MR. EATON: I'm going to move to strike that response
18 as narrative and nonresponsive. And I would ask the court if we
19 could get an answer to the question, please.

20 MR. HALL: Join.

21 THE COURT: Restate the question.

22 Q. BY MR. EATON: My question was: At the time you executed
23 the declaration, this document 62-1 -- I believe we talked about
24 this earlier -- you had not read any Idaho Department of
25 Correction policies or procedures; correct?

1 A. Policies or procedures, no.

2 Q. Correct?

3 A. Correct.

4 Q. And why is it important to have transgender history?

5 A. It's important in every clinical situation where you're
6 treating a patient to have a history so that you can base their
7 care on that.

8 Q. And you acknowledge now that Dr. Eliason and Dr. Lake both
9 provided a transgender history in their documents in 2012 when
10 they were assessing her for GID; correct?

11 A. Correct.

12 Q. Doctor, you don't know one way or another the
13 qualifications of Jeremy Clark, the clinician that we were
14 talking about that was referenced in Dr. Eliason's record;
15 right?

16 A. From his record, I mean, it has his educational -- I mean
17 the letters after his name. I mean --

18 Q. It shows he's --

19 A. -- I don't know what training he had or what school he went
20 to, no.

21 Q. Right. So you don't know, one way or another, his
22 qualifications -- Jeremy Clark's; correct?

23 A. Well, I know some of his qualifications in that he is
24 licensed --

25 Q. You just know --

1 A. -- as a clinician.

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

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

4 MR. EATON: Your Honor, I don't believe I have any
5 further questions at this time.

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

8 THE COURT: Yes.

9 Counsel, why don't we -- we will probably end up taking two
10 breaks since we're going to go I think until 3:00 or
11 thereabouts. Why don't we take a 15-minute break now, and then
12 we'll see how that plays out.

13 We will be in recess for 15 minutes.

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

15 THE COURT: Dr. Gorton, I'll remind you you are still
16 under oath. And I will ask you to speak a little more slowly, a
17 little more clearly to make it easy on the court reporter.

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

19 MR. HALL: No additional cross for defendants.

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

21 Ms. Whelan, redirect.

22 MS. WHELAN: Thank you.

23 REDIRECT EXAMINATION

24 BY MS. WHELAN:

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

1 pro bono on this case and just being compensated for expenses.

2 Do you remember that?

3 A. I do.

4 Q. Can you explain why you're doing that.

5 A. I'm very well compensated as an ER doctor, and I think it's
6 an ethical requirement as a professional, as a healthcare
7 provider that, if you're able to, you should do some pro bono
8 work.

9 So all the work that I have done at Lyon-Martin is pro
10 bono. And because of my experience working at the clinic, I
11 have a set of -- you know, a knowledge and skill set that is
12 sometimes useful in other situations.

13 And so I, you know, use that in situations like this. And
14 it's the same reason. I mean, I think if you're -- you know,
15 being a doctor has certain responsibilities, and I think one of
16 them is that you have to do some pro bono work in a society
17 where not everybody has access to care.

18 Q. Now, defense counsel asked you about a number of categories
19 of documents that you've now reviewed.

20 Do you recall that?

21 A. Yes.

22 Q. And since you have reviewed all of those documents, have
23 they changed your opinion about whether Ms. Edmo needs surgery?

24 A. No.

25 Q. And what is that opinion?

1 A. That she needs genital sex reassignment surgery.

2 MS. WHELAN: Thank you. I have no further questions.

3 THE COURT: All right. Give me just a moment,
4 Counsel.

5 All right. I guess I have none.

6 Any recross?

7 MR. EATON: Just one question, Your Honor.

8 THE COURT: Yes.

9 RECCROSS-EXAMINATION

10 BY MR. EATON:

11 Q. Are you aware that Dr. Ettner, the other expert in this
12 case, charges a fee?

13 A. I know Dr. Ettner charges a fee. I don't know if she is
14 charging it in this case, but I assume so.

15 THE COURT: All right. You may step down. Thank you
16 very much, Dr. Gorton.

17 Plaintiffs may call their next witness.

18 MS. RIFKIN: That completes plaintiff's witnesses,
19 Your Honor.

20 THE COURT: I'm not sure who is going to go first from
21 the defense.

22 Mr. Hall.

23 MR. HALL: Your Honor, in the interest of time, we are
24 going to kind of mix up witnesses as to who is going to call
25 who.

1 THE COURT: All right.

2 MR. HALL: IDOC is going to call witness Jeremy Clark
3 at this time.

4 THE COURT: Mr. Clark, would you step before the clerk
5 and be sworn. Just come forward, sir. Ms. Bracke will place
6 you under oath. Step a little closer.

7 JEREMY JUNIOR CLARK, DEFENDANT'S WITNESS, SWORN

8 THE CLERK: Please take a seat in the witness stand.
9 Please state your complete name and spell your name for the
10 record.

11 THE WITNESS: Jeremy Junior Clark. J-E-R-E-M-Y,
12 J-U-N-I-O-R, C-L-A-R-K.

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

14 MR. HALL: Thank you, Your Honor.

15 DIRECT EXAMINATION

16 BY MR. HALL:

17 Q. Good afternoon, Mr. Clark.

18 A. Good afternoon.

19 Q. How are you employed?

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

21 Q. And in what position?

22 A. I'm a clinical supervisor.

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

24 A. It will be six years this November.

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

1 A. I have supervised -- direct supervisors over our clinical
2 staff. I have supervised our behavioral health unit, our acute
3 mental health unit, provide consultation, clinical consultation.
4 I have also done sex offender treatment consultation.

5 I believe that's it.

6 Q. How long have you been employed with the Idaho Department
7 of Corrections?

8 A. Six years this November.

9 Q. And in that time period, have you held other positions?

10 A. I have been a member of our Management and Treatment
11 Committee. I have also -- shoot. That would be it.

12 Q. You mentioned a Management Treatment Committee. Can you
13 tell the court what that is, please.

14 A. It's a multiple-disciplinary team that the Department has
15 to address treatment and planning and security issues associated
16 with our transgender population, our inmates that have gender
17 dysphoria.

18 Q. Is that a specific committee set up to address the mental
19 health needs and housing of the gender dysphoric inmates?

20 A. Yes, that's correct.

21 Q. Okay. And when you started on that, approximately how many
22 inmates had a diagnosis of GD or GID?

23 A. Say, approximately 10.

24 Q. And has that since expanded?

25 A. Yes, it has. We're just over 30 currently incarcerated.

1 Q. So over the last six years, approximately, it's gone from
2 10 diagnosed to 30 now?

3 A. Yes, that is correct.

4 Q. And what is the role of the MTC?

5 A. We review when an appropriate assessor does an assessment
6 on somebody for gender dysphoria. The Management and Treatment
7 Committee reviews that assessment, determines if it's
8 appropriate, develops a treatment plan that would include mental
9 health services, medical services, and we recommend housing
10 placement.

11 Q. And does the MTC review the treatment and situations of all
12 of the GD offenders?

13 A. Yes, that is correct.

14 Q. And is that throughout the entire state in all
15 institutions?

16 A. Yes, that is correct.

17 THE COURT: Just so I'm clear, the 30 inmates you
18 refer to, is that throughout all the institutions or just at the
19 medium-security facility? Or does IDOC try to have all of the
20 gender dysphoric inmates housed at one facility?

21 There are a lot of questions in that, but I think you
22 understand.

23 THE WITNESS: Early on, we tended to keep them in one
24 facility, but now they are throughout all the facilities, even
25 in our current female facilities.

1 THE COURT: So the 30 includes inmates at all
2 facilities?

3 THE WITNESS: Yes, that is correct.

4 THE COURT: But the same Management and Treatment
5 Committee oversees treatment for all of them?

6 THE WITNESS: Yes.

7 THE COURT: All right. So I just wanted to get that
8 clarified before we moved on.

9 Q. BY MR. HALL: Does the Management Treatment Committee make
10 medical decisions?

11 A. No.

12 Q. Okay. And who makes those medical decisions?

13 A. They are referred to a medical provider to determine those
14 needs.

15 Q. I want to talk about your qualifications, Mr. Clark.
16 Placed in front of you is a copy of your CV marked as
17 Defendant's Exhibit 2019, page 1.

18 Do you recognize this document?

19 A. Yes, I do.

20 Q. Does that set forth accurately your qualifications?

21 A. Yes, it does.

22 Q. Okay. Did you create this document?

23 A. Yes, I did.

24 Q. And is this document current?

25 A. Yes.

1 MR. HALL: Your Honor, move to admit Defendant's
2 Exhibit 2019.

3 THE COURT: Any objection?

4 MS. RIFKIN: No.

5 THE COURT: The exhibit will be admitted.

6 (Defendants' Exhibit 2019 admitted.)

7 Q. BY MR. HALL: Are you familiar with the World Professional
8 Association for Transgender Health?

9 A. Yes, I am.

10 Q. And what is that organization, to your knowledge?

11 A. It's an international organization that addresses the needs
12 for transgender population and gender-nonconforming population
13 and individuals who have gender dysphoria.

14 Q. Now, there has been some testimony about membership.

15 Are you a member of the WPATH?

16 A. Yes, I am.

17 Q. What does that mean?

18 A. Essentially, I -- you pay a fee every month, but you have
19 all the resources available to you from that association;
20 articles. I receive periodic emails about updates about what's
21 going on within the association. You're notified about
22 conferences throughout the world that address transgender
23 health.

24 Q. And how long have you been a member?

25 A. Since late 2013.

1 Q. And are you aware that the WPATH provides some competency
2 requirements or criteria for individuals who are going to be
3 working with gender dysphoric patients?

4 A. Yes.

5 Q. Okay. Do you recognize the document --

6 A. I do.

7 Q. -- placed here in front of you marked Joint Exhibit 15,
8 page No. 28?

9 A. Yes, I do.

10 Q. Okay. And do you recognize that as the criteria that's set
11 forth by the WPATH?

12 A. Yes. It's in their Standards of Care Version 7.

13 Q. I would like to go through some of these. The first one is
14 a master's degree or its equivalent in a clinical behavioral
15 science field.

16 Do you meet that requirement?

17 A. Yes, I do.

18 Q. In what way?

19 A. I have a master's degree in counseling and guidance.

20 Q. And what is your -- what is your certification?

21 A. Do you mean my licensure?

22 Q. Your licensure.

23 A. I'm a licensed clinical professional counselor here in the
24 State of Idaho.

25 Q. LCPC; correct?

1 A. Yes, that is correct.

2 Q. Okay. Tell the court about that position or that
3 licensure.

4 Are you permitted to diagnose?

5 A. Yes, I am permitted to diagnose.

6 Q. And is it within your scope of practice to provide
7 psychotherapy?

8 A. Yes.

9 Q. And does that include individual therapy, group therapy?

10 A. And I have had training in family therapy as well.

11 Q. Okay. Let's take a look at the second criteria.

12 Do you have competence in using the Diagnostic Statistical
13 Manual of Mental Disorders?

14 A. Yes, I do have training.

15 Q. Is that the DSM?

16 A. Yes.

17 Q. And you've had training in that?

18 A. Yes.

19 Q. And where have you obtained training in that?

20 A. It started in my graduate school. I have had other
21 trainings because it changed to a different version about four
22 or five years ago, I believe. And I had training to update with
23 that. And I actually did some training at a lower level on
24 this; undergraduate level.

25 Q. And other than training, have you used the DSM in your

1 professional experience?

2 A. Yes, for the past 11 years as a licensed professional in
3 Idaho.

4 Q. Is that a document that you consult frequently in your
5 profession?

6 A. Yes.

7 Q. The third criteria is the ability to recognize and diagnose
8 coexisting mental health concerns and to distinguish these from
9 gender dysphoria.

10 Do you have competency in that?

11 A. Yes, I do.

12 MS. RIFKIN: Objection, Your Honor. Lacks foundation.
13 Mr. Clark has been named as a nonretained expert witness by
14 defendants.

15 THE COURT: Well, the witness -- okay. My
16 understanding is that counsel is trying to establish that the
17 witness has the credentials to meet the requirements for the
18 WPATH criteria to be a gender dysphoria treatment provider. And
19 I think that's all we're testifying to, not offering opinions,
20 per se.

21 MS. RIFKIN: Mr. Clark hasn't testified to any
22 experience with gender dysphoria at this point, which is a
23 prerequisite to answering a question, his opinion about No. 3
24 here, the ability to recognize and distinguish --

25 THE COURT: Well, he can have him explain what -- I'll

1 overrule the objection.

2 MR. HALL: Right. Right.

3 Q. BY MR. HALL: Mr. Clark, do you have familiarity in
4 recognizing and distinguishing coexisting mental health concerns
5 from gender dysphoria?

6 A. Yes, I do.

7 Q. Okay. And can you explain that.

8 A. Through my experience treating and talking with both
9 inmates, I have dealt with multiple mental health issues, and I
10 have also worked with the inmates that do have gender dysphoria
11 along with those other issues, such as schizophrenia and other
12 mood disorders.

13 Q. And have you reviewed the DSM's criteria for diagnosis of
14 gender dysphoria?

15 A. Yes.

16 Q. And have you applied that to patients who have diagnosis of
17 gender dysphoria?

18 A. Yes.

19 Q. So you would say you're familiar with gender dysphoria as
20 it's defined under the DSM?

21 A. Yes, I am.

22 Q. Okay. And what is your understanding as to coexisting
23 mental health concerns?

24 A. If someone has a diagnosis of gender dysphoria, it is
25 possible to have other identified mental health disorders, such

1 as mood disorders, possible personality disorders, psychosis,
2 and other identified mental health disorders. Substance abuse
3 would be another example.

4 Q. And is it your understanding that the WPATH is only
5 concerned with diagnoses or mental health concerns?

6 A. Mental health concerns.

7 Q. Okay. How do those differ from a diagnosis of a mental
8 health disorder?

9 A. From my standpoint, the diagnosis is a label, a name to put
10 on a set of behaviors. When you're talking about mental health
11 behaviors, you take all the issues that the person is having --
12 whether it's depression, anxiety, gender dysphoria -- and you
13 need to take that into consideration in your treatment.

14 Q. The fifth criteria is knowledge about gender-nonconforming
15 identities and expression in the assessment and treatment of
16 gender dysphoria.

17 Do you have knowledge about gender-nonconforming identities
18 and expressions?

19 A. Yes.

20 Q. Would you tell the court what your knowledge is.

21 A. When I was asked to become a WPATH member, at that time I
22 have attended four -- I believe it was four conferences, some
23 presented by WPATH, where I was able to get training in that
24 what is constituted as someone who is cisgender, gender
25 nonconforming, transgender. And I have also read several

1 articles that also talks about those distinctions.

2 Q. Can you name some of those articles? I think there is --

3 A. I presented a few. Osborne and Lawrence comes into play.
4 I can't think of the exact titles of the articles at this time.

5 Q. Mr. Clark, I have placed in front of you here Exhibit
6 No. 19 -- Joint Exhibit 19-1.

7 Do you recognize this article?

8 A. Yes. That's the article I was referring to, Osborne --
9 written by Osborne and Lawrence.

10 Q. And you have read this article; is that what your testimony
11 was?

12 A. Yes.

13 Q. Okay. And have you relied upon that article in your
14 profession?

15 A. I have.

16 Q. Mr. Clark, the sixth criteria speaks about continuing
17 education in the assessment and treatment of gender dysphoria.

18 Have you obtained continuing education in the assessment
19 and treatment of gender dysphoria?

20 A. I have, through those conferences presented by WPATH. I
21 have also started their global training -- I can't think of the
22 word, but their program where they are starting to provide more
23 specific training to professionals such as myself, to help us
24 better treat folks with gender dysphoria.

25 Q. And you mentioned WPATH trainings.

1 Describe for me those. What are those?

2 A. There have been several conferences. I have been to
3 Oakland. I've been to Chicago. I've been to Los Angeles where
4 they put on two- to three-day trainings where they provide
5 classes that address transgender, gender nonconforming, and
6 training for folks with gender dysphoria.

7 Q. And these trainings that were in Oakland, Chicago, and
8 Los Angeles, were those trainings put on by WPATH?

9 A. The one in Oakland was not, but it was sponsored. But the
10 others were sponsored by WPATH, yes.

11 Q. So the one in Oakland was sponsored by WPATH, but it wasn't
12 hosted by WPATH?

13 A. That's correct.

14 Q. Have you been to any other trainings over the last, say,
15 five years where you received experience in -- continuing
16 education in the assessment and treatment of gender dysphoria?

17 A. During this year, early this spring, we had our all
18 clinical staff training, and we had some people from the
19 Washington State DOC come and talk to us about their program for
20 assisting the transgender population of people with gender
21 dysphoria.

22 And I have provided some training for our staff, based on
23 the trainings I have been to, to help educate them as well.

24 Q. And have you provided training to mental health clinicians
25 at IDOC on gender dysphoria topics?

1 A. Yes, at least twice.

2 Q. And have you been involved in any trainings at IDOC that --
3 where outside speakers have come?

4 A. That one that happened this year, we brought people from
5 Washington State DOC.

6 Q. Okay. And do you remember who those people were from
7 Washington State DOC?

8 A. I cannot remember at this time.

9 Q. And what was the subject matter that those individuals
10 spoke on?

11 A. Mainly the management, how they were managing the inmates
12 with gender dysphoria, how they looked at it, how they assessed
13 it. They also had a multiple disciplinary team that was very
14 similar to our Management and Treatment Committee and how they
15 used that. And so we did a lot of comparison.

16 They also gave some basic stuff, like what -- definitions
17 of what gender nonconforming, transgender, and other topics like
18 that.

19 Q. And were you present during a presentation provided by a
20 Dr. Levine?

21 A. I was.

22 Q. Do you remember when that was?

23 A. It was in the summer of 2016.

24 Q. And do you recall what the subject matter of Dr. Levine's
25 presentation was?

1 A. It was his opinion on different paradigms associated with
2 people with transgender issues and gender dysphoria. And he
3 gave some suggestions on how to manage the inmates in prison.
4 And he quoted a lot from the Osborne and Lawrence article that
5 you had up earlier because that had just come out as well. And
6 so he used those topics.

7 Q. At part of that presentation, did you get the understanding
8 that Dr. Levine's opinion was that SRS surgery for a gender
9 dysphoric inmate is never appropriate?

10 MS. RIFKIN: Objection. Leading.

11 THE COURT: Sustained. Rephrase that question.

12 Q. BY MR. HALL: What were the -- did you arrive at any
13 conclusions as to the opinions that Dr. Levine had presented
14 during his presentation?

15 A. In general, it was talking about the different paradigms,
16 what might explain why a person experiences gender dysphoria.
17 In the end, it was suggestions that caution should be taken when
18 talking about things such as sexual affirming surgery, talked
19 about medical necessity and his opinions about that and also
20 time frames, making sure that you can address all the issues a
21 person may have in prison because it's a different environment
22 compared to the community.

23 Q. Do you recall Dr. Levine making any opinions as to the
24 appropriateness of surgery for a gender dysphoric inmate?

25 A. I felt he emphasized, actually, that it was appropriate and

1 that it needed to happen when it was appropriate.

2 Q. Did you ever hear Dr. Levine espouse an opinion at that
3 presentation that SRS is never appropriate for a gender
4 dysphoric inmate?

5 A. I did not.

6 Q. What is your understanding as to the criteria under the
7 WPATH for sexual reassignment surgery or gender confirmation
8 surgery?

9 A. Documented persistent gender dysphoria. They have to be of
10 the age of consent. They have to be able to give informed
11 consent.

12 MS. RIFKIN: Objection, Your Honor. Counsel has put a
13 document on in order to coach the witness about how to answer.

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

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

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

17 MS. RIFKIN: He asked his understanding and then put
18 the document in front of the witness.

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

20 MS. RIFKIN: Between asking the question --

21 THE COURT: Well, Counsel -- Counsel, he has already
22 indicated his familiarity with the WPATH criteria. That's what
23 this is.

24 I suspect you did the same thing with all of the other
25 witnesses, as well, to give them a chance to go through item by

1 item.

2 I'm going to overrule the objection. I don't think
3 it's -- unless the test here is whether or not the witness has
4 an encyclopedic memory as to each of the WPATH standards, I
5 don't think it's an issue.

6 If that's what we're trying to get at -- but I suspect
7 that's not, and it's more just a discussion about his view of
8 what those criteria are. So I don't think showing it to him is
9 in any way improper.

10 Go ahead and proceed.

11 Q. BY MR. HALL: Mr. Clark, are you familiar with the document
12 that's been placed in front of you and marked as Joint Exhibit
13 15, page 66?

14 A. I am.

15 Q. And what is this document?

16 A. This is the criteria set up for a phalloplasty associated
17 by the WPATH standards in their Version 7.

18 Q. And are you familiar with the standards -- the six
19 standards or criteria presented there?

20 A. I am.

21 Q. Okay. Have you ever had an opportunity to apply those
22 standards to a gender dysphoric patient?

23 A. Yes, several times.

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

25 A. I am.

1 Q. Okay. And explain for me your familiarity with Ms. Edmo.

2 A. I have had occasional bump-ins, so to say, run-ins with
3 Ms. Edmo throughout the time. I have attended a couple of
4 groups where Ms. Edmo has attended.

5 But much of my information has come secondary through the
6 Management Treatment Committee and when I supervised the
7 clinicians who were providing treatment for Ms. Edmo.

8 Q. And has Ms. Edmo and her gender dysphoria been topics of
9 discussion at the MTC meetings?

10 A. Yes.

11 Q. And approximately how many times during those meetings
12 have -- where you have been present that Ms. Edmo was addressed?

13 A. Say, about a dozen.

14 Q. And is there a time range there? Is it beginning ever
15 since you were on the MTC committee?

16 A. Yes. From my best knowledge, yes.

17 Q. Over the last five years?

18 A. I would say that is correct, yes.

19 Q. Okay. And have you gained a familiarity with Ms. Edmo's
20 gender dysphoria and the treatment she has received at IDOC?

21 A. Yes.

22 Q. And what is your understanding as to Ms. Edmo's treatment
23 that she has received for her gender dysphoria?

24 A. Been attending groups for most of that five years that are
25 associated with gender -- other inmates that have gender

1 dysphoria; been provided hormone replacement therapy to
2 associate -- that was prescribed by a medical provider -- and
3 also, there has been individual contacts with clinicians over
4 the years with Ms. Edmo.

5 Q. You've had conversations with clinicians that have provided
6 direct contact with Ms. Edmo; is that what you're saying?

7 A. Yes.

8 Q. And have you reviewed any medical records or mental health
9 records for Ms. Edmo?

10 A. Periodically, yes.

11 Q. And have you reviewed the clinical notes from the mental
12 health contact she has had during her incarceration?

13 A. Not all of them, but some of them, yes.

14 Q. And have you reviewed or had an opportunity to review the
15 presentence investigation?

16 A. Yes, I have.

17 Q. And is it your understanding that that document was
18 produced prior to Ms. Edmo's incarceration?

19 A. Yes.

20 Q. Are there any other documents that you've reviewed
21 regarding Ms. Edmo and her gender dysphoria?

22 A. I looked at her assessments when she requested to be
23 assessed for gender dysphoria. That happened before my time on
24 the MTC. I have reviewed those records as well.

25 Q. And do you know who did that assessment?

1 A. I know -- I believe Dr. Eliason was one, and I can't
2 remember the other person.

3 Q. Does Claudia Lake ring a bell?

4 A. Yes.

5 MS. RIFKIN: Objection. Leading, Your Honor.

6 MR. HALL: Your Honor, I'm merely trying to get an
7 answer as to whether or not the witness --

8 THE COURT: Overruled. Generally, counsel is allowed
9 to ask leading questions on foundational matters. And, frankly,
10 in a proceeding before the court, as long as you're not putting
11 words in the witness's mouth, I'm going to give counsel some
12 leeway. I have tried to do it on both sides, do the same.

13 So proceed.

14 Q. BY MR. HALL: And from your review of Ms. Edmo's medical
15 records and your involvement on the MTC, have you gained a
16 familiarity with Ms. Edmo's coexisting mental health concerns?

17 A. I feel that I have, yes.

18 Q. And what are those, to your knowledge?

19 A. The main thing that's always stuck out is major depressive
20 order or her struggles with depression and anxiety. That was
21 noted in the PSI, the presentence investigation. And it appears
22 to be a constant issue for Ms. Edmo.

23 And there has also been addressed some personality trait
24 struggles, such as borderline traits, antisocial traits.

25 Q. Right. Can you name some of those borderline personality

1 trait disorders that you have noticed?

2 A. Interpersonal issues, self-harming behavior, sexual
3 offending, you know -- inappropriate sexual behaviors, and
4 manipulation.

5 Q. Are you familiar with Ms. Edmo's disciplinary history?

6 A. Yes.

7 Q. And do you find that Ms. Edmo's disciplinary history is
8 relevant in any way to your -- your profession as a mental
9 health clinician?

10 A. I feel that it is.

11 Q. In what way?

12 A. Much of any inmate's disciplinary issue, we have to look at
13 and see if mental health is a contributing factor into those
14 behaviors to help address that, such as interpersonal issues;
15 psychosis may play a role. And so we have to look into those
16 issues to ensure we're doing our part to help treat the mental
17 health side that might be associated with those misbehaviors.

18 Q. Are you aware of any DORs or disciplinary history that
19 Ms. Edmo has received that would indicate or suggest or be
20 consistent with borderline personality disorder traits?

21 A. Yes. There have been several DORs for sexually acting out,
22 assaulting other inmates, not following orders of the officers,
23 and struggling with other inmates within the facility.

24 Q. Did you have an opportunity to assess whether or not
25 Ms. Edmo has ever met the criteria of the WPATH for surgery?

1 A. Yes. That was looked at back in 2016.

2 Q. And describe for me how that -- how that occurred. How
3 were you involved in that?

4 A. I believe Ms. Edmo made the request, and Dr. Scott Eliason
5 said he would do the assessment. And once he completed the
6 assessment, he brought it before the MTC.

7 Q. And did you have an opportunity to apply Mrs. Edmo's mental
8 health conditions to the criteria of the WPATH at that time?

9 A. I did.

10 Q. Okay. And did you make a -- did you have an opinion at
11 that time as to whether or not Ms. Edmo met the criteria for
12 surgery?

13 A. I did.

14 Q. What was that opinion?

15 A. That surgery was not appropriate.

16 Q. And what is the basis for that opinion?

17 A. I personally felt and clinically felt that Ms. Edmo's
18 mental health issues were not well controlled.

19 Q. And what mental health conditions did you believe were not
20 well controlled?

21 A. The depression, the anxiety, along with the borderline
22 personality traits.

23 Q. Were there any particular traits of borderline personality
24 disorder that you felt were not well controlled at that time in
25 2016?

1 A. Within six months, there were several DORs; one was for
2 assaulting another inmate.

3 Also, at that time, Ms. Edmo had gone on suicide watch for
4 self-harming behaviors and was continuing to engage in
5 self-harming behaviors at that time.

6 Q. Do you know if -- around that time, in 2016, whether
7 Ms. Edmo had exhibited sexual acting-out in the prison?

8 A. Yes. There had been a -- there had been a DOR for sexual
9 activity within that six-month frame as well.

10 Q. Six months prior to the evaluation?

11 A. Yes.

12 Q. And were you aware of other DORs where Ms. Edmo was cited
13 for inappropriate sexual contact in a prison?

14 A. I believe there was two or three throughout her time in
15 incarceration.

16 Q. And why -- well, do you believe that prior to someone
17 meeting the criteria for surgery under the WPATH, that it's
18 important that their coexisting mental health concerns be well
19 controlled?

20 A. In my opinion, I really -- what really stood out for me
21 with the Osborne and Lawrence article was surgery is an
22 identified treatment for gender dysphoria, but there is no
23 evidence to indicate that surgery would alleviate major
24 depressive disorder, eliminate self-harming behaviors.

25 And so, in my opinion, I feel like that's why the WPATH

1 said the other cooccurring issues need to be well controlled
2 because the surgery is there to alleviate the gender dysphoria.

3 Q. And do you believe that it's important also to have these
4 coexisting mental health concerns well controlled prior to a
5 surgery because of the stressors that may come after a surgery?

6 A. I do feel that is accurate.

7 Q. Okay. And explain that to me.

8 A. I would say this really plays a big role in prison.
9 Because, based on current policy throughout the United States,
10 inmates are housed based on their primary genitalia.

11 So this would mean, naturally, a person would automatically
12 move to female facility, which has different dynamics, different
13 social transitioning issues that would come into play.

14 And also -- so needing to have that well controlled at that
15 time would be significant because I believe, especially in
16 prison, new stressors are going to arise even after prison --
17 after surgery.

18 Q. Is it your understanding that, for Ms. Edmo, sex
19 reassignment surgery will be an irreversible procedure?

20 A. Yes.

21 Q. Is it your understanding that it will be a significant
22 medical procedure for Ms. Edmo?

23 A. Based on the trainings I have seen and attended, yes.

24 Q. And do you feel that -- or did you feel in 2016 that
25 Ms. Edmo's mental health conditions -- coexisting mental health

1 conditions were well controlled such that she could cope with
2 the stressors postsurgery?

3 A. I did not feel that.

4 Q. Okay. Have you made any opinions or -- let me strike that.

5 Do you feel that Ms. Edmo has been compliant with her
6 treatment plan?

7 A. No.

8 Q. Do you feel that Ms. Edmo has been compliant with the
9 recommendations that her mental health conditions have made to
10 her over the years?

11 A. Not consistently.

12 Q. And in what ways?

13 A. Often will attend group for a while and then will quit.
14 Has often rejected our recommendations for other things to
15 address the interpersonal issues and the mood management issues.

16 And I believe Ms. Edmo feels this is all part of her gender
17 dysphoria, and we haven't been offered an opportunity to make
18 sure that if there is cooccurring stuff, that that's actually
19 affecting the behaviors as well.

20 Q. And you're familiar that in 2016, Dr. Eliason provided
21 a -- an assessment to Ms. Edmo as to whether or not she met the
22 criteria for sex reassignment surgery?

23 A. Yes.

24 Q. And did you have a conversation with Dr. Eliason at that
25 time?

1 A. I did, shortly after he did the assessment.

2 Q. And did he reach out to you to ask your opinion on
3 Ms. Edmo's mental health condition?

4 A. He did. He consulted with me.

5 Q. And did he consult with you as to whether or not you felt
6 it was appropriate for Ms. Edmo to have sex reassignment
7 surgery?

8 A. Yes. That was the topic of the conversation.

9 Q. And did you provide him with your thoughts at that time?

10 A. I did.

11 Q. And what did you -- what did you explain to Dr. Eliason at
12 that time?

13 A. Essentially what you -- we have been just talking about.
14 At that time, Ms. Edmo was engaging in a lot of misbehavior,
15 sexually acting out, self-harming behavior, wasn't attending
16 groups consistently.

17 In my opinion, at that time, her mental health was not well
18 controlled based on those factors.

19 Q. And is it your understanding that, after speaking with you
20 and with others, other medical or mental health providers, that
21 Dr. Eliason concluded that surgery for Ms. Edmo in 2016 was not
22 medically necessary or appropriate?

23 A. That is what I recall, yes.

24 Q. Are you familiar or are you aware that Ms. Edmo has been
25 engaging in some cutting behaviors over the last year?

1 A. I was informed of that by her treating clinician, yes.

2 Q. And who is that?

3 A. Ms. Krina Stewart.

4 Q. And have you had conversations with Ms. Stewart about
5 Ms. Edmo?

6 A. Throughout the past couple years, yes.

7 Q. And what was your understanding after speaking with
8 Ms. Stewart as to Ms. Edmo's cutting?

9 A. That a lot of times -- and probably in particular with
10 Ms. Edmo -- cutting is a form of coping with stress. And so our
11 conversations, we were talking about what other coping skills we
12 can encourage Ms. Edmo to engage in and how to address that
13 issue.

14 Q. And that Ms. Edmo was engaging in cutting, did that -- does
15 that affect your opinion either way at this point as to whether
16 or not Ms. Edmo's coexisting mental health concerns are well
17 controlled?

18 A. I feel that it supports my idea that it's not well
19 controlled.

20 Q. Do you believe that cutting is a helpful and safe coping
21 mechanism?

22 A. No, I do not.

23 Q. Do you think that cutting to someone's body is contrary to
24 a claim that their mental health conditions are well controlled?

25 A. Yes, I would consider that contrary.

1 Q. Okay. At this point, do you believe that Ms. Edmo's
2 coexisting mental health concerns are well controlled?

3 A. At this time, based on the information I have been given,
4 no, I do not feel that it's currently well controlled.

5 Q. Do you have any concerns for Ms. Edmo if she undergoes
6 surgery at this time when her mental health concerns are not
7 well controlled?

8 A. Yes. I believe the behaviors would continue even if the
9 surgery were to happen.

10 Q. And which behaviors in particular?

11 A. The cutting. I do feel that some of the mood disorder
12 stuff, the depression and anxiety, would be lessened, but I
13 don't think it would be alleviated as it hasn't been completely
14 addressed.

15 Q. Are you familiar with the policies and standard operating
16 procedures of the Department of Corrections?

17 A. Yes.

18 Q. And when you started at the Idaho Department of
19 Corrections, was there a policy dealing with gender identity
20 disorder, gender dysphoria?

21 A. Yes, there was.

22 Q. And were you familiar with that policy?

23 A. Yes, I was.

24 Q. Okay. And what is your understanding as to what that
25 policy said as to whether or not surgery, sexual reassignment

1 surgery, would be provided or made available to offenders with
2 gender dysphoria?

3 A. That it would require it to be medically necessary, and it
4 would be looked at on a case-by-case basis.

5 Q. Was there anything in that policy that you were aware of
6 that stated that IDOC would not provide sex reassignment surgery
7 under any circumstances?

8 A. To the best of my recollection, there was no language in
9 there that said that.

10 Q. And has that policy since been revised, the gender
11 dysphoria policy?

12 A. Yes.

13 Q. And when was that revised?

14 A. It was officially released October 5th, just last week.

15 Q. And are there any major differences between the 2011 policy
16 and the policy that was enacted last week?

17 A. Yes. In particular, in the areas of social transitioning,
18 needing to allow the inmates with gender dysphoria to have the
19 commissary -- all commissary.

20 So for our trans females, they can access makeup. They can
21 have traditional feminine hairstyles. They would be given
22 female undergarments. And then it would be vice versa for our
23 trans male population.

24 Q. And does this current policy, to your knowledge, still
25 provide that sex reassignment surgery will be provided to a

1 gender dysphoric inmate on a case-by-case basis?

2 A. Yes, also based on medical necessity.

3 Q. Okay. Thank you.

4 MR. HALL: No further questions. Thank you.

5 THE WITNESS: You're welcome.

6 THE COURT: Mr. Eaton, do you have any questions you
7 want to ask before I ask for cross?

8 MR. EATON: No, Your Honor. Thank you.

9 THE COURT: All right. Ms. Rifkin.

10 CROSS-EXAMINATION

11 BY MS. RIFKIN:

12 Q. Good afternoon, Mr. Clark.

13 A. Good afternoon.

14 Q. You have never provided direct treatment for any patients
15 with gender dysphoria or gender identity disorder; correct?

16 A. That is correct.

17 Q. In direct exam a few moments ago, you testified that you
18 were able to distinguish mental health concerns from gender
19 dysphoria; correct?

20 A. Yes.

21 Q. And you testified that you can do that based on your
22 experience treating patients; correct?

23 A. And also based on the diagnosis in the DSM.

24 Q. But you haven't actually treated any patients with gender
25 dysphoria; correct?

1 A. No, but I have given assessments where I have given a
2 diagnosis of gender dysphoria as well as other cooccurring
3 mental health disorders.

4 Q. You have never personally provided any assessments for sex
5 reassignment surgery; correct?

6 A. That is correct.

7 Q. You have never consulted with other providers regarding
8 assessments for sex reassignment surgery; correct?

9 A. I have consulted with Dr. Eliason when he did the
10 assessment for Ms. Edmo.

11 MS. RIFKIN: Your Honor, I would like to use the
12 deposition of Mr. Clark.

13 THE COURT: Yes. Let's have it published. Do you
14 have the original?

15 MS. RIFKIN: I do.

16 THE COURT: Perhaps Mr. Severson can get that, and
17 I'll direct Ms. Bracke to publish the deposition.

18 LAW CLERK: We don't have the sealed original. It's
19 in the office that's close.

20 THE COURT: Well, I assume there is no serious
21 objection.

22 MR. HALL: Your Honor, I don't -- I don't believe so.
23 This was a deposition that actually took place last week, and
24 currently we have not had an opportunity to have a
25 read-and-sign. So there may be some transcription errors that

1 the witness has not had an opportunity to review.

2 THE COURT: All right.

3 MS. RIFKIN: Your Honor, the dates being after the
4 cutoff were proposed by defendants for this witness. So we got
5 the deposition transcript processed.

6 THE COURT: I understand.

7 MR. HALL: That's not my issue. I just --

8 THE COURT: Yeah. Let's just solve the problem. We
9 don't need to say who is at fault. Let's just solve the
10 problem.

11 What I would suggest -- again, we have a court trial.
12 Let's go ahead and use the unsigned copy of the deposition.

13 I would indicate to the witness that if you have some
14 concern over how the question and answer -- whether it's
15 different from what you recall, you can so indicate, and then
16 we'll give you a chance to kind of correct the deposition on the
17 fly.

18 Do you understand?

19 THE WITNESS: Yes.

20 THE COURT: In other words, a court reporter like
21 Ms. Hohenleitner is taking it down, doing the best job they can.
22 Sometimes mistakes are made for that reason. A copy is given to
23 the person being deposed, given a chance to read it and then
24 make corrections. They can't change answers, but they can
25 indicate that when they said "the," they really meant "that," or

1 they thought they said "that," but the court reporter perhaps
2 didn't pick it up. So we can correct those kinds of things.

3 If you see a problem, let's note it. I may allow you to
4 confer with your attorney to go over that change as we proceed
5 along. My guess is there won't be any of those problems. That
6 would be quite rare, but I think we need to protect the
7 witness's right to review and correct the deposition.

8 And then when it is available, we need to publish it and
9 make it part of the court record. All right?

10 MS. RIFKIN: Yes. We can publish it to the court now
11 and the witness.

12 THE COURT: Well, typically, "publish" means we are
13 taking the final approved and signed deposition and now
14 publishing it as part of the court record. I don't know that we
15 can do that until we have been through that process.

16 So we are just going to use this copy. But at some point,
17 you will need to submit the final signed version of the
18 deposition to complete the court record. And if there is any
19 variation, we will need to note that for the record as well.
20 All right?

21 MS. RIFKIN: Understood, Your Honor.

22 THE COURT: Yes, let's go ahead and hand it to him.
23 We won't formally publish it since we don't have the original.

24 MS. RIFKIN: Can we display, please, Mr. Clark's
25 deposition, page 29.

1 THE COURT: It would be helpful if you zoom in
2 on -- that's a little hard to read.

3 MS. RIFKIN: Can we zoom in on lines 2 through 8,
4 please.

5 THE COURT: Okay. Now you should be able to read that
6 easily.

7 Q. BY MS. RIFKIN: Do you see those lines, Mr. Clark?

8 A. I do.

9 MS. RIFKIN: May I read them, Your Honor?

10 THE COURT: Well, you can ask him whether these
11 questions were asked and ask him whether he gave those answers.

12 Q. BY MS. RIFKIN: Do you see the question on line 2, "Have
13 you personally provided any assessments for sex reassignment
14 surgery or gender reaffirmation surgery?"

15 A. Yes, I do see it.

16 Q. And your answer was no?

17 A. That is correct.

18 Q. Is that -- is that accurate?

19 A. That is accurate.

20 Q. And the next line, line 6, question: "Have you consulted
21 with other providers regarding assessments for surgery?"

22 Answer: "No. I haven't had the opportunity."

23 Was that your answer?

24 A. It was. I believe in the context at the time, I was
25 thinking outside providers, not within the Department.

1 Q. Your experience providing supervision to clinicians who are
2 directly treating patients with gender dysphoria was mainly
3 while you were at ISCI, where Ms. Edmo is housed; correct?

4 A. Yes, at the time, because that's where most of them were
5 housed when I was a clinical supervisor.

6 Q. Okay. And I'm just going to ask you to make sure to answer
7 the question I ask and not give additional narrative unless it's
8 directly responsive to my question.

9 You were the clinical supervisor at ISCI for eight months;
10 correct?

11 A. Yes.

12 Q. Prior to that time, your experience with patients with
13 gender dysphoria was limited to supervising a clinician who had
14 a single patient with gender dysphoria; correct?

15 A. Yes.

16 Q. And you do not currently provide clinical supervision to
17 any clinicians who provide direct treatment to inmates with
18 gender dysphoria; correct?

19 A. Not at this time.

20 Q. You testified a moment ago in direct that Dr. Eliason --
21 that you provided consultation with -- to Dr. Eliason regarding
22 his assessment of Ms. Edmo for gender confirmation surgery;
23 correct?

24 A. Yes, that's correct.

25 Q. And you testified that you relied on the WPATH criteria for

1 medical necessity in consulting with Dr. Eliason; correct?

2 A. Yes.

3 Q. That consultation -- you have testified that that
4 consultation with Dr. Eliason was actually an informal consult;
5 correct?

6 A. Yes.

7 Q. It occurred when you ran into each other in passing at
8 ISCI; correct?

9 A. Yes.

10 Q. And it lasted no more than 15 to 20 minutes; correct?

11 A. From my best recollection, yes.

12 Q. And you didn't document this informal consultation
13 anywhere; correct?

14 A. I did not.

15 Q. And in your discussion with him about what medically
16 necessary entailed, you specifically recall telling Dr. Eliason,
17 "I don't know. That's kind of doctor things"; correct?

18 A. In particular to the topic of medically necessary, yes.

19 Q. And you didn't provide him an opinion about what medically
20 necessary means; correct?

21 A. No, I did not.

22 Q. You testified a moment ago that the MTC doesn't decide
23 whether surgery is medically necessary; correct?

24 A. From my -- I don't know what I testified to or said before,
25 but the MTC would be the multiple disciplinary team that would

1 take that assessment, address and assess where it's appropriate,
2 and then possibly refer surgery if it was felt it was
3 appropriate.

4 Q. Didn't you testify a moment ago that the MTC doesn't
5 consider -- doesn't decide whether surgery is appropriate; the
6 medical provider does that separately?

7 A. I thought that was about diagnosis, but I could be wrong.

8 Q. Is it your testimony that the MTC considered Ms. Edmo and
9 assessed her for surgery separate from what Dr. Eliason did?

10 A. No. At that time, we relied on Dr. Eliason's assessment.

11 Q. Did the MTC discuss and review Dr. Eliason's assessment for
12 Ms. Edmo?

13 A. Yes, that was done.

14 Q. If that had occurred, it would be in the minutes of the
15 MTC, wouldn't it?

16 MR. HALL: Objection. Foundation.

17 THE COURT: Just a moment.

18 MR. EATON: Join.

19 THE COURT: Overruled.

20 You may answer. You presided over the MTC; did I
21 understand that?

22 THE WITNESS: At that time, I was just a member.

23 THE COURT: Would you be familiar with the method by
24 which its meetings and transactions within the meetings are
25 memorialized?

1 THE WITNESS: I was not part of the minutes.

2 THE COURT: Well, that wasn't my question.

3 THE WITNESS: I'm sorry.

4 THE COURT: The question was: Are you familiar with
5 the way in which those meetings are documented?

6 THE WITNESS: Yes.

7 THE COURT: Okay. The objection is overruled. You
8 may inquire.

9 THE WITNESS: It should have been, is my response.

10 Q. BY MS. RIFKIN: Mr. Clark, I'm going to show you -- can you
11 read this document okay from your computer, Mr. Clark?

12 A. Yes.

13 Q. Okay. This is Joint Exhibit 7, page 78. It reads,
14 "Management and Treatment Team Committee Minutes," and it is
15 dated June 1, 2016.

16 Do you see that?

17 A. I do.

18 Q. Have you seen this kind of document before?

19 A. Yes, I have.

20 Q. And I would like to show you the third page of this
21 particular document. I'll show you the second page first so you
22 see the whole document. That's page 79 of Joint Exhibit 7.

23 And now I would like to show you the third page of Joint
24 Exhibit 7, page 80.

25 Do you see that "approved by"?

1 A. Yes, I do.

2 Q. And is that your name underneath?

3 A. It is.

4 Q. So you were involved in the minutes; isn't that right,
5 Mr. Clark?

6 A. I did not write them. I reviewed them and then should have
7 signed off on them.

8 Q. That was your responsibility, to review the minutes to make
9 sure that they are accurate and reflect the discussion of the
10 MTC; correct?

11 A. Yes.

12 Q. So I'm going to show you again the second page of this
13 document.

14 Do you see where it says "Edmo"?

15 A. Yes.

16 Q. Is there any documented consideration of Ms. Edmo --
17 Dr. Eliason's evaluation of Ms. Edmo for surgery?

18 A. No, there is not.

19 Q. These are the June 1, 2016, minutes for the MTC committee.

20 Do you think that that discussion would be documented in
21 another set of minutes for the MTC?

22 A. Possibly. I don't know.

23 Q. What month do you think? So Dr. Eliason's assessment was
24 in April 2016. What month do you think when the MTC met they
25 would have been discussing Dr. Eliason's assessment of Ms. Edmo

1 for surgery?

2 A. Possibly this one or the next one. I don't know.

3 Q. I'm going to show you what's been marked as Joint
4 Exhibit 7, page 81.

5 Do you see that these are the Management and Treatment Team
6 Committee minutes for September 7, 2016?

7 A. I do.

8 Q. Would that have been the next time the MTC met after June
9 2016?

10 A. More than likely.

11 Q. At this time, the MTC met every three months; is that
12 correct?

13 A. Yes.

14 Q. So I'm going to show you page 79 of Joint Exhibit 7.
15 Do you see the section where it says "Additional
16 discussion" and Ms. Edmo's name appears?

17 A. Yes.

18 Q. Is there any discussion documented of Dr. Eliason's
19 assessment of Ms. Edmo for surgery?

20 A. No, but it looks exactly like the one from the previous
21 minutes.

22 MR. HALL: I believe the witness has already been
23 shown this.

24 THE COURT: What's the concern, Mr. Hall?

25 MR. HALL: I think counsel might have a couple of

1 these pages just mixed up.

2 MS. RIFKIN: Oh, you're right. I'm sorry. Thank you
3 for the clarification.

4 Q. BY MS. RIFKIN: All right. I'm showing you page 84, which
5 is part of the September minutes. I apologize for that
6 confusion.

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

8 A. I do.

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

10 Have you had a chance to review that?

11 A. Yes.

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

13 Do you see the top, the continuation of the discussion for
14 Ms. Edmo?

15 A. I do.

16 Q. Is there a discussion of Dr. Eliason's assessment of
17 Ms. Edmo for surgery?

18 A. There is not.

19 Q. I'm going to show you the last page of these minutes, Joint
20 Exhibit 7, page 86.

21 That, again, has your name; correct?

22 A. Yes.

23 Q. At this time, you were responsible for reviewing the
24 minutes to make sure that they were accurate; correct?

25 A. Yes, I was.

1 Q. And neither of these minutes reflect any discussion by the
2 MTC of Dr. Eliason's assessment of Ms. Edmo for surgery;
3 correct?

4 A. That is correct.

5 Q. You have never provided direct treatment to Ms. Edmo;
6 correct?

7 A. That is correct.

8 Q. And you have never reviewed Ms. Edmo's preincarceration
9 medical records other than what was in the PSI report counsel
10 referenced; correct?

11 A. That is correct.

12 Q. You agree that Ms. Edmo continues to experience gender
13 dysphoria; correct?

14 A. Yes.

15 Q. And in your opinion, Ms. Edmo is not exaggerating her
16 gender dysphoria; correct?

17 A. I don't think so.

18 Q. You have never diagnosed Ms. Edmo as having borderline
19 personality disorder; correct?

20 A. That is correct.

21 Q. To your knowledge, no other IDOC or Corizon providers have
22 diagnosed Ms. Edmo with borderline personality disorder;
23 correct?

24 A. That is true.

25 Q. Over the six years that she has been in IDOC custody, none

1 of them have diagnosed her with borderline personality disorder;
2 correct?

3 A. Yes.

4 Q. You agree that Ms. Edmo is not psychotic; correct?

5 A. I do.

6 Q. To your knowledge, she has never been psychotic or
7 demonstrating psychosis; correct?

8 A. Not since I have known her.

9 Q. You believe Ms. Edmo is capable of forming informed consent
10 for medical procedures; correct?

11 MR. HALL: Object to form and foundation. It goes
12 beyond the scope of direct.

13 MS. RIFKIN: Mr. Clark testified --

14 THE COURT: Overruled. Overruled. The testimony was
15 as to WPATH standards, and this is directly relevant to that, I
16 think. So I'll overrule the objection -- or at least directly
17 relevant based upon Dr. Ettner's interpretation of the WPATH
18 standards, which counsel is free to dispute, but I think it's
19 within the scope.

20 Go ahead.

21 MR. HALL: You mentioned Dr. Ettner, Judge, just a
22 second ago.

23 THE COURT: Yes.

24 MR. HALL: I'm sorry. What did you mean by that?

25 THE COURT: I said that Dr. Ettner had indicated what

1 her understanding of that fourth requirement of serious mental
2 health concerns being well controlled, that that focused upon
3 competency to consent to treatment and a number of other
4 factors.

5 MR. HALL: Right. Mr. Clark, though.

6 THE COURT: I understand that. But I think it's
7 still -- counsel is simply using that understanding to
8 cross-examine the witness, which I think is appropriate.

9 I'm not in any way suggesting that Mr. Clark agrees with
10 that, but I think it's fair to ask questions using the standard
11 as another expert understands them.

12 MR. HALL: May I clarify my objection, Your Honor, on
13 one particular issue?

14 THE COURT: Yes.

15 MR. HALL: Ms. Rifkin is asking him to go through all
16 the criteria. He did not say that he believes Ms. Edmo meets
17 all those criteria. So he was actually never asked in direct
18 nor has he testified that she has informed consent.

19 THE COURT: But he has very specifically testified
20 that the one criteria that was not met was that she had serious
21 mental health concerns that were not well controlled. And
22 therefore, since that's what this question pertains to, based
23 upon Dr. Ettner's reading of that standard, the objection is
24 overruled.

25 MR. HALL: All right. Thank you, Your Honor.

1 THE COURT: Proceed.

2 Q. BY MS. RIFKIN: Mr. Clark, you believe Ms. Edmo is oriented
3 as to reality; correct?

4 A. Yes.

5 Q. And at ISCI, the institution where Ms. Edmo resides, there
6 are special mental health units for inmates who are not able to
7 function in the general population because of their mental
8 illness; correct?

9 A. Yes.

10 Q. And Ms. Edmo is housed in general population, not in one of
11 the mental health units; correct?

12 A. She has been housed in the BHU, yes.

13 Q. When was the last time she was housed in the behavioral
14 health unit?

15 A. Approximately two years.

16 Q. So for the last two years, Ms. Edmo has been housed in
17 general population; isn't that correct?

18 A. To my best recollection, yes.

19 Q. You testified that you relied in part on Ms. Edmo's
20 disciplinary record in opining she is not appropriate for
21 surgery; correct?

22 A. Yes.

23 Q. You believe her disciplinary record demonstrates
24 uncontrolled mental health concerns?

25 A. I do.

1 Q. And you testified that Ms. Edmo's DORs for sexual activity
2 and assault were related to mental health concerns and
3 borderline personality disorder; correct?

4 A. Border personality traits.

5 Q. And mental health --

6 THE COURT: Just a moment. Did you mean "borderline
7 personality traits?

8 THE WITNESS: Excuse me. Borderline.

9 THE COURT: I have been guilty of the same. Sometimes
10 when people saying "borderline personality disorder," I wish
11 they would change that term, because I initially thought that
12 meant you were on the edge of having a personality disorder
13 instead of a defined specific personality disorder. So I'm kind
14 of acutely sensitive to that.

15 So you are referring to borderline personality disorder?

16 THE WITNESS: Traits, yes.

17 THE COURT: Traits, as recognized in the DSM-5?

18 THE WITNESS: Yes.

19 THE COURT: All right. Go ahead. I apologize for
20 that little rant.

21 MS. RIFKIN: That's perfectly fine, Your Honor.

22 THE COURT: I have always wondered why they chose that
23 term. There has to be a better term.

24 MS. RIFKIN: So if we could show the witness what's
25 been marked as Joint Exhibit 1, page 524, please.

1 Q. BY MS. RIFKIN: Mr. Clark, you're familiar with this mental
2 health DOR recommendation form used by IDOC; correct?

3 A. Yes, I am.

4 Q. They have to be filled out for inmates with mental health
5 diagnoses when there is a DOR charged against them; is that
6 correct?

7 A. Yes.

8 Q. You supervise and train IDOC clinicians about how to fill
9 these out; correct?

10 A. I do.

11 Q. And one of the questions on this form asks whether mental
12 illness was a contributing factor in the incident leading to a
13 DOR; correct?

14 A. Yes.

15 Q. And there is also a box to check mental illness is not a
16 factor in the incident; correct?

17 A. That is correct.

18 Q. And you instruct IDOC clinicians that you supervise that if
19 any mental health issue played a role in the behavior, they have
20 to mark the "yes" box; right?

21 A. Yes, if they feel that's appropriate.

22 Q. So looking at the DOR recommendation right here, the
23 offense date is December 30, 2015; correct?

24 A. Yes.

25 Q. And the offense description is "sexual activity"?

1 A. Yes.

2 Q. This is one of the DORs you said shows that Ms. Edmo's
3 mental health concerns are uncontrolled; correct?

4 A. That's one of the behaviors, yes.

5 Q. Which box is checked for whether mental illness
6 contributed -- was a contributing factor in the incident?

7 A. This clinician felt that -- excuse me. Mental illness was
8 not a factor.

9 Q. So the box "no" for mental illness a contributing factor in
10 incident is checked; correct?

11 A. Yes.

12 Q. And also, the box "Mental illness is not a factor in
13 incident," that one is also checked; right?

14 A. That is correct.

15 Q. Can we show the witness Joint Exhibit 1, page 610. Zoom in
16 a little bit. Thank you.

17 This is another mental health DOR recommendation for
18 Ms. Edmo; correct?

19 A. Yes.

20 Q. This is dated March 30, 2017; correct?

21 A. Yes.

22 Q. This is for assault?

23 A. Yes.

24 Q. And this is another one of the DORs that you said shows
25 that her mental health concerns are not well controlled; right?

1 A. That's one of the behaviors.

2 Q. This DOR documents behavior that shows to you her mental
3 health concerns are not well controlled; right?

4 A. Can you rephrase that a little bit. Are you saying this
5 DOR or the behavior?

6 Q. The behavior.

7 You referenced that Ms. Edmo received DORs for assault;
8 correct?

9 A. Yes.

10 Q. And you said that that shows -- the fact that she got a DOR
11 for assaultive behavior shows that her mental health concerns
12 are not well controlled; correct?

13 A. The fact she assaulted somebody, yes.

14 Q. And you train a clinician that if the behavior for which
15 Ms. Edmo got a DOR is related to mental health, they have to
16 check the "yes" box on this form, Mental Health DOR
17 Recommendation; correct?

18 A. Yes.

19 MR. HALL: Objection. Foundation.

20 THE COURT: Overruled.

21 THE WITNESS: If it's found in each case.

22 Q. BY MS. RIFKIN: Can you answer the question, Mr. Clark?

23 You train IDOC clinicians that if they believe the behavior
24 for which a person receives a DOR is related to mental health
25 concerns, they have to check the "yes" box on this form;

1 correct?

2 A. Yes.

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

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

5 Q. It's checked, for "Mental illness contributing factor in
6 incident," "no"; correct?

7 A. Yes.

8 Q. And the next box, "Mental illness not a factor in
9 incident," that's checked "yes"; right?

10 A. Yes.

11 Q. So it wasn't a mistake on the clinician's part, accidentally
12 checking the box; right?

13 A. Not that I'm aware of.

14 Q. You agree that Ms. Edmo has been compliant with her hormone
15 treatments since they started in September 2012; correct?

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

17 Q. And you agree that Ms. Edmo has been compliant with her
18 medication for depression; correct?

19 A. Yes.

20 Q. And you testified that when you learned that Ms. Edmo had
21 attempted to cut her testicle, you didn't know whether this was
22 related to her gender dysphoria; correct?

23 A. That is correct, because I didn't do the assessment on
24 Ms. Edmo to know that.

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

1 Dr. Levine in 2016; correct?

2 A. Yes.

3 Q. And after that training, you created a training to train
4 other IDOC clinicians on gender dysphoria; correct?

5 A. Yes, I did.

6 Q. And for this training, you borrowed quite a bit from
7 Dr. Levine, didn't you?

8 A. Yes.

9 Q. You felt that using Dr. Levine's material was a good way to
10 talk about identities and different identity possibilities;
11 correct?

12 A. Yes.

13 Q. Can we show Plaintiff's Exhibit 1025, please.

14 Is this the training that you and your supervisor created
15 to give to IDOC clinicians in September 2017?

16 A. Yes.

17 THE COURT: Are you offering the exhibit before we
18 discuss it further?

19 MS. RIFKIN: Yes, Your Honor, I'm offering this.

20 THE COURT: Any objection?

21 MR. HALL: No, Your Honor.

22 THE COURT: Mr. Eaton?

23 MR. HALL: Sorry. We have stipulated to authenticity;
24 however, these are hearsay statements. So to that extent, I'll
25 object.

1 THE COURT: Mr. Eaton?

2 MR. EATON: I'll join that.

3 THE COURT: Well, as I understand it, this is
4 a -- some slide -- PowerPoint slides prepared for a presentation
5 to IDOC staff prepared at least in part by Mr. Clark with regard
6 to how to assess gender dysphoria.

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

8 MS. RIFKIN: Yes, Your Honor.

9 THE COURT: And what is the date? I don't see a date
10 on the exhibit list.

11 MS. RIFKIN: Mr. Clark produced this at his deposition
12 and handwrote the date September 2017, Your Honor, which he
13 testified was the date of the presentation.

14 THE COURT: All right. I'll overrule the objection.
15 The exhibit will be admitted.

16 (Plaintiff's Exhibit 1025 admitted.)

17 THE COURT: I might note that it potentially could be
18 used for impeachment even if not offered to prove the truth of
19 the matter asserted, and it is proper impeachment based -- based
20 upon his prior testimony.

21 So go ahead and proceed.

22 MS. RIFKIN: All right. Can we show, please, page 5
23 of this exhibit. And I would like to zoom in on the lower
24 left-hand corner slide.

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

1 well, that how the staff is actually trained is probably also an
2 issue in the case. So it has direct relevance as to proper
3 training. Even if not offered to prove the truth of the matter
4 asserted, it can be offered to show what training was actually
5 provided to staff concerning gender dysphoria assessments.

6 So I'd just state that as another grounds for the court's
7 decision.

8 MS. RIFKIN: I'm sorry, Your Honor. Just one minute.

9 THE COURT: I was just clarifying the record. Go
10 ahead.

11 Q. BY MS. RIFKIN: All right. This is one of the slides from
12 Dr. Levine that you took and put in your own training to IDOC
13 clinicians; correct?

14 A. Yes.

15 Q. And you took No. 2 from Dr. Levine.

16 The SOC, that refers to the WPATH standards of care;
17 correct?

18 A. That is correct.

19 Q. "SOC, which claims to be a scientific and minority
20 rights document, ignores the profound differences
21 between science and advocacy."

22 That's part of the training you presented to the IDOC
23 clinicians; correct?

24 A. Yes.

25 Q. And if we can go over to the slide directly next to that

1 one, bottom right-hand corner.

2 THE COURT: Could you back up? I apologize. Could I
3 see that prior blow-up that you had?

4 So the statement is that -- "SOC" is standard of care? Is
5 that what that means?

6 THE WITNESS: Yes, it does.

7 THE COURT: Standard of care which claims to be a
8 scientific and minority rights document ignores the difference
9 between science and advocacy.

10 So what you're saying is that the standard of care, rather
11 than to be neutral, is, in fact, an advocacy position taken by
12 someone with expertise in the field? Is that, in essence, what
13 you're saying there?

14 THE WITNESS: That's what Dr. Levine said.

15 MR. HALL: Objection.

16 THE COURT: Okay. But it's what you were then
17 presenting to the staff?

18 THE WITNESS: Yes.

19 THE COURT: All right. Okay. Go ahead.

20 Q. BY MS. RIFKIN: All right. If we can move over to the
21 bottom right-hand corner slide, please.

22 No. 5:

23 "Judges, who are schooled in civil rights, look to
24 professional societies like WPATH for guidance. It is
25 an uphill battle to convince them that a professional

1 society is wrong and a dissenting expert in the
2 courtroom is right."

3 That's another one of Dr. Levine's theories that you
4 trained IDOC clinicians on, isn't it?

5 A. Yes.

6 Q. If we can turn to page 6 of this exhibit.

7 Before I go to those, prior to providing this training, in
8 addition to attending Dr. Levine's training to IDOC, you also
9 had a direct conversation with him; correct?

10 A. No.

11 Q. You communicated directly with Dr. Levine after that
12 training; correct?

13 A. Oh, after training. Yes.

14 Q. And based on the conversation you and he had, he sent you
15 some additional slides to use for your own presentation to IDOC
16 clinicians; correct?

17 A. Not specifically for me to use them, but I chose to use
18 them.

19 Q. So he sent you some additional slides based on your
20 conversation, and you chose to include those slides in this
21 training that we're looking at; correct?

22 A. Yes.

23 Q. Okay. If we can zoom in on the upper right-hand corner
24 slide. Thank you. I think that's good.

25 Can you read -- can you read the words on that, Doctor --

1 Mr. Clark?

2 A. Yes.

3 Q. Okay. This is one of the slides that you testified
4 Dr. Levine sent you after the training that you chose to
5 include?

6 A. Yes.

7 Q. And the slide starts:

8 "The justice paradigm reminds us that the inmate is in
9 prison as a punishment for a crime, for the protection
10 of citizens, and for an opportunity for civic
11 rehabilitation."

12 Correct?

13 A. Yes.

14 Q. And No. 3 on this slide, bullet point 3, says:

15 "This paradigm might be alternatively labeled common
16 sense paradigm or a citizens paradigm."

17 Correct?

18 A. Yes.

19 Q. And under No. 2, this slide says:

20 "Most individuals -- professional, government
21 officials and laypersons -- do not support the surgery
22 and express bafflement and outrage when they learn of
23 court decisions to mandate it for inmates at public
24 expense."

25 Correct?

1 A. That's what it says, yes.

2 Q. And this is information you included when training IDOC
3 clinicians about gender dysphoria; correct?

4 A. Yes.

5 Q. And treatment for gender dysphoria?

6 A. Yes.

7 Q. And how to treat people within their care for gender
8 dysphoria; correct?

9 A. It was part of the training, yes.

10 Q. You became familiar with the Osborne and Lawrence article
11 and proposed extra requirements for prisoners who want gender
12 confirmation surgery through Dr. Levine's training; correct?

13 A. No. I had the article prior to that.

14 Q. Didn't you testify a few moments ago on direct that
15 Dr. Levine's training to you included the Osborne and Levine
16 [sic] standards and, based on that, you rely upon them?

17 A. It wasn't based on that. I had the article prior to that
18 training.

19 Q. Okay. Are you aware of any professional associations that
20 had endorsed or accepted the standards proposed by Osborne and
21 Lawrence for treating patients with gender dysphoria?

22 A. I'm not aware of any, no.

23 Q. And IDOC has never provided gender confirmation surgery to
24 a prisoner; correct?

25 A. Not to my knowledge.

1 Q. And out of the 30 patients with gender dysphoria at IDOC,
2 not one has been referred for gender confirmation surgery;
3 correct?

4 A. That is correct.

5 MS. RIFKIN: No more questions at this time.

6 THE COURT: Redirect.

7 MR. HALL: Yes, Your Honor.

8 Excuse me, Madam Clerk. Is there a magic button I need to
9 press here? Thank you.

10 THE CLERK: You're welcome.

11 REDIRECT EXAMINATION

12 BY MR. HALL:

13 Q. Mr. Clark, I want to refer you back to the competency of
14 mental health professionals under the WPATH. We discussed this
15 previously. It is Joint Exhibit 15, page 28.

16 Do you see that there in front of you?

17 A. Yes, I do.

18 Q. Do you see anywhere where it says in order to be competent,
19 you must have provided an assessment for sex reassignment
20 surgery?

21 A. I do not see that.

22 Q. I have placed before you Joint Exhibit 15, page 66.

23 Do you see that in front of you there?

24 A. Yes, I do.

25 Q. Looking at the criteria for surgery, do you see anywhere

1 there where it says the words "medical necessity"?

2 A. I do not.

3 Q. Let's talk a little bit about these mental health DOR
4 recommendations, in particular, this one, Joint Exhibit 1, page
5 524.

6 Do you see that in front of you?

7 A. Yes, I do.

8 Q. Now, these aren't done for every offender who gets a -- let
9 me rephrase that.

10 Are these mental health recommendation for DORs done for
11 every offender in the Idaho Department of Corrections who
12 receives a DOR?

13 A. No.

14 Q. Who are they done for?

15 A. For folks that -- the inmates that have a certain level of
16 care associated with their mental health.

17 Q. What does that mean, the level of care for their health?

18 A. We have several levels of medical care that we provide.
19 For example, we have some that are just med management only;
20 like your neighbor on Zoloft, for example. But others attend
21 groups, have to be put in a mental health unit. And these
22 recommendations are associated for people that are at that
23 higher level of mental health need.

24 Q. Okay. And was Ms. Edmo at that higher level of mental
25 health need?

1 A. Yes.

2 Q. Okay. Does it say anywhere on here that Ms. Edmo does not
3 have a mental health illness? And I'm referring to Joint
4 Exhibit 1, page 525.

5 A. It does not say that.

6 Q. Is there any conclusion here that -- well, let me talk to
7 you about this.

8 At the top here, it says, "Documented history, mental
9 illness that could impair decision-making."

10 Do you see that?

11 A. Yes.

12 Q. What does that mean?

13 A. Meaning there is a history that the particular inmate has
14 demonstrated issues of mental health.

15 Q. And that box was marked "yes" for Ms. Edmo; correct?

16 A. Yes.

17 Q. Okay. Who reviews these forms?

18 A. I don't know who -- the clinicians complete those, and then
19 they are given to a duty officer.

20 Q. Okay. That's my question.

21 A clinician is going to complete these forms after
22 reviewing the DOR; is that correct?

23 A. Reviews the DOR. They are supposed to review the medical
24 file and any other history.

25 Q. And then they complete it, and they pass it off to

1 security?

2 A. That is accurate, yes.

3 Q. And then does someone review that in the process as to
4 determining whether or not to affirm or overrule the DOR?

5 A. That's on the responsibility of the security staff.

6 Q. Okay. Is it your understanding that the security staff
7 uses this form not to determine if mental illness was involved
8 but whether or not mental illness should be a mitigating factor
9 in either affirming or overruling the DOR?

10 A. Yes. That's the intention.

11 Q. Okay. So the intention is not to make a statement that the
12 person is not suffering from any mental health concerns at the
13 time; is that fair?

14 A. That is accurate.

15 Q. And you didn't complete this form; correct?

16 A. I did not.

17 Q. Sorry. Marked as Joint Exhibit 1-524.

18 A. I did not.

19 Q. Now, have you provided more training to IDOC staff other
20 than the slides that were discussed with you by Ms. Rifkin
21 marked as Plaintiff's Exhibit 1025?

22 A. I believe that was the last one that I did, but we have
23 future ones planned.

24 Q. Right. And do you believe that when you present training,
25 that you present only one side of a debate or an issue?

1 A. Absolutely not.

2 Q. And was it your intention in including information from
3 Dr. Levine to present the WPATH and another side of the debate?

4 A. No.

5 Q. Do you think it's good training to provide staff with a
6 balanced look at both sides of a debate?

7 MS. RIFKIN: I'm sorry, Your Honor. I'm going to
8 object as leading the witness here.

9 THE COURT: I'm sorry. You're objecting to leading?

10 MS. RIFKIN: Leading the witness, yes, as this is
11 direct.

12 THE COURT: Rephrase the question.

13 Q. BY MR. HALL: Do you find it important to present both
14 sides of a debate?

15 A. Yes, I do.

16 Q. Why?

17 A. I feel like all of the things need to be on the table to
18 empower my staff to make the best decisions possible based on
19 all the information.

20 Q. Do you feel that the WPATH has adequately addressed how to
21 apply the standards in a prison context?

22 MS. RIFKIN: Objection as beyond the scope of cross.

23 MR. HALL: I think it goes directly to cross and the
24 basis and foundation for the presentations and the training that
25 he has provided to IDOC clinicians.

1 THE COURT: Overruled. You may answer.

2 THE WITNESS: I feel it covers a lot of what we can do
3 in prison for this population, but I do feel it is missing areas
4 on how to deal with specific issues associated with prisons.

5 Q. BY MR. HALL: And do you believe that Levine and Osborne
6 and Lawrence have attempted to try and comment on how to apply
7 the WPATH in the context of a prison?

8 A. That was how I interpreted it, yes.

9 Q. And you've -- you have reviewed Osborne and Lawrence's
10 article; correct?

11 A. Yes.

12 Q. And have you ever presented any opinions to IDOC staff that
13 the IDOC should not ever provide sex reassignment surgery to a
14 gender dysphoric inmate?

15 A. I have never said that, no.

16 Q. Do you believe that?

17 A. I do not.

18 Q. Okay. Did you present in this slide, this presentation,
19 Plaintiff's Exhibit 1025-1, that it's actually Dr. Levine's
20 opinion that SRS should never be provided in a prison?

21 A. No, I never presented that to them.

22 Q. Do you believe that there may be gender dysphoric inmates
23 at the Idaho Department of Corrections who may one day meet the
24 criteria for sex reassignment surgery?

25 MS. RIFKIN: Objection. Calls for speculation, beyond

1 the scope.

2 THE COURT: Well, I'm going to allow it because I was
3 going to ask that question myself. So I guess that defines
4 relevance.

5 So you can answer.

6 THE WITNESS: I do believe there will come a time
7 where we will have a person incarcerated that will meet the
8 criteria for surgery.

9 Q. BY MR. HALL: And is it your opinion that if someone meets
10 the criteria under the WPATH, that it would be appropriate to
11 provide sex reassignment surgery or refer to a physician who
12 could make that determination?

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

14 Q. But going back to your opinion, while that may be possible
15 for some offender someday, you don't believe that Ms. Edmo meets
16 the criteria for sex reassignment surgery; correct?

17 A. That is correct.

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

19 A. Yes, that was my opinion.

20 Q. And you weren't lying when you said that you considered the
21 WPATH in 2016 and in assessing whether or not Ms. Edmo had
22 mental health concerns that made SRS inappropriate, were you?

23 A. No, I was not.

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

25 A. Yes, I did.

1 Q. And have you seen Dr. Eliason's note from that assessment?

2 A. Yes, I have.

3 Q. And did you see where he referenced you in there as a WPATH
4 member and that he had specifically staffed it with you?

5 A. Yes, I did.

6 MR. HALL: Okay. No further questions.

7 THE COURT: All right. I was going to ask some
8 questions, and I should have asked them after Ms. Rifkin's
9 questions. But I'll do it now and give both sides a chance to
10 follow up if I ask anything that raises a concern.

11 EXAMINATION

12 BY THE COURT:

13 Q. Just to be clear, the training that you provided to the
14 IDOC staff, it was not training to assist the staff in making a
15 gender dysphoria assessment, because that's not their role;
16 correct?

17 A. No. That particular one for September 2017 was for a group
18 of clinicians that we were training to do assessments.

19 Q. So it was to do assessments?

20 A. Yes.

21 Q. And was the upshot of the training that you use the WPATH
22 criteria to determine whether or not a person should, in fact,
23 receive gender-conforming surgery?

24 A. I don't recall if I covered surgery in the further slides
25 or not. I think I was focusing mainly on the assessments.

1 Q. In other words, to assess whether or not a person suffers
2 from gender dysphoria?

3 A. Yes.

4 Q. Is that all you're doing?

5 A. Yes.

6 Q. You're not recommending a particular treatment program?
7 That's not the role of the assessment?

8 A. For that training, no, that was not the purpose of it.

9 Q. Okay. Well, the second question, I think I understood
10 that -- just earlier today, that apparently as of the last
11 Friday, there was a change in IDOC policy allowing female
12 underwear, makeup, and hairstyles according to an inmate's
13 desired gender and directing correctional officers to address
14 them according to that desired gender.

15 First of all, did I get that right? And secondly, were you
16 involved in that change in policy? Or do you know? Maybe you
17 don't even know.

18 A. Yes. First of all -- okay. Remind me your first question.
19 I apologize.

20 Q. Well, it was basically, there has been a change in IDOC
21 policy. You were aware of that?

22 A. Yes.

23 Q. And were you involved in creating that change in policy?

24 A. Yes, I was involved in that process.

25 Q. So was that your recommendation?

1 A. To offer those?

2 Q. Make those changes.

3 A. Yes, it was.

4 Q. Okay. Was that a -- well, let me just leave it at that.
5 Maybe I don't need to go any further because it's not directly
6 relevant to the issue before the court.

7 Let me ask now just a couple questions about, I guess, the
8 WPATH standards.

9 In the last few questions asked by Mr. Hall, you talked
10 about whether there would be someone at some point who IDOC
11 might well approve for gender confirmation surgery. And I'm
12 assuming that that person would need to qualify under the WPATH
13 standards; that would be maybe the or at least a criteria for
14 making that determination.

15 Is that --

16 A. I would rely on those standards heavily, yes.

17 Q. WPATH standards?

18 A. Yes, the WPATH standards.

19 Q. All right. And you agree that, as I understand your
20 testimony, that other than that fourth requirement that any
21 serious existing or serious mental health concerns be well
22 controlled, that the plaintiff, Ms. Edmo, qualifies under the
23 WPATH standards?

24 A. From my opinion, yes.

25 Q. Okay. So let me ask -- and I have no idea what the answer

1 to this is. First of all, gender dysphoria -- and I want to be
2 careful on terminology. I know that DSM-5 at least provides the
3 standard for diagnosing gender dysphoria, but would gender
4 dysphoria by itself constitute a serious mental health concern?

5 A. I think it can, yes.

6 Q. But you would agree that if that is the only uncontrolled
7 serious mental health concern, that should not be a
8 disqualifying factor under the WPATH standards; or, otherwise,
9 you have complete circular reasoning?

10 A. Yes, that is correct.

11 Q. All right. Then, if all of Ms. Edmo or any inmate's
12 existing mental health concerns are either gender dysphoria or
13 other recognized mental health issues which were a direct
14 consequence of gender dysphoria or greatly exacerbated by gender
15 dysphoria, would that, in your view, be disqualifying under that
16 fourth requirement of the WPATH standards?

17 A. I think that would have to be taken in great consideration
18 if you can really establish the gender dysphoria as the basis of
19 it.

20 Q. Well, that's my next question, is that you, presumably, as
21 a licensed mental health professional but not having a Ph.D. or
22 not being a psychiatrist, I'm assuming that you don't know how
23 we would ever differentiate between those mental health issues
24 which are directly tied to gender dysphoria and those which are
25 not?

1 A. I think it can be difficult with some people, yes.

2 Q. Okay. But you would agree that, at least potentially, if
3 they are, in fact, directly tied to gender dysphoria, those also
4 should not be considered in making that assessment under that
5 fourth requirement of the WPATH?

6 A. Yeah.

7 THE COURT: All right. Counsel, go ahead.

8 Again, Mr. Hall and Mr. Eaton, I assume you will follow up
9 on my questions. That's one of the great advantages of being up
10 here; I have a question, I get to ask it.

11 Go ahead.

12 MS. RIFKIN: Thank you, Your Honor. If we can show
13 Mr. Clark Joint Exhibit 8, please.

14 RECCROSS-EXAMINATION

15 BY MS. RIFKIN:

16 Q. Mr. Clark, this is the IDOC policy relating to GD -- folks
17 in prison with GD that was operative until last Friday; correct?

18 A. Yes.

19 Q. Okay. And if we can turn to what is I believe page 3 of
20 this exhibit. And can we zoom in on "Qualified gender identity
21 disorder evaluator," please.

22 In this policy which has been operative right up until
23 Friday and was operative in 2016 when Ms. Edmo was assessed for
24 surgery, this was the definition of qualified gender identity
25 disorder evaluator employed under IDOC policy; correct?

1 A. Yes.

2 MR. HALL: Your Honor, I'm going to object. This line
3 of questioning goes well beyond the scope of the initial cross
4 or the court's questions.

5 THE COURT: It seems like it does. I don't know --
6 can you tie it back in?

7 MS. RIFKIN: I can, Your Honor. Mr. Hall put the six
8 criteria in front of Mr. Clark and stated that he -- that he had
9 been able to assess Ms. Edmo. The questions are about his
10 assessment of Ms. Edmo for surgery and his qualifications to do
11 that, and this directly addresses that.

12 THE COURT: Your objection is -- oh, go ahead,
13 Mr. Hall.

14 MR. HALL: Your Honor, the line of questioning was
15 dealing solely with the WPATH criteria, whether he was competent
16 under the WPATH, not this policy.

17 I think this takes it well beyond the WPATH and to a policy
18 which is no longer in effect. And I have offered nothing to
19 suggest that Mr. Clark -- well, really, no analysis as to
20 whether he qualifies under that definition.

21 MS. RIFKIN: Your Honor, if counsel will stipulate
22 that Mr. Clark was not qualified as of prior to last Friday
23 under IDOC policy to assess patients with gender dysphoria as to
24 appropriateness or medical necessity for sex reassignment
25 surgery -- if they will stipulate that he was not qualified

1 under their own policy, I'll withdraw the questions.

2 THE COURT: Mr. Eaton -- or are you willing to concede
3 that you are not arguing that, in any event? You're not arguing
4 that he, in fact, was qualified to do assessments?

5 MR. HALL: Well, that takes it out of context. But we
6 never -- we have never presented any testimony that, under this
7 definition, that Mr. Clark meets that. He is not a doctor of
8 philosophy, so I don't see what the point is.

9 But there are other physicians that may qualify in that --
10 Claudia Lake, Dr. Eliason.

11 THE COURT: All that is being asked here is whether or
12 not IDOC is arguing that Mr. Clark was, in fact, a qualified
13 gender dysphoria evaluator.

14 And you're not arguing that he is; correct?

15 MR. HALL: Under that definition, no.

16 THE COURT: You're trying to qualify it. So let's
17 flesh out why -- under what definition. Today, he is.
18 Apparently, there was a change made on Friday. And are you
19 saying now that he is qualified?

20 MR. HALL: Under this policy, it describes qualified
21 gender identity disorder evaluator as a doctor of philosophy or
22 a psychiatrist -- sorry -- a medical doctor, a physician
23 licensed by a state board of medicine.

24 I think Mr. Clark has not testified that he is a doctor of
25 philosophy nor has he testified that he is a medical doctor.

1 THE COURT: The question, though, is whether or not
2 you are going to argue Mr. Clark is, in fact, a -- I'll use the
3 word, well, gender identity disorder evaluator. And you're not
4 offering him as such or suggesting, in fact, he has made that
5 evaluation in a way that was operative in this proceeding?

6 MR. HALL: Correct, Your Honor.

7 THE COURT: Okay. I don't know what more we can do.
8 Frankly, I now know what the IDOC policy is, so let's just move
9 on.

10 MS. RIFKIN: That's fine.

11 Q. BY MS. RIFKIN: Mr. Clark, you testified about the policy
12 change and that you were involved in the policy change.
13 You -- based on your own experience, IDOC started the process to
14 revise its GD policy in 2016; correct?

15 A. That was the approximate time, yes.

16 Q. And so after two-and-a-half or more years in the process of
17 revising its policy, it happened to adopt a new policy last
18 Friday; correct?

19 A. Officially, yes.

20 MR. HALL: Objection, Your Honor. This is also going
21 beyond the scope of cross and the court's questioning. She had
22 the opportunity to cross about the policy.

23 THE COURT: I understand. And I injected some of that
24 into the case by asking about the change in policy.

25 I'm going to allow some leeway, Counsel, but my questions

1 were tied to changes regarding how the correctional officers
2 were to refer to the inmate and the physical aspects of this.
3 So I think we need to limit it to that.

4 MS. RIFKIN: I'll move on, Your Honor.

5 THE COURT: All right.

6 MS. RIFKIN: May I have -- I would like to be able to
7 show Mr. Clark the exhibit, Plaintiff's Exhibit 1025, that we
8 have been talking about. I would like him to be able to look
9 through that entire document to be able to answer questions.

10 May I approach the witness?

11 THE COURT: Yes. Mr. Severson will -- if you have a
12 hard copy, we'll provide that to him so he can review it.

13 Counsel, we need to take one more short break, and we'll
14 probably limit it to just five minutes, and then we'll go
15 through until 3:00, a little after 3:00 maybe. Will that work?

16 MS. RIFKIN: Take a break in five minutes or now?

17 THE COURT: Well, the reason I'm suggesting that, too,
18 is if you want Mr. Clark to review the entire thing, he can do
19 that on the break.

20 MS. RIFKIN: Sure.

21 THE COURT: Then you can come back and ask questions
22 about it.

23 MS. RIFKIN: That works, Your Honor.

24 THE COURT: All right. Let's take a 10-minute break.
25 And we'll probably run until 3:00 or 3:10 to try to catch up the

1 time we lost yesterday.

2 THE WITNESS: I have a question. I'm supposed to
3 review this whole thing?

4 THE COURT: I'm assuming you're only talking about one
5 exhibit, which is Exhibit 1025.

6 THE WITNESS: Okay. Thank you.

7 MS. RIFKIN: I mean, I'm tempted to say yes. But, no,
8 just 1025.

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

10 Yeah, just Exhibit 1025, which I think is the PowerPoint
11 slides you looked at earlier, but she wants you to look at all
12 of them.

13 Right? Okay.

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

15 THE COURT: Yes.

16 MR. HALL: -- so I don't run afoul of anything. Would
17 it be permissible if Mr. Clark leaves the witness stand during
18 this?

19 THE COURT: Oh, yes. No. We are going to take a
20 10-minute break. So he can -- we'll take a break and, yes, he
21 can --

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

23 THE COURT: No, not at all.

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

25 THE COURT: No, not at all.

1 MR. HALL: Thank you.

2 THE COURT: All right. We'll be in recess for 10
3 minutes.

4 (Recess at 2:02 p.m. until 2:17 p.m.)

5 THE COURT: Mr. Clark, I'll remind you you are still
6 under oath.

7 Ms. Rifkin, you may resume your examination.

8 MS. RIFKIN: Thank you, Your Honor.

9 Q. BY MS. RIFKIN: Mr. Clark, have you had a chance to review
10 Plaintiff's Exhibit 1025?

11 A. Yes.

12 Q. Okay. And it's there in front of you?

13 A. Yes.

14 Q. Okay. You told the court before the break that this
15 training was about assessment and not surgery; correct?

16 A. Yes.

17 Q. Can you please turn to what's labeled page 6 of
18 Exhibit 1025.

19 A. I'm there.

20 Q. So looking at the slide in the upper left-hand corner, this
21 slide discusses surgery; right?

22 A. Yes.

23 Q. "Assumes that genital surgery will cure the problem
24 and withholding SRS constitutes a gross violation of
25 the Eighth Amendment."

1 That's the top part of this slide?

2 A. Yes.

3 Q. And it ends with:

4 "This paradigm assumes that SRS is a cure that if
5 withheld constitutes a gross violation of the Eighth
6 Amendment."

7 A. Yes.

8 Q. And the next slide, "Is there a fifth hidden paradigm,"
9 this is one of the ones we talked about earlier. This also
10 talks about surgery; correct?

11 A. Yes.

12 Q. And the next slide, "Is there a fifth hidden paradigm -- a
13 justice paradigm?" this slide also talks about surgery; correct?

14 A. Yes.

15 Q. So you chose to include these slides from Dr. Levine with
16 perceptions -- his perceptions about providing surgery for
17 inmates with gender dysphoria in a training about assessment of
18 gender dysphoria; correct?

19 A. Yes.

20 Q. I'm going to represent to you that, besides the cover
21 slide, there are 38 slides in this PowerPoint.

22 Do you know how many of those slides you took from
23 Dr. Levine's presentation?

24 A. The majority.

25 Q. Does 32 out of the 38 slides sound like the right number?

1 A. Yes.

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

6 A. That's accurate.

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

10 A. Yes.

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

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

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

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

21 MR. HALL: Objection.

22 THE WITNESS: I don't recall that.

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

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

1 THE COURT: Well, let's ask the question whether he
2 disagrees or not. And then if he gives an answer contrary to
3 his deposition, you can impeach.

4 Go ahead.

5 Q. BY MS. RIFKIN: Do you recall testifying at your deposition
6 that you didn't discuss your disagreement with any of
7 Dr. Levine's slides during the training?

8 A. I don't recall that, no.

9 MS. RIFKIN: No further questions, Your Honor.

10 THE COURT: Mr. Hall.

11 MR. HALL: Your Honor, a couple brief questions.

12 Madam Clerk, could I have this converted over. Thank you.

13 FURTHER REDIRECT EXAMINATION

14 BY MR. HALL:

15 Q. I want to show you again Joint Exhibit 15, page No. 28.

16 Again, these are the competencies under the WPATH of being
17 able to work with someone who is gender dysphoric; correct?

18 A. Yes.

19 MS. RIFKIN: Objection. This is beyond the scope of
20 the recross.

21 MR. HALL: Can I have a little leeway, Your Honor?

22 THE COURT: I'm going to give you some leeway. Go
23 ahead and proceed.

24 Q. BY MR. HALL: The court asked you some questions about
25 whether or not the roles of a psychologist versus a clinician,

1 the role of a medical doctor, psychiatrist versus a clinician.

2 Under Joint Exhibit 15, page No. 28, does it say in there
3 anywhere that to be competent under the WPATH, you have to be a
4 medical doctor?

5 A. No.

6 Q. Does it say you have to be a Ph.D.-level provider or
7 professional?

8 A. No, it doesn't.

9 Q. Okay. And do you -- to your knowledge, can only a
10 psychiatrist or a psychologist determine the relationship
11 between gender dysphoria and other coexisting mental health
12 concerns?

13 A. No.

14 Q. And in your profession, within your scope of care, can you
15 determine the difference between a gender dysphoric -- gender
16 dysphoria and other coexisting mental health concerns?

17 A. Yes. I have that experience.

18 Q. Okay. And the WPATH expects you to do that, doesn't it?

19 A. Yes.

20 Q. And I just want to ask one more question, maybe two, about
21 the slides under Plaintiff's Exhibit 1025.

22 This is the title right here of the presentation, "Gender
23 Dysphoria Assessment"; correct?

24 A. Yeah.

25 Q. And just to make it very clear, because I don't think it's

1 been very clear -- I just want to make it very clear -- this
2 presentation was not about treatment options, including surgery;
3 right?

4 A. That is correct.

5 Q. It was about training for diagnosis of gender dysphoria; is
6 that correct?

7 A. Yes.

8 MR. HALL: Thank you. No further questions.

9 THE COURT: Anything else?

10 MS. RIFKIN: No, Your Honor, not from plaintiff.

11 THE COURT: All right. Mr. Clark, you may step down.

12 Thank you.

13 THE WITNESS: Am I free?

14 THE COURT: You are.

15 I assume he is released from any subpoena, not subject to
16 recall.

17 MR. HALL: Right, Your Honor.

18 THE COURT: Well, presumably you know where to find
19 him if need be. So you are released.

20 MR. HALL: I think he is taking off. He will be in
21 the mountains.

22 THE COURT: That's right. It is that time of the
23 year.

24 THE WITNESS: Thank you.

25 THE COURT: Call your next witness, Mr. Eaton.

1 MR. EATON: Yes, Your Honor. The defendants call
2 Dr. Eliason.

3 THE COURT: Sir, would you step before the clerk and
4 be sworn.

5 SCOTT ELIASON, M.D., DEFENDANTS' WITNESS, SWORN

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

7 Please state your complete name and spell your name for the
8 record.

9 THE WITNESS: Scott Eliason, S-C-O-T-T, E-L-I-A-S-O-N.

10 THE COURT: You may inquire.

11 MR. EATON: Thank you, Your Honor.

12 DIRECT EXAMINATION

13 BY MR. EATON:

14 Q. So I have been saying it right. It's Eliason; right?

15 A. Yes.

16 Q. I told everybody the first time I met you, you said, "I'm a
17 psychiatrist. I listen."

18 It's Eliason; is that right?

19 A. That's right.

20 Q. Okay. Well, I know you have been ill this week, so I'm
21 glad you can be here, and I hope you're feeling better.

22 A. Thanks.

23 Q. How are you employed?

24 A. I'm employed by Corizon full time, but also I -- I work at
25 Ada County Jail. And then I have a small consulting business

1 called Boise Forensic Psychiatry where I consult with lawyers on
2 cases.

3 Q. Okay. And what is your job title with Corizon?

4 A. I'm the regional psychiatric director.

5 Q. Okay. And is that a full-time job?

6 A. Yes.

7 Q. Okay. And how long have you been employed with Corizon?

8 A. I have been with Corizon before it was Corizon, but it used
9 to be called Correctional Medical Services. And I joined them
10 the end of 2009.

11 Q. Okay. And then that was a name change eventually?

12 A. Yeah. Then it became -- it merged with some other company
13 and changed to Corizon.

14 Q. Okay. And have you been the psychiatric director
15 since -- since 2009?

16 A. It was really -- it was the spring of 2010 that I became
17 the director.

18 Q. Okay. And what did you do before that for Corizon?

19 A. I just -- I just saw patients as a psychiatrist.

20 Q. Okay. And the official title, again, is?

21 A. Regional psychiatric director.

22 Q. Okay. So as the regional psychiatric director, what are
23 your duties?

24 A. Primarily, I see patients for 90 percent of the time. And
25 then I oversee the psychiatric providers throughout the state.

1 So that includes psychiatrists and nurse practitioners and
2 physician's assistants throughout the state.

3 Q. When you say "throughout the state," is that at state
4 prisons?

5 A. Yes, throughout the state prison system. That's right.

6 Q. And so you have a supervisory role over those
7 psychiatrists. And do you call them "mid-levels"?

8 A. Yeah, that's right.

9 Q. Okay. And do you have administrative roles?

10 A. Yes. I do peer reviews, read credentialing interviews.
11 I'm involved with the hiring process and interviewing, things
12 like that.

13 Q. And then if I understood you, the majority of your time is
14 spent treating and caring for patients?

15 A. Yes.

16 Q. And what does that entail?

17 A. The treating patients? Sitting down, talking with
18 patients, reviewing their records, and prescribing treatments.

19 Q. And at what facilities do you do that?

20 A. I give direct care on a regular basis at Idaho State
21 Correctional Institution and Idaho Maximum Security Institution.

22 Q. And is there a specific unit that you provide the direct
23 care at ISCI?

24 A. There is two units. I work at the behavioral health unit
25 at ISCI, and I also work at the receptions and diagnostic unit.

1 Q. And is that separate from the general population?

2 A. Yes. That's the arrival area.

3 Q. And the behavioral health unit is separate from the general
4 population as well?

5 A. Yes.

6 Q. And what do you do for Ada County?

7 A. For Ada County, I provide some direct patient care, and
8 then I oversee a nurse practitioner who works there, too.

9 Q. Okay. Could we pull up Dr. Eliason's CV. This is -- can
10 you scroll down a little bit. This is Defendant's Exhibit 2022.

11 Dr. Eliason, do you see this?

12 A. Yes.

13 Q. Okay. Is this your CV?

14 A. Yeah, this is my CV.

15 Q. Do you want us to scroll through it?

16 Why don't you scroll through it just briefly so he can see
17 it.

18 Is that your CV?

19 A. Yes.

20 Q. Did you write that?

21 A. Yes.

22 Q. Okay. And is it accurate?

23 A. Yes.

24 MR. EATON: All right. We would move to admit the CV,
25 Your Honor.

1 THE COURT: Any objection?

2 MS. SHANBHAG: No objection, Your Honor.

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

4 MR. EATON: 2022 of Defendants' exhibits.

5 THE COURT: 2022 is admitted.

6 MR. EATON: Thank you, Your Honor.

7 (Defendant's Exhibit 2022 admitted.)

8 Q. BY MR. EATON: The court has your CV now, but I would still
9 like to talk to you and highlight a little bit of your
10 background. So let's talk about your education first.

11 Did you graduate from medical school?

12 A. Yes.

13 Q. Where was that?

14 A. Medical College of Wisconsin.

15 Q. Okay. And when was that?

16 A. In 2003.

17 Q. Okay. And then why don't you walk me through your formal
18 training -- excuse me -- formal education.

19 A. I did a psychiatric residency at the University of
20 Washington, where I did my first two years in Seattle and then
21 my last two years in Spokane.

22 And then I did a forensic psychiatry fellowship at the
23 University of California, San Francisco, where I trained at
24 several facilities, but I primarily worked at San Quentin
25 Prison.

1 And then -- and then I graduated from training. I worked
2 at the Department of Health and Welfare for the first
3 year-and-a-half out of training, and then I got the job at the
4 prison.

5 Q. Which prison?

6 A. With Corizon here in Idaho.

7 Q. And when was that? That was in 2009?

8 A. 2009.

9 Q. And you mentioned a fellowship.

10 In any of that education, did you encounter any gender
11 dysphoria or, I guess, it may have been gender identity disorder
12 patients at that time?

13 A. Yes. At San Quentin, I didn't directly treat patients, but
14 I shadowed my attending, who did have patients that were
15 transgender.

16 Q. Can you scroll down one page.

17 On this page, you mention NCCHC.

18 Do you see that in the middle?

19 A. The recent CME?

20 Q. Yes.

21 A. Yes.

22 Q. What is that?

23 A. NCCHC stands for National Commission, I think, of
24 Correctional Health Care.

25 Q. Can you just explain what you're referencing there?

1 A. I reference a conference that specializes in correctional
2 healthcare that I had attended.

3 Q. Okay. And are you board certified?

4 A. Yes.

5 Q. In what?

6 A. In forensic psychiatry and general psychiatry.

7 Q. Okay. What's the difference?

8 A. General psychiatry is the psychiatric treatment of adults
9 and also children but doesn't specialize in children.

10 And then forensic psychiatry is really the interface of
11 mental health and the legal system. And so you're trained in
12 all sorts of different aspects of psychiatry when it has to do
13 with the law. And as an offshoot of that forensic psychiatry is
14 considered the fellowship training for correctional
15 psychiatrists.

16 Q. And do you have any certifications or credentialing related
17 to providing treatment and care to prisoners?

18 A. Yes. Through the NCCHC, I am what's called a "CCHP," which
19 stands for a Certified Correctional Healthcare Provider. And I
20 both have the physician certification and the mental health
21 certification for that.

22 Q. And I assume, through your training and education and
23 experience, you are familiar with the DSM?

24 A. Yes.

25 Q. And what is that?

1 A. That's the Diagnostic and Statistics Manual, which is the
2 textbook full of psychiatric disorders and their diagnostic
3 criteria.

4 Q. And what version are we on now?

5 A. Version 5.

6 Q. Of the DSM?

7 A. Yes.

8 Q. Okay. And so through your training, education, and
9 experience, are you familiar with the disorders and criteria of
10 mental health disorders in the DSM?

11 A. Yes.

12 Q. Does that include previously gender identity disorder?

13 A. Yes.

14 Q. And has that changed, that diagnosis?

15 A. Yes. It's now called gender dysphoria.

16 Q. Okay. And do you have an appreciation as to why that
17 changed?

18 A. You know, there is -- mental health disorders are somewhat
19 difficult to define and often have a lot to do with society.
20 Like, if you look back at the earlier editions of the DSM, you
21 might find things like homosexuality in there, but now we know
22 that to just be a normal variant of human behavior.

23 And so over time, some things that have in the past been
24 considered mental disorders become not mental disorders.

25 And there has been some movement, I think, with the

1 transgender population to destigmatize or depathologize
2 transgender behavior.

3 And I think that the change from gender identity disorder
4 to gender dysphoria was to kind of support that and to help
5 de-stigmatize the transgender population.

6 Q. But is gender dysphoria still a -- do you call it a
7 diagnosis?

8 A. Yeah. It is still a diagnosis that you can find in the
9 DSM.

10 Q. Okay. I would like to pull up his records. I think it's
11 the second page.

12 So do you know Ms. Edmo, who is the plaintiff in this case?

13 A. Yes.

14 Q. And how did it come about that you know Ms. Edmo
15 originally?

16 A. Originally, I was asked to evaluate Ms. Edmo for gender
17 identity disorder.

18 Q. And how did that process work at that time?

19 A. Usually the inmate would bring to the attention of the
20 Department of Corrections that they wanted to be evaluated for
21 gender identity disorder, and that usually had to go through the
22 chief psychologist, who was Dr. Craig at that time. And then
23 Dr. Craig would assign people to do the evaluations.

24 Q. Actually, can we scroll up one record.

25 So here we have a Health Services Request form; correct?

1 A. Yes.

2 Q. And this is Joint Exhibit 1-12.

3 And what -- is that Ms. Edmo asking for something --

4 A. Yes.

5 Q. -- can you tell?

6 What is she asking for?

7 A. She said, "I would like to speak to Dr. Eliason about
8 hormone therapy. Thank you."

9 Q. And what's the date on that?

10 A. It looks like -- oh, 6 -- June 13, 2012.

11 Q. And to your knowledge, is that how it came about that you
12 were assessing Ms. Edmo?

13 A. Well, I'm not sure if there were prior communications about
14 this as well. I think this could have led to it. But if you go
15 to my note below that you just had --

16 Q. Yeah, let's go to that.

17 A. -- the date is June 25th. And so it could have been that,
18 but it could have also been some prior communications.

19 Q. In any event, was Ms. Edmo referred to you for an
20 assessment?

21 A. Yes.

22 Q. An assessment of what?

23 A. An assessment of her gender identity disorder.

24 Q. Okay. And so what -- the court has this note, so I don't
25 want you to read it all.

1 But can you walk us through generally what the subjective
2 section and what she was saying to you at that time that was
3 significant to your assessment.

4 A. Just that, primarily, she had always felt feminine and felt
5 that she was supposed to have been born a female and not a male
6 and that she used to think that that meant that she was supposed
7 to be a homosexual, but that now that she thought that she
8 wasn't a gay man but really a woman.

9 Do you want me to go further?

10 Q. Yeah. What else was significant to you in that
11 conversation?

12 A. And so then we talked about her sexual orientation some and
13 then about how she interacted and felt about being a man versus
14 being a woman and the kinds of things she felt comfortable
15 doing.

16 And then we also talked about some about her mental health
17 medications.

18 Q. So what mental health medications was she on at that time?

19 A. She was taking a medicine called Lamictal.

20 Q. What's that for?

21 A. Lamictal is a mood stabilizer that's primarily indicated
22 for bipolar disorder but used in depression as well.

23 Q. Anything else in the subjective section that you found
24 significant?

25 A. Not really.

1 Q. And then you have an objective section.

2 What did you do there and document?

3 A. So objective is basically like my physical exam or, in
4 psychiatry, we call it our mental status exam, which is when we
5 describe what we see related to their mental health.

6 So I noted that she appeared feminine in demeanor and
7 interaction style.

8 Q. And you also indicate in there --

9 Can you stop moving it, please. Thank you.

10 And then in there, you also indicate "mood depressed";
11 right?

12 A. Yes.

13 Q. All right. And so did you have an assessment?

14 A. Yes.

15 Q. And what was your assessment?

16 A. Well, first I commented about her mood disorder and that
17 she reported that she had done better on Zoloft. Then I said
18 that I thought that she met criteria for gender identity
19 disorder and that it was consistent with presentation and his
20 reported -- her reported history.

21 Q. And then did you make an assessment?

22 A. Yes.

23 Q. What was that?

24 A. Well, that was my assessment. Then I made a diagnosis down
25 here.

1 Q. Okay.

2 A. And under diagnosis for axis 1, which is where we would put
3 major mental illnesses at the time, I put "alcohol dependence,
4 mood disorder not otherwise specified."

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

6 So what was the basis for that assessment or that
7 diagnosis?

8 A. The alcohol dependence? That was based on previous records
9 that I was provided.

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

11 A. Yes. Mood disorder not otherwise specified.

12 Q. What was the reason for that diagnosis?

13 A. That was partially based on what we talked about, but also
14 prior records as well.

15 Q. Okay. What about any other diagnosis?

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

18 Q. Why did you make that assessment?

19 A. I made that assessment based on my objective evaluation and
20 then her report.

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

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

23 Q. And why did you do that?

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

1 Q. Okay. And so now that Ms. Edmo had a diagnosis from you of
2 gender identity disorder, what were the next steps, if any, in
3 the process?

4 A. So in the process in the Department of Corrections, you
5 would get two evaluations, one by -- it was usually by me and
6 then one by a psychologist.

7 And then the two evaluations would be brought to the MTC,
8 the management and treatment team, and we would discuss the
9 evaluations. And then if -- the Department of Corrections
10 oftentimes would also have more information based on outside
11 records or outside interviews with collateral people. And then
12 we would use that information to determine whether or not the
13 diagnosis of gender identity disorder was appropriate.

14 Q. And so do you have any understanding as to whether Ms. Edmo
15 received another assessment by a psychologist?

16 A. Yes.

17 Q. And who was that?

18 A. That was Claudia Lake.

19 Q. Have you reviewed that?

20 A. Not recently, but I have.

21 Q. Okay. And you mentioned the MTC, the Management Treatment
22 Committee. I believe the court heard Mr. Clark testify about
23 that committee.

24 But, generally, what was the makeup of that committee?

25 A. It was a multidisciplinary committee, meaning that we had

1 people from security, usually a deputy or warden; but we also
2 had people from mental health, which was the primary clinicians
3 who interact on a daily or weekly basis with their patients; and
4 then we also had medical representation.

5 And I was on that committee as kind of a combination since
6 I was a psychiatrist; but I worked for Corizon, so I was from
7 the medical portion and the mental health portion.

8 Q. What did you understand your role was on the MTC?

9 A. My role was to provide assistance and some expertise and
10 commentary and insight into the different patients.

11 Q. Okay. And do you know whether the MTC met after your
12 diagnosis and Dr. Lake's diagnosis of GID?

13 A. Yes, it did meet.

14 Q. And what happened at that point, at that meeting regarding
15 the GID assessment?

16 A. I believe it was agreed by the committee that Ms. Edmo did
17 have gender identity disorder.

18 Q. Okay. And do you have any appreciation as to whether
19 hormones were started after that?

20 A. They were started after that. I can't remember how
21 quickly, but they were.

22 Q. Okay. Were you involved in providing the hormone therapy?

23 A. No. The committee would basically decide whether or not
24 the patient should be put into the medical clinic to then be
25 seen if it was appropriate to be put on hormones. The medical

1 provider would then sit down with them and determine if there
2 was any contraindications or reasons why they shouldn't be on
3 them.

4 Q. Now, did you see Ms. Edmo after the GID diagnosis?

5 A. Yes.

6 Q. Okay. Did you see her continuously in the months following
7 or the years following?

8 A. Yeah, fairly regularly.

9 Q. Can you explain, elaborate on that.

10 A. So as long as she was housed in the behavioral health unit,
11 I saw her at a minimum of every three months, and provided her
12 psychiatric care.

13 There was a little bit of a difference with the care and
14 treatment of gender identity disorder and gender dysphoria.

15 Q. How is that?

16 A. And that was in my ongoing interactions with her, although
17 I may assess some of the gender dysphoria components or
18 symptoms, the treatment for gender dysphoria was primarily
19 driven through the MTC. And the treatment for the other mental
20 health conditions, the medication, the prescriptions was done in
21 those monthly -- every-three-month visits.

22 Q. Okay. So in the month -- in the year after your GID
23 diagnosis -- so 2012 to 2013 -- did Ms. Edmo have other mental
24 health disorders?

25 A. I don't recall without looking at my notes, but I think so.

1 Q. Well, I guess what I'm asking is: Did you have any
2 diagnosis -- and I think we have talked about this some
3 already from your first note -- other than GID?

4 A. Yes.

5 Q. And so what were those?

6 A. I think the diagnosis was called "mood disorder not
7 otherwise specified," but the primary symptom that we were
8 treating was depression.

9 Q. And, in fact, you periodically would meet with Ms. Edmo
10 over the years after GID to treat her underlying mental health
11 issues; right?

12 A. Yes.

13 Q. Can we scroll down to Joint Exhibit 1-370.

14 So I'm showing you now what is marked, I believe, as
15 Joint Exhibit 1-370.

16 Can you scroll up, please. Thank you.

17 Do you recognize this?

18 A. Yes.

19 Q. What is it?

20 A. It's a letter to the Department of Transportation.

21 Q. And how did this letter come about?

22 A. I remember Ms. Edmo was trying to get her driver's license
23 changed so, when she got released, it would reflect that she was
24 a female. And I guess part of that procedure was you had to
25 have a letter from a doctor.

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

2 A. Yes.

3 Q. Okay. Is this that letter?

4 A. Yes.

5 Q. Is that your signature?

6 A. It is.

7 Q. What did you indicate in that letter?

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

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

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

15 A. Yes.

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

18 A. Yes.

19 Q. And what were you using there?

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

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

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

1 thing I learned was the importance and power of words. And, you
2 know, at this point, I felt it was warranted to call Ms. Edmo a
3 "she" in there.

4 Q. Were you always consistent with that in your records?

5 A. No. I mean, you can see here, you know, I clearly have
6 changed at the top. But in the objective portion, I said
7 "appears feminine in his demeanor," you know. So it wasn't
8 100 percent consistent, but --

9 Q. Did you mean any ill intent by referring to Ms. Edmo as
10 "he"?

11 A. No.

12 Q. In fact, you were trying to recognize the she pronoun, and
13 you transitioned with that; right?

14 A. Yes.

15 THE COURT: Counsel, could I just inquire? You
16 indicate "return of depressive symptoms with decrease of dose."

17 That's decrease of Zoloft; correct?

18 THE WITNESS: Yes; that's right.

19 THE COURT: All right.

20 Q. BY MR. EATON: And I'm not going to walk through each one
21 of your notes when you're addressing her depression and other
22 mental health records, but this was an example that I wanted to
23 talk to you about.

24 Could we bring up Joint Exhibit 1-538. This is the
25 April 20, 2016 note. There we go.

1 So you're now being shown Joint Exhibit 1-538.

2 Do you see that?

3 A. Yes.

4 Q. Okay. And what is this note?

5 A. Well, this is basically my assessment of Ms. Edmo for the
6 medical necessity of gender reassignment surgery.

7 Q. And how did that come about?

8 A. Ms. Edmo requested to be evaluated for sexual reassignment
9 surgery and had sent several concern forms to several people.
10 And then so in the MTC, we discussed it.

11 And as part of the Idaho Department of Corrections standard
12 operating procedures, it says something to the effect of gender
13 reassignment surgery would not be provided unless deemed
14 medically necessary.

15 And so the committee felt like I was the best
16 representative to determine whether or not it was medically
17 necessary, since I was the one with medical training.

18 Q. And did you understand that the Idaho Department of
19 Corrections required -- their standard operating procedure
20 required a qualified GID evaluator?

21 A. Yes.

22 Q. Okay. And do you know what that required, what it meant to
23 be a qualified GID provider?

24 A. At least what I remember from the earlier testimony, it
25 said "physician" but that also had the expertise and familiarity

1 with gender identity disorder, I think it was.

2 Q. Did you consider yourself a qualified GID evaluator --

3 A. Yes.

4 Q. -- to assess Ms. Edmo?

5 A. Yes.

6 Q. Why is that?

7 A. Because, you know, I have extensive training in all sorts
8 of mental health disorders, but I have also treated patients
9 with gender identity disorder prior to working in the Department
10 of Corrections.

11 And I don't know how many I had assessed prior to Ms. Edmo
12 at this time, but I'm sure I had assessed at least a handful of
13 inmates with gender identity disorder.

14 Q. Okay. And so let's talk about the subjective section in
15 this note.

16 What -- what did you discuss with Ms. Edmo that was
17 significant to you regarding your assessment for SRS?

18 A. We talked about several things.

19 Can we zoom in on that a little bit?

20 Q. Yeah. Let's zoom in.

21 First, before we talk about that, I believe you indicated
22 this was an SRS assessment; right?

23 A. Yes.

24 Q. Can you elaborate and explain what that means.

25 A. So this is an assessment to determine whether or not

1 surgery was needed to treat her gender dysphoria.

2 Q. Okay. What kind of surgery?

3 A. By "surgery," it's a very blanket term. At this point, we
4 were primarily talking about a surgery to remove the penis and
5 put in a vagina and -- but there are several other surgeries
6 that gender reassignment surgery could entail.

7 Q. Is that a vaginoplasty? Is that what you're referring to?

8 A. Yeah, that's the term for it.

9 Q. I have been learning.

10 So I was asking you about your subjective section.

11 So what was significant in that regarding your conversation
12 with Ms. Edmo?

13 A. Well, what was important? I felt like it was all important
14 because I put it there.

15 Q. Why don't you just go through that with us.

16 A. You know, I felt like -- so she said she was doing all
17 right. And so, subjectively, she felt like things were going
18 well. She was eligible for parole, but this had not been
19 granted because there were multiple DORs. And she had mentioned
20 that she had received DORs for makeup and feminine appearance.

21 And she was really frustrated by this because, I mean, how
22 do you determine if somebody appears too feminine? You know,
23 which makes sense. It's kind of a blurry line; right? But she
24 found that frustrating.

25 And she wanted to discuss sex reassignment surgery. She

1 had been on hormone replacement for the last year-and-a-half but
2 felt that she needed more than just the hormones. And she said
3 that the hormones had helped her gender dysphoria but was still
4 frustrated by her current anatomy, which meant her genitals.

5 And then she said that she had made several attempts to
6 mutilate her genitals the past fall, which means cutting on
7 them, because of that distress that she felt.

8 Q. She reported that to you?

9 A. Yes.

10 Q. Do you have any understanding as to when that may have
11 happened in relation to your meeting here, your appointment?

12 A. I think it was the preceding September or something around
13 there.

14 Q. And what specifically are you referring to?

15 A. Her cutting on her genitals.

16 Q. Okay. So that was several months before?

17 A. Yes.

18 And then she also requested to be assigned to a different
19 housing unit and didn't want to be in the behavioral health unit
20 anymore.

21 And then we both talked about the importance of having
22 intact genitals for a successful sexual reassignment surgery.
23 And I kind of brought that up and talked to her about it, hoping
24 it would be kind of a deterrent to the self-mutilation.

25 And then I also consulted with the prison staff about the

1 inmate's behavior. And they had noted that she seemed pleasant
2 and didn't see any, like, overt depressive symptoms.

3 And I had also seen Ms. Edmo in several different settings
4 and appear her looking -- I say here "did not observe
5 significant dysphoria." In layman's terms, that would mean that
6 she looked pleasant and had a good mood.

7 Q. Okay. And she was on medications at the time of this
8 assessment?

9 A. Yes.

10 Q. And what was she on?

11 A. She was on Effexor and Remeron, which are two different
12 antidepressants.

13 Q. Why was she on those?

14 A. Because of her history of depression.

15 Q. All right. Let's scroll down a little bit.

16 You made some observations; is that right?

17 A. That's right.

18 Q. What observations did you make?

19 A. That she had eyebrows colored in with black pencil. Her
20 hygiene was good. She was wearing foundation. She appeared
21 feminine in demeanor and interaction style. And her thoughts
22 were logical and linear. And she denied any suicidal or
23 homicidal thoughts. And she had no overt delusions, which means
24 she wasn't discussing openly that she was paranoid or...

25 Her affect, which means like her expressed emotions, had a

1 full range, so a healthy range, what were generally euthymic,
2 which means generally pleasant but, yet, frustrated with the
3 whole process, which is what I mean by that, frustrated.

4 And then her speech was regular in rate, rhythm, and
5 volume, which means she had a regular quality of speech and that
6 her mood was, quote, "doing all right."

7 Q. Okay. And then did you make an assessment?

8 A. Yes.

9 Q. And how did you go about making that assessment?

10 A. So I incorporated what I had available to me, which was
11 prior history, my interaction with the patient, her clinicians,
12 and so her regular treating counselors and therapists.

13 Q. Let me stop you there.

14 So you have access to the clinicians' records at that time?

15 A. Oh, yes. I mean, I rely on those heavily.

16 If you look at my notes, they are fairly brief compared to
17 if you looked at some community evaluations or some of the
18 evaluations like in this case, some of the experts who have
19 written. They will have really long evaluations.

20 But in correctional medicine, it's a little bit different
21 because we have access to a wide variety of information right in
22 our system. And the therapist and the clinicians and all of
23 their information is all available to us.

24 Q. And did you review that at this time?

25 A. Yes. And so I incorporated all of that.

1 Q. Okay.

2 A. And then I also staffed this case with multiple people.
3 And what I tried to do is I tried to staff it with people that I
4 thought would come from differing backgrounds and different
5 viewpoints. So I --

6 Q. Why don't we walk through those that you staffed with.

7 A. I staffed it first with Dr. Jeremy Stoddart. I chose him
8 because he was a psychiatrist who wasn't the person doing the
9 evaluation, so it wasn't me.

10 Then I chose Dr. Murray Young, because he was the regional
11 medical director, so he had the medical expertise.

12 And then I chose Jeremy Clark because Jeremy Clark was a
13 WPATH member and had been to several WPATH conferences and was
14 somebody who I felt knew a lot about WPATH and their standards.

15 Q. Okay. And when did you staff this?

16 A. With all those people?

17 Q. Yes.

18 A. Oh, right after I did the -- that day.

19 Q. Okay. And what did -- and you say, "and they agreed with
20 my assessment"; is that right?

21 A. Yes; that's right.

22 Q. And "they" is referring to the various folks that you
23 staffed it with?

24 A. Yes.

25 Q. All right. And you heard Jeremy Clark testify today;

1 correct?

2 A. Yes.

3 Q. And he testified about your conversation with him?

4 A. Uh-huh.

5 Q. Is that a "yes"?

6 A. Yes. Sorry.

7 Q. Okay. What do you recall -- did that refresh your
8 recollection as to your conversation with Mr. Clark?

9 A. Yes, a little bit.

10 Q. And what do you remember about it, if anything?

11 A. This is a couple years ago, so it's a little bit foggy.
12 But I remember beforehand deciding who I wanted to staff it
13 with. And then if my -- if my memory is correct, I was walking
14 out of the prison and walked past Jeremy. And I was like, "Oh,
15 my gosh. I need to talk to you about something." And then we
16 discussed this case.

17 Q. Okay. And do you remember what he --

18 A. And then the other two I called on the phone.

19 Q. Okay. Do you remember what Jeremy Clark said to you at
20 that time?

21 A. Well, the way that medical consultations and staffings like
22 this happen is the person asking for help presents the case;
23 right?

24 So to these three people, I presented Ms. Edmo's case,
25 discussed what I knew about it and discussed, you know, my

1 observations, interactions and then what I thought would be the
2 right choice. And then they would ask questions if they wanted
3 to and then tell me if they agree or disagree or what points
4 they disagree.

5 Q. Okay. What else, if anything, did you do for your
6 assessment?

7 A. You know, I also did research, and I reached out to staff
8 throughout the country.

9 You know, I'm a regional psychiatric director, so that
10 means I'm involved in meetings with psychiatric directors of
11 other states. And I have been to several different NCCHC, which
12 is the national commission on health care for correctional
13 providers.

14 And in those meetings, I've both presented and been to
15 different presentations of people who have struggled with how to
16 treat the transgender population in the prison setting. And
17 it's something that the correctional profession is really trying
18 to grapple with how to do appropriately.

19 And so, you know, I acquired a certain level of expertise
20 about it through all of that. And then I went online, and I
21 searched also for healthcare insurances and looked up Medicare
22 and Medicaid and what they were doing with sex reassignment
23 surgeries and just trying to basically figure out how do you
24 decide this.

25 And, you know, if you read -- there is a second paragraph

1 in my assessment.

2 Q. Why don't you talk to us about that.

3 A. And where I basically talk about how to define medical
4 necessity for sexual reassignment surgery. And I know this is
5 very contested -- this is probably, you know, the whole crux of
6 this --

7 Q. Well, just talk about the facts.

8 A. -- case.

9 But, to me and to many of my colleagues in the correctional
10 healthcare, we don't feel as if the medical necessity for sexual
11 reassignment surgery in the inmate population has been very well
12 defined.

13 Q. Why is that?

14 A. Well, because, you know, in the community, you have the
15 WPATH standards that are fairly clear. And then you have
16 insurance companies and different groups who lay out this
17 criteria for what they think is appropriate for somebody before
18 they can get a sexual reassignment surgery.

19 But the inmate population is a very different population,
20 and it's a very strange environment. And to try to just squeeze
21 every person in the inmate population and say it's exactly the
22 same, it's not; it's very different.

23 And so it's not very well defined. And I think that in
24 each case, you have multiple things you can rely on, but you
25 also -- you rely on these things, and then you also rely on your

1 clinical judgment with the patient sitting in front of you in
2 the correctional environment, and you try to determine if it's
3 well defined -- if it's medically necessary.

4 And here I listed several cases where I thought this would
5 be an example of something which may meet medical criteria for
6 necessity. And I say in here that there was some sort of birth
7 defect or ambiguous genitalia that required some sort of
8 reconstructive or reparative surgery. Or I list in here "severe
9 and devastating dysphoria primarily due to genitals," and say
10 that that could also potentially meet criteria, which is
11 somewhat similar to one of the WPATH standards.

12 THE COURT: Just so I'm clear, Doctor, are you
13 suggesting those three criteria that you point out here would be
14 the things that you think maybe should be added onto the WPATH
15 criteria in the inmate population?

16 THE WITNESS: No, I don't think that's what I was
17 doing. I think primarily what I was doing is I was trying to
18 say: Are there cases when I think it would meet medical
19 necessity? And I am saying, yes, there are cases; and here are
20 a few examples of some cases.

21 THE COURT: So you are suggesting this in lieu of the
22 WPATH criteria for noninmate populations?

23 THE WITNESS: No. I was just -- I was basically
24 trying to come up with a couple examples of cases where I would
25 say there are cases that would meet medical necessity; here are

1 some examples.

2 THE COURT: Did I understand you to say, though, that
3 you felt that the WPATH criteria just doesn't fit comfortably
4 with the inmate population?

5 THE WITNESS: Yeah, depending on how you look at the
6 WPATH standards. Because in the WPATH standards themselves --

7 THE COURT: Let me tell you, to avoid -- I am going to
8 ask you at some point to tell me what you think needs to be
9 changed in the WPATH standards to fit the inmate population. So
10 be thinking about that, or counsel can cover that. Because it's
11 certainly something that's nagging at me a bit.

12 So go ahead, Mr. Eaton.

13 MR. EATON: Maybe one way to at least partially
14 address that is --

15 THE COURT: And we are going to take a break for the
16 evening in about seven minutes. So I don't want to cut -- go
17 ahead. I didn't mean for that question to get you off your
18 stride. We can cover that at a later point. So go ahead.

19 Q. BY MR. EATON: So maybe one way to address that, or at
20 least in part, is: So what ultimately did you conclude with
21 this assessment?

22 A. Ultimately, I concluded that Ms. Edmo did not meet criteria
23 for medical necessity at that time.

24 Q. And why?

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

1 that Ms. Edmo's mental health concerns were not fully in
2 adequate control.

3 And then, number two -- and this, to me, was even the more
4 important of the two -- is that I didn't feel like it was doing
5 Ms. Edmo any service to rush through getting gender reassignment
6 surgery in that current social situation.

7 The WPATH standards talk about a 12-month period of living
8 in your identified gender role. And in my knowledge of
9 Ms. Edmo, she had not really done that yet.

10 And although it's -- you know, gender reassignment surgery
11 can be very helpful for people who are transgender and have
12 gender dysphoria, there is a real important study that was done
13 that showed that even in postoperative transgender population,
14 those patients are still very likely -- much more likely than
15 the general population -- to kill themselves.

16 And the author of that paper goes on to say that it's
17 important to note that it's not because gender reassignment
18 surgery is bad; right? She is not saying that in this paper.
19 But what she was saying was that society and people's social
20 networks aren't supporting people enough through their
21 transitions; and that if people are better supported through
22 their transitions, then this huge increase in suicide over the
23 general population could be decreased.

24 And my main goal for my patients -- and primarily in this
25 case, Ms. Edmo -- is to have a happy, healthy life. And I think

1 that Ms. Edmo at this time was parole eligible. She could very
2 soon have been getting out and, at worst-case scenario, I
3 believe, tops out in 2021.

4 And it's my opinion that at this time, that I thought that
5 it would be most helpful to, number one, spend time getting her
6 mental health under better control; and then, number two, to get
7 her to have the experience around her real social network -- her
8 family and friends on the outside -- living as a woman to
9 determine whether or not she felt like that was her real
10 identity and to not make that determination in prison when I
11 felt like she could get out and would get out.

12 Q. And you also in the top -- this first paragraph under
13 assessment, the last couple of lines, you talk about the plan;
14 is that right?

15 A. Okay. Wait. Where are we looking here?

16 Q. The first paragraph with assessment, last couple of lines.

17 A. Okay. Yeah. Where I said --

18 Q. You say, "That being said..." If you could go over that.

19 A. "That being said." Yeah.

20 "That being said, I will continue to monitor and
21 assess this inmate for the medical necessity of SRS
22 throughout their stay here. For the time being, it is
23 my opinion that the combination of hormone treatment
24 and supportive counseling is sufficient for her gender
25 dysphoria."

1 Q. And in this note, did you identify other mental health
2 disorders?

3 A. Yes.

4 Q. And what did you identify?

5 A. Down below, you can see it says "MDD," which stands for
6 major depressive disorder, and also alcohol use disorder.

7 Q. And so what happened after you completed this assessment?
8 Do you know?

9 A. So after I completed this assessment, it was -- it weighed
10 heavily on my mind. And I -- I met with Ms. Edmo again soon
11 thereafter. And I had decided that I didn't want to, like, be
12 the lone person saying no for something that was this
13 potentially important and something that was very political and
14 something that I thought I needed some help.

15 And so I decided to form a committee of physicians who
16 could be trained on how to decide whether or not sexual
17 reassignment surgery was necessary.

18 So I met with Ms. Edmo, and I said, "Hey, so we're going to
19 do this differently. We're going to form a committee." And I
20 told her about the committee.

21 And then I put together a training with Dr. Stephen
22 Levine -- Levine.

23 Q. How did that training come about?

24 A. Well, he had been identified to me as someone who was an
25 expert in the field and also had some correctional experience,

1 and that it was in an NCCHC training and from the Department of
2 Corrections from Massachusetts who had been, you know, recently
3 sued about the same kind of issue and that they consulted
4 frequently with Dr. Levine, from Case Western.

5 And so I reached out to Dr. Levine on my own and said,
6 "Hey, how would you like to come out and do a day-long training
7 to me and some fellow physicians?" And he agreed to do it.

8 And then we opened that up to also the Department of
9 Corrections, and the MTC committee members also attended that.

10 And so the plan was to make this committee to help me
11 determine medical necessity for sexual reassignment surgery.
12 And I had identified several different physicians that were
13 going to be on it. They all came. They got trained.

14 Q. And I have a note for that. So let's pull up the --

15 THE COURT: Counsel, we're right at where we take the
16 break. I'll let you follow up with these questions, and then
17 we'll have to take the break.

18 MR. EATON: Okay. Thank you.

19 Q. BY MR. EATON: So there is a Levine list of attendees.

20 Is this what you're talking about?

21 A. Yes.

22 Q. And are those people that you understand attended the
23 Levine presentation?

24 A. Yes, that's right.

25 Q. And there has been some testimony in this case by experts

1 that Levine was an outlier, maybe didn't, like, follow or was
2 not a member of the WPATH.

3 Did you appreciate that at the time?

4 A. You know, I think probably determining if someone is an
5 outlier depends on where you start from. But Dr. Levine, at
6 least from my experience, is not at all someone who is opposed
7 to gender reassignment surgery.

8 And he has, I think, 35 or more years in running a
9 transgender health clinic and is very successful and very well
10 liked by his patients and frequently recommends gender
11 reassignment surgery.

12 And so in the presentation that he gave that day, I never
13 once felt like he was saying don't give inmates gender
14 reassignment surgery. I do feel like he might have posed some
15 questions to say, like, here are some --

16 MS. SHANBHAG: Objection. Hearsay.

17 THE COURT: Just a moment. I'm sorry. I was not
18 thinking along those lines.

19 Well, the witness is characterizing what his understanding
20 of the message, not necessarily what was actually said. The
21 witness can be cross-examined on that assessment, I think,
22 without getting into the substance. So I'll allow it.

23 The objection is overruled, but it is a close question.

24 Is it Ms. Shanbhag?

25 MS. SHANBHAG: Shanbhag, yes.

1 THE COURT: Shanbhag. Okay. I apologize. I wanted
2 to make sure I had that right.

3 Go ahead. But, again, you have got about one or two more
4 questions, and then we'll have to call it a day.

5 MR. EATON: Okay.

6 Q. BY MR. EATON: You were talking about --

7 A. I'm going to say --

8 Q. Hold on. You were talking about your impressions with --

9 A. -- that I never once felt like he didn't want inmates to
10 receive gender reassignment surgery, and would oftentimes pose
11 some opposing arguments to why it might not be a safe option or
12 might not be a good option but would also talk about how it was
13 necessary.

14 Q. Are you aware of whether Corizon received other trainings
15 from other people regarding gender dysphoria?

16 A. Yes. After that, one of the attendees, Dr. Stoddart, said
17 he worked with the local physician who treated the majority of
18 the transgender population in Boise and offered to get him to
19 come and present education.

20 MS. SHANBHAG: Objection.

21 THE COURT: Just a moment.

22 MS. SHANBHAG: Hearsay.

23 THE COURT: Sustained.

24 The witness can testify as to what he did or didn't do.

25 But what someone said, I mean, unless it has independent

1 relevance, would be hearsay.

2 Q. BY MR. EATON: Did you attend any other trainings regarding
3 gender dysphoria through Corizon other than the Levine
4 presentation?

5 A. Yes. There was a presentation by a Dr. Alviso from here in
6 town.

7 Q. And what was your understanding of that presentation?

8 A. Dr. Alviso talked about his experience in the treatment of
9 the transgender population and how he treated them.

10 Q. Okay. And did you appear for that?

11 A. I attended by phone.

12 MR. EATON: Okay. Your Honor, I know you're wanting
13 to call it. So I can --

14 THE COURT: I think we can't get Dr. Eliason done
15 today, unfortunately. And I hope you are feeling better,
16 Dr. Eliason.

17 Counsel, let's take a break. We'll recess [sic] at 8:30.
18 I think I kind of messed up the clock by asking questions that
19 can't be charged to anyone. So I'll have Mr. Severson visit
20 with counsel and see how much time we need to spend tomorrow to
21 give you the allotted time. But we do need to wrap up tomorrow
22 because, as I said, I'm going to be in trial for the next three
23 week on different matters. So if we can't wrap it up tomorrow,
24 we would have to come back more than a month from now.

25 All right. We will be in recess, then, until 8:30 tomorrow

1 morning.

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

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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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