No. 22-11707

UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

PAUL A. EKNES-TUCKER, et al.,
Plaintiffs-Appellees,

&

UNITED STATES OF AMERICA
Intervenor-Plaintiff-Appellee,

v.

GOVERNOR OF THE STATE OF ALABAMA, et al.,
Defendants-Appellants.

On Appeal from the United States District Court
for the Middle District of Alabama
Case No. 2:22-cv-184-LCB

APPELLANTS' APPENDIX VOLUME X OF XIII

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July 5, 2022

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Patient Information for Informed Consent
FEMINIZING MEDICATIONS FOR TRANSGENDER CLIENTS
Minors and Parents/Guardians
University of Alabama at Birmingham Pediatric Endocrinology
Multidisciplinary Gender Health Team

Before using medications to transition and feminize, you and your parents or guardians need to know the possible advantages, disadvantages and risks of these medications. We have listed them here for you. It's important that you understand all of this information before you begin taking these medications.

Please read the following with your parent or guardian. Once your questions or concerns are addressed, and you have decided to proceed with the medication(s), both you and your parent or guardian will need to sign this information and consent form.

We are happy to answer any questions you have.

What are the different medications that can feminize my appearance?

Part of transition for many transgender people involves taking hormones. For hormone treatment to be most effective, transgender girls and women take not only estrogens (female hormones), but also medicines to block their body from producing or utilizing testosterone (male hormones).

Different forms of the hormone estrogen are used to feminize appearance in transgender females. Estrogen can be given as an injection, weekly or every other week, as a pill, daily or twice a day, or as a patch, which is changed every three or four days.

Medications that block the production or effects of testosterone are called androgen blockers. Androgen is another term for male sex hormones. Spironolactone is the androgen blocker that is most commonly used in the United States. Other medicines are sometimes used, but because spironolactone is relatively safe, inexpensive, and effective to block testosterone, it is the primary androgen blocker used for transgender women.

Every medication has risks, benefits, and side effects that are important to understand before starting. The effects and side effects of medicines used for transition need to be monitored with laboratory studies and regular visits to your provider to make sure that there are no negative effects on your body.

Both the medicines that you take, as well as the process of transitioning can affect your mood. While trans women are relieved and happy with the changes that occur, it is important that you are under the care of a gender-qualified therapist while undergoing transition. The therapist can work with you, your family and friends and your school staff.

Estrogen can cause blood clots. We must be careful that you are not at risk to develop a blood clot. Who should not take estrogen?

Estrogen should not be used by anyone who has a history of

- an estrogen-dependent cancer
- a disorder that makes them more likely to get blood clots that could travel to the lungs (unless they are also taking blood thinners and are followed by a specialist)

Estrogen should be used with caution and only after a full discussion of risks by anyone who

- has a strong family history of breast cancer or other cancers that grow quicker when estrogens are present
- has uncontrolled diabetes
- has heart disease
- has chronic hepatitis or other liver disease
- has uncontrolled high cholesterol
- has migraines or seizure
- is obese
- smokes cigarettes

Both you and your parent or guardian should initial and date each statement on this form to show that you and your parent or guardian understand the benefits, risks, and changes that may occur from taking these medications.

Effects of Feminizing Medications

_____ _____I know that estrogen or anti-androgens – or both – may be prescribed to feminize my appearance.

_____ _____I know it can take several months or longer for the effects to become noticeable. I know that no one can predict how fast – or how much – change will happen.

_____ _____I know that if I am taking estrogen I will develop breasts.

- I know it takes several years for breasts to get to their full size.
- I know the breasts will remain, even if I stop taking estrogen.
- I know I might have a milky discharge from my nipples (called galactorrhea). If I do, I know I should check it out with my healthcare provider because it could be caused by the estrogen or by something else.
- I know that while we do not know the exact risk the risk, my risk of breast cancer may be increased to as high as if I had been born female
- I know that I should take care of my breasts like every other woman. This includes annual breast exams from my health provider, and when I am older, regular mammograms.

_____ _____I know that the following changes are usually not permanent — they are likely to go away if I stop taking the medicines.

- I know my body hair will become less noticeable and will grow more slowly. But it won't stop completely, even if I take the medicines for years.
- I know I will probably have less fat on my abdomen and more on my buttocks, hips, and thighs. It will be redistributed to a more female shape — changing from "apple" shape to "pear" shape.
- I know that if I have the predisposition to have male pattern baldness it may start later than it would have, but may not stop completely.
- If I stop taking hormones I may lose my hair faster than if I hadn't taken hormones.
- I know I may lose muscle and strength in my upper body.
- I know that my skin may become softer.

_____ _____I know that my body will make less testosterone (an androgen, or male hormone). This may affect my sex life in different ways and future ability to cause a pregnancy:

- I know my sperm may no longer get to full maturity. This could make me less able to cause a pregnancy. I also know that there is a small risk that I might never produce mature sperm again. But I know that it's also possible that my sperm could still mature even while I am taking hormones. So, I know that I might get someone pregnant if we have vaginal intercourse and we don't use birth control.
- The options for sperm banking have been explained to me.
- I know that my testicles may shrink down to half their size. Even so, I know that they are part of my body and that I need to take care of them unless I have surgery to remove them. This means that I will need regular checkups for them.
- I know that I won't have as much semen when I ejaculate.
- I know it is likely that I won't have erections upon waking as often as before, and it is likely that I will have fewer spontaneous erections.
- I know I may not be able to achieve or maintain an erection for penetrative sex.
- I know that I may want to masturbate less or have sex less, and may find it harder to ejaculate when I do.
- I know this treatment may (but is not assured to) make me permanently unable to make a woman pregnant.

_____ _____I know that some parts of my body will not change much by using these medicines.

- I know the hair of my beard and mustache may grow more slowly than before. It may become less noticeable, but it will not go away unless I have treatments like electrolysis.
- I know the pitch of my voice will not rise, and my speech patterns will not become more like a woman's.
- I know my Adam's apple (called the laryngeal prominence) will not shrink.
- Although these medicines can't make these changes happen, there are other treatments that may be helpful.

_____ _____ I know that there may be mood changes with these medicines. I agree to continue therapy with a qualified therapist.

_____ _____I know if I have any concerns about these issues, you can make referrals for me to help me explore other treatment options.

Risks of Feminizing Medications

_____ _____I know that the side effects and safety of these medicines are not completely known. There may be long-term risks that are not yet known.

_____ _____I know not to take more medicine than I am prescribed. I know it increases health risks. I know that taking more than I am prescribed won't make changes happen more quickly or more significantly.

_____ _____ I know these medicines may damage the liver and may lead to lead to liver disease. I know I should be checked for possible liver damage as long as I take them.

_____ _____I know these medicines cause changes that other people will notice. Some transgender people have experienced discrimination because of this. I know my clinician can help me find advocacy and support resources.

Risks of Estrogen

_____ _____I know that taking estrogen increases the risk of blood clots or problems with blood vessels that can result in

- chronic problems with veins in the legs
- heart attack
- pulmonary embolism – blood clot to the lungs – which may cause permanent lung damage or death
- stroke, which may cause permanent brain damage or death

_____ _____I know that the risk of blood clots is much worse if I smoke cigarettes. I know the danger is so high that I should stop smoking completely if I start taking estrogen. I know that I can ask my clinician for advice about how to stop smoking.

_____ _____ I know taking estrogen can increase the deposits of fat around my internal organs. This can increase my risk for diabetes and heart disease.

_____ _____I know taking estrogen can raise my blood pressure. I know that if it goes up, my clinician can work with me to try to control it with diet, lifestyle changes, and/or medication.

_____ _____I know that taking estrogen increases my risk of getting gallstones. I know I should talk with my clinician if I get severe or long-lasting pain in my abdomen.

_____ _____I know that estrogen can cause nausea and vomiting. I know I should talk with my clinician if I have long-lasting nausea or vomiting.

_____ _____I know that estrogen can cause migraines or make them worse if I already have them. I know I should talk with my clinician if I have headaches or migraines often or if the pain is unusually severe.

_____ _____I know that it is not yet known if taking estrogen increases the risk of prolactinomas. These are non-cancerous tumors of the pituitary gland. I know they are not

usually life threatening, but they can damage vision and cause headaches if they are not treated properly. I know that changes in vision, headaches that are worse when I wake up in the morning, and milky discharge from my nipples can be signs of a prolactinoma, and I should talk to my health care provider if I develop these symptoms. There is a blood test that can check for this.

_____ _____I know that I am more likely to have dangerous side effects if

- I smoke.
- I am overweight.
- I have a personal or family history of blood clots.
- I have a personal or family history of heart disease and stroke.
- My family has a history of breast cancer.

Risks of Androgen Antagonists (Spironolactone)

_____ _____I know that spironolactone affects the balance of water and salts in the kidneys. This may

- Increase the amount of urine I produce, making it necessary to urinate more frequently.
- Increase thirst.
- Rarely, cause high levels of potassium in the blood, which can cause changes in heart rhythms that may be life-threatening.
- Reduce blood pressure.

_____ _____I know some androgen antagonists make it more difficult to evaluate test results for cancer of the prostate. This can make it more difficult to check up on prostate problems. I know that if I am over 50, I should discuss appropriate prostate cancer screening with my care provider. I know that even if I have genital sex reassignment surgery the prostate is not usually removed.

Prevention of Medical Complications

_____ _____I agree to take feminizing medications as prescribed. And I agree to tell my care provider if I have any problems or am unhappy with the treatment.

_____ _____I know that the dose and type of medication that's prescribed for me may not be the same as someone else's.

_____ _____I know I need periodic physical exams and blood tests to check for any side effects.

_____ _____I know that in addition to periodic checks from my provider, I must also treat my body with respect. This means that paying attention and talking to my provider if I develop any symptoms that might be side effects from medicines. This also means keeping my partners and myself safe, when and if I choose to have sex with others, by using condoms or methods to keep me safe from sexually transmitted infections (STIs).

_____ _____I know that feminization medications can interact with other drugs and prescribed and over the counter medicines. These include alcohol, diet supplements, herbs, other hormones, and street drugs. This kind of interaction can cause dangerous complications. I know that I need to prevent complications because they can be life threatening. That's why I need to be honest with my provider about whatever else I take. I also know that I will continue to get medical care here no matter what I share about what I take.

_____ _____I know that it can be risky for anyone with certain conditions to take these medicines. I agree to be evaluated if my clinician thinks I may have one of them. Then we will decide if it's a good idea for me to start or continue using them.

_____ _____I know that I should stop taking estrogen two weeks before any surgery or when I may be immobile for a long time (for example, if I break my leg and am in a cast).
This will lower the risk of getting blood clots. I know I can start taking it again a week after I'm back to normal or when my clinician says it's okay.

_____ _____ I know that even if I have to stop my estrogens, I may still be able to take the testosterone blockers that I am on, to help prevent the effects of my testicles producing testosterone again.

_____ _____I know that using these medicines to feminize is an off-label use. I know this means it is not approved by the Food and Drug Administration (FDA). I know that the medicine and dose that is recommended for me is based on the judgment and experience of my health care provider and the best information that is currently available in the medical literature.

_____ _____I know that I can choose to stop taking these medicines at any time. I know that if I decide to do that, I should do it with the help of my clinician. This will help me make sure there are no negative reactions. I also know my clinician may suggest that I cut the dose or stop taking it at all if certain conditions develop. This may happen if the side effects are severe or there are health risks that can't be controlled.

Alternatives

There are alternatives to using feminizing medicines to help people appear more feminine. Some transgender people choose to not take hormones or have surgery and may only socially transition. If you are interested in alternatives, talk with your health care provider about your options.

Our signatures below confirm that

- My clinician has talked with me and my parents or guardian about
  - the benefits and risks of taking feminizing medication
  - the possible or likely consequences of hormone therapy
  - potential alternative treatments
- I understand the risks that may be involved.
- I know that the information in this form includes the known effects and risks. I also know that there may be unknown long-term effects of risks.
- I have had enough opportunity to discuss treatment options with my clinician.
- All of my questions have been answered to my satisfaction.
- I believe I know enough to give informed consent to take, refuse, or postpone therapy with feminizing medications.

Based on all this information

_____ I want to begin taking estrogen.

_____ I want to begin taking androgen antagonists (e.g., spironolactone).

_____ I do not wish to begin taking feminizing medication at this time.

_____ _____
Patient Signature Date

_____ _____
Signature of Parent or Guardian Date

_____ _____
Prescribing clinician signature Date

Your health is important to us. If you have any questions or concerns please call us at (205) 638 9107. We are happy to help you.

Client Information for Informed Consent

TESTOSTERONE FOR TRANSGENDER CLIENTS
Minors and Parents/Guardians
University of Alabama at Birmingham Pediatric Endocrinology
Multidisciplinary Gender Health Team

Before using testosterone to transition and masculinize your body, you and your parents or guardians need to know the possible advantages, disadvantages and risks of these medications. We have listed them here for you. It's important that you understand all of this information before you begin taking these medications.

Please read the following with your parent or guardian. Once your questions or concerns are addressed, and you have decided to proceed with the medication(s), both you and your parent or guardian will need to sign this information and consent form.

We are happy to answer any questions you have.

What is testosterone?

It is the sex hormone that makes certain features appear typically male. It builds muscle and causes the development of facial hair and a deeper voice.

How is testosterone taken?

It is usually injected every one to four weeks. It is not used as a pill because the body may not absorb it properly and may cause potentially fatal liver problems. Some people use skin creams and patches, but they tend to be more expensive and aren't recommended for initiating puberty or for use in teenagers and young adults.

The doses used for injection differ from product to product and from patient to patient. They may range from 50 to 400mg. The injections are given in a large muscle to slow the release of the hormone. You may experience unwanted swings in hormone levels. You may control the swings by changing how often the dose is given and how much of a dose is given.

Every medication has risks, benefits, and side effects that are important to understand before starting. The effects and side effects of medicines used for transition need to be monitored with laboratory studies and regular visits to your provider to make sure that there are no negative effects on your body.

The medicines that you take, as well as the process of transitioning can affect your mood. While trans men are usually relieved and happy with the changes that occur, it is important that you are under the care of a gender-qualified therapist while undergoing transition. The therapist can work with you, your family and friends and your school staff.

Warning — Who should not take testosterone?

It should *not* be used by anyone who is pregnant or has uncontrolled coronary artery disease as it could increase your risk for a fatal heart attack:

It should be used with caution and only after a full discussion of risks by anyone who

- Has acne
- Has a family history of heart disease or breast cancer
- Has had a blood clot
- Has high levels of cholesterol
- Has liver disease
- Has a high red-blood-cell count
- Is obese
- Smokes cigarettes

Periodic blood tests to check on the effects of the hormone will be needed. Routine breast exams and pelvic exams with Pap tests should be continued, when applicable.

Summary of Testosterone Benefits and Risks

BENEFITS	RISKS

• Appearing more like a man
  ○ Bigger clitoris
  ○ Coarser skin
  ○ Lower voice
  ○ More body hair
  ○ More facial hair
  ○ More muscle mass
  ○ More strength
  ○ No more menstrual periods
• More physical energy
• More sex drive
• Protection against bone thinning (osteoporosis)
	• Acne (may permanently scar)
	• Blood clots (thrombophlebitis), risk significantly increased by smoking
	• Emotional changes, for example, more aggression
	• Headache
	• High blood pressure (hypertension)
	• Increased red-blood-cell count
	• Infertility
	• Inflamed liver
	• Interaction with drugs for diabetes and blood thinning — for example Coumadin and Warfarin
	• Male pattern baldness
	• More abdominal fat — redistributed to a male shape
	• More risk of heart disease
	• Swelling of hands, feet, and legs
	• Weight gain

Both you and your parent or guardian should initial and date each statement on this form to show that you and your parent or guardian understand the benefits, risks, and changes that may occur from taking this medications.

Masculinizing

_____I know that testosterone may be prescribed to make me appear less like a woman and more like a man.

_____ I know it can take several months or longer for the effects to become noticeable. I know that no one can predict how fast – or how much – change will happen. I know that the changes may not be complete for two to five years after I start.

_____I know that the following changes are likely and permanent even if I stop taking testosterone:

- Bigger clitoris — typically about half an inch to a little more than an inch
- Deeper voice
- Gradual growth of mustache and beard
- Hair loss at the temples and crown of the head — possibility of being completely bald
- More, thicker, and coarser hairs on abdomen, arms, back, chest, and legs

_____ I know that the following changes are usually not permanent — they are likely to go away if I stop taking testosterone:

- Acne (although there may be permanent scars)
- Menstrual periods typically stop one to six months after starting
- More abdominal fat – redistributed to a male shape: decreased on buttocks, hips, and thighs; increased in abdomen – changing from “pear shape” to “apple shape”
- More muscle mass and strength
- More sex drive
- Vaginal dryness

_____I know that the effects of testosterone on fertility are unknown. I have been told that I may or may not be able to get pregnant even if I stop taking testosterone. I know that I might still get pregnant even after testosterone stops my menstrual periods. I know about my birth control options (if applicable). And I know that I can’t take testosterone if I am pregnant and that I must take a pregnancy test prior to starting testosterone therapy.

_____ I know that some aspects of my body will not be changed:

- Losing some fat may make my breasts appear slightly smaller, but they will not shrink very much.
- My voice will deepen, but other aspects of the way I speak may not sound more masculine.
- Although testosterone can’t make these changes happen, there are other treatments that may be helpful.

_____I know that there may be mood changes with these medicines. I agree to continue therapy with a qualified therapist.

_____I know if I have any concerns about these issues, you can make referrals for me to help me explore other treatment options.

Risks of Testosterone

_____I know the medical effects and the safety of testosterone are not completely known. There may be long-term risks that are not yet known.

_____I know not to take more testosterone than prescribed. Taking too much:

- Will increase health risks
- Won't make changes happen more quickly or more significantly
- Can cause my body to convert extra testosterone into estrogen, and that can slow down or stop my appearing more masculine

_____I know that testosterone can cause changes that increase my risk of heart disease. These changes include having:

- Less good cholesterol (HDL) that may protect against heart disease and more bad cholesterol (LDL) that may increase the risk of heart disease
- Higher blood pressure
- More deposits of fat around my internal organs

_____I know that my risk of heart disease is higher if people in my family have had heart disease, if I am overweight, or if I smoke.

_____I know that I should have periodic heart-health checkups for as long as I take testosterone. This means I must watch my weight and cholesterol levels and have them checked by my clinician.

_____I know testosterone can damage the liver and possibly lead to liver disease and I should be checked for possible liver damage for as long as I take testosterone.

_____I know testosterone can increase my red blood cells and hemoglobin. This increase is usually only to what is normal for a man and shouldn't cause any health risks. However, there is a small possibility that higher levels of red blood cells and hemoglobin may increase my risk of life-threatening problems such as stroke or heart attack. That's why I know I need to have periodic blood checks for as long as I take testosterone.

_____I know that taking testosterone can increase my risk for diabetes. It may decrease my body's response to insulin, cause weight gain, and increase deposits of fat around my internal organs. Therefore, I should have periodic checks of my blood glucose for as long as I take testosterone.

_____I know my body can turn testosterone into estrogen and that no one knows if that could increase the risk of cancers of the breast, the ovaries, or the uterus.

_____I know taking testosterone can thin the tissue of my cervix and the walls of my vagina. This can lead to tears or abrasions during vaginal sex or play with a male or female partner. These tears increase my risk of getting a sexually transmitted infection, including HIV. I know I should speak frankly with my primary care provider about my sex life to learn the best ways to prevent and check for infections.

_____I know that testosterone can give me headaches or migraines. I know that it's best to talk with my clinician if I get them a lot or if the pain is unusually severe.

_____I know that testosterone can cause emotional changes. For example, I could become more irritable, frustrated, or angry. I know that my clinician can help me find resources to explore and cope with these changes.

_____I know that testosterone causes changes that other people will notice. Some transgender people have experienced harassment, discrimination, and violence because of this. Others have lost the support of loved ones. I know my clinician can help me find advocacy and support resources.

Prevention of Medical Complications

_____I agree to take testosterone as prescribed. I agree to not purchase testosterone or other hormones without my physician's knowledge, and I agree to tell my clinician if I have any problems or am unhappy with the treatment.

_____I know that the dose and type of medication that's prescribed for me may not be the same as someone else's.

_____I understand that the medications prescribed are for my use only and I will not supply these medications to others.

_____I know I need periodic physical exams and blood tests to check for any side effects.

_____I know testosterone can interact with other drugs and medicines. These include alcohol, diet supplements, herbs, other hormones, and street drugs. This kind of interaction can cause complications. I know that I need to prevent complications because they can be life-threatening. That's why I need to be honest with my clinician about whatever else I take. I also know that I will continue to get medical care here no matter what I share about what I take.

_____ _____ I know that it can be risky for anyone with certain conditions to take testosterone. I agree to be evaluated if my clinician thinks I may have one of them. Then we will decide if it's a good idea to start or continue using testosterone.

_____ _____ I know that using testosterone to masculinize is an off-label use. This means it is not approved by the Food and Drug Administration (FDA). I know that the medicine and dose that is recommended for me is based on the judgment and experience of my health care provider and the best information that is currently available in the medical literature.

_____ _____ I understand that my insurance company may not cover the costs of this treatment. If so, I accept responsibility for any charges associated with this treatment. Costs of treatment can be obtained by contacting The Pediatric Endocrinology office at 205 638 9107.

_____I know that I can choose to stop taking testosterone at any time. I know that if I decide to do that, I should do it with the help of my clinician. This will help me make sure there are no negative reactions. I also know my clinician may suggest that I cut the dose or stop taking it at all if certain conditions develop. This may happen if the side effects are severe or there are health risks that can't be controlled.

Alternatives

There are alternatives to using testosterone to help people appear more masculine. Some transgender people choose to not take hormones or have surgery and may only socially transition. If you are interested in alternatives, talk with your health care provider about your options.

Our signatures below confirm that:

- My clinician has talked with me and my parents or guardians about
  - The benefits and risks of taking testosterone
  - The possible or likely consequences of hormone therapy
  - Potential alternative treatments
- I understand the risks that may be involved.
- I know that the information in this form includes the known effects and risks. I also know that there may be unknown long-term effects of risks.
- I have had enough opportunity to discuss treatment options with my clinician.
- All of my questions have been answered to my satisfaction.
- I believe I know enough to give informed consent to take, refuse, or postpone testosterone therapy.

Based on all this information:

_____I want to begin taking testosterone.

_____I do not wish to begin taking testosterone at this time.

_____ _____
Patient Signature Date

_____ _____
Signature of Parent or Guardian Date

_____ _____
Prescribing Clinician Signature Date

Your health is important to us. If you have any questions or concerns please call us at (205) 638 9107. We are always happy to help you.

DOC. 87

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

REV. PAUL A. EKNES-TUCKER, *et al.*,	)	
Plaintiffs,	)	
v.	)	No. 2:22-cv-00184-LCB-SRW
KAY IVEY, in her official capacity as Governor of the State of Alabama, *et al.*,	)	
Defendants.	)	

DEFENDANTS' NOTICE OF FILING
CORRECTED EXHIBIT 41

Defendants Kay Ivey, in her official capacity as Governor of the State of Alabama; Steve Marshall, in his official capacity as Attorney General of the State of Alabama; Daryl D. Bailey, in his official capacity as District Attorney for Montgomery County; C. Wilson Blaylock, in his official capacity as District Attorney for Cullman County; Jessica Ventiere, in her official capacity as District Attorney for Lee County; Tom Anderson, in his official capacity as District Attorney for the 12th Judicial Circuit; and Danny Carr, in his official capacity as District Attorney for Jefferson County, give notice of filing the attached corrected copy of Defense Exhibit 41.

Respectfully submitted,

Steve Marshall
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Solicitor General

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s/ James W. Davis
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CERTIFICATE OF SERVICE

I certify that I electronically filed this document using the Court's CM/ECF system on May 3, 2022, which will serve all counsel of record.

s/ James W. Davis
Counsel for Defendants

DOC. 87-1

SOCIETY COMMENTARY

I Spent a Year as a Trans Man. Doctors Failed Me at Every Turn.

Sydney Wright October 07, 2019

COMMENTARY BY

Sydney Wright

Sydney Wright is a business sales representative in the private sector and a student at Georgia Northwestern Technical College.
I can't wrap my head around all that I've done to myself in the last two years, much less the "help" that some health care professionals have done to me.

Two years ago, I was a healthy, beautiful girl heading toward high school graduation. Before long, I turned into an overweight, pre-diabetic nightmare of a transgender man.

I won't place the full blame on health care providers, because I should have known better. But they sure helped me do a lot of harm to myself—and they made a hefty buck doing it.

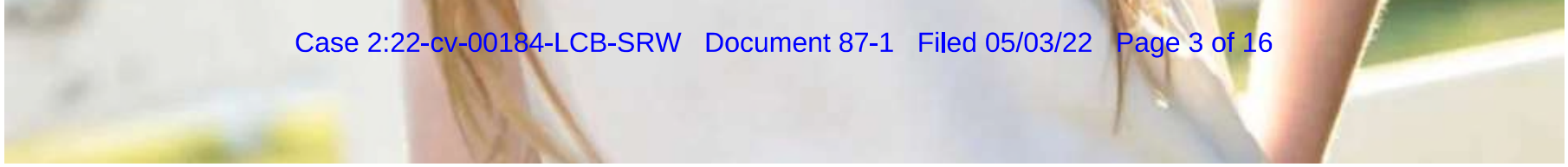
Here's my story.

From my earliest years, I was always different from the other girls. I wore boy clothes, and I played with boy toys. I was a classic tomboy.

As I got older, I became romantically interested in other girls. In fact, with the exception of one guy I dated in high school, I exclusively dated girls.

At the time, you wouldn't have been able to tell I was gay just from looking at me. I had long, blond hair, wore makeup, and carried myself rather femininely. But in my head, I knew I was gay—though I was more of a self-loathing gay.

The truth is, I didn't like gays, and didn't want to be associated with them. Yet there I was, dating only other girls.



Sydney as a senior in high school. (Photo: Sydney Wright)

By the time I was 17, my parents had long divorced and I was living with my dad. That's when he found out I was dating girls. He promptly kicked me out of the house, saying it was his way or the highway.

With little choice, I moved in with my mom.

Soon after that, I cut my hair—a decision that grieved both my parents. But what happened next grieved them far more.

At age 18, I started seeing a bunch of transgender men's "success stories" on Instagram. The trans men talked about how something had always "felt off" with them, and they said people couldn't tell they had been the opposite sex after their transition.

Their stories all seemed to have a happy ending—and it made me rather jealous.

Here I was getting frowned upon for holding hands with my girlfriend in public, feeling like I'm constantly being judged by everyone, while transgenders could date their same-sex significant other while looking like the opposite sex.

I resented that and began to envy the transgenders. I looked into it for myself.

A Fast Track to Transgender

Everything I read was in favor of transitioning.

> ***They only mentioned how brave the transition would make you, and how good it would be for you.***

Regrettably, I couldn't find any articles about transgender regret or the huge health issues that would come from making the transition. They only mentioned how brave the transition would make you, and how good it would be for you.

I tried my best to find books that discussed the issue critically and offered opposing views, but all I found were pro-transgender authors. That left me with the obvious conclusion: If all the "experts" were in favor of transition, why not do it?

Every passing day, I saw myself as this awful "dyke," this unnatural lesbian. I hated that image and would much rather have been a guy dating girls. So I Googled how to make the transition to male.

Sydney after cutting her hair. (Photo: Sydney Wright)

The first step was to find a therapist who would write me a letter to start me on male hormones.

I soon found a therapist who said she would help me, and I told her I wanted to start the hormones on my 19th birthday, which was only five weeks off. She required only a one-hour appointment each week.

That's hardly enough time to get to know someone. Yet those five hours got me an official letter that unlocked the doors for me to get hormone therapy and become a "man." It also helped me change my "sex" on my driver's license from female to male.

> ***Not once did she tap the brakes to keep me from gender transition.***

I now see a huge problem with how easy this was. If the therapist had gone slower and been more careful, she would have seen that I wasn't actually trans.

But by this time, I'd seen the promotional videos. I was convinced that my gender is what was "off," and the therapist guided me along and made me feel like a sex change is what I needed.

By this point, my friends were also encouraging me to transition. "You're a hot girl," they said. "You'll be a hot guy, too!" Others were too afraid to say anything against it, because after all, it was 2017. I never got pushback from anyone.

In reality, of course, I was not a boy, and hearing otherwise was the last thing I needed. I was simply insecure about being tomboyish and a lesbian in public.

My therapist never once tried to sit down with me and figure that out. Instead, she asked me questions like: "When did you start feeling this way?" "Why do you feel you're this way?"

Not once did she tap the brakes to keep me from gender transition.

The Scam That Scarred Me

Once I got my letter, I went to a doctor in Atlanta in what turned out to be the worst treatment of my life.

> ***I was not a boy, and hearing otherwise was the last thing I needed.***

The doctor came in and asked if I had any questions. I told him, "I'm just a little nervous." He asked, "Do you not want to do this?" I said, "I do," and he replied, "All right. Where's your letter?"

I gave him my letter, but he didn't open it—not even to check if it was real.

He said, "I'll call in your prescription for testosterone." That surprised me—I thought he was going to administer it himself.

I asked, "Are you not going to give me the shot yourself?" He then sarcastically suggested I could drive all the way back to Rome, Georgia, (four hours) to get my prescription, and then come back to his office to get the shot.

That wasn't realistic, and he knew it.

"But I don't know how to give myself a shot," I said.

He replied, "There's no wrong way to give it." He told me to go home and figure it out. He suggested watching a YouTube video.

That honestly scared me. It should have been red flag No. 1 that the doctor didn't care, that this was just a money scam. His hands-off approach showed he was confident he wouldn't be held accountable for this treatment.

But at this point, I was still caught in the delusion. I thought gender transition could make me "normal."

Unfortunately, that's not the reality that awaited me.

Destroying My Own Body

The injections of male hormones started to have their effect, but not in the way I expected. I started gaining more and more weight. My skin started to get more and more puffy and discolored. My blood started to thicken.

The doctor's office was running bloodwork for me every three months, and it actually said I was now pre-diabetic—something that was totally new for me.

My gender-transition doctor said not to worry, but I decided to see another doctor for a second opinion. He said my thickening blood put me at risk for a heart attack or stroke.

Sydney during the first few months on hormones. (Photo: Sydney Wright)

I did this to myself for almost a year. During that time, I gained 50 pounds and was miserable. None of my problems that I thought this would solve were being solved, and I came to have even less self-confidence than before.

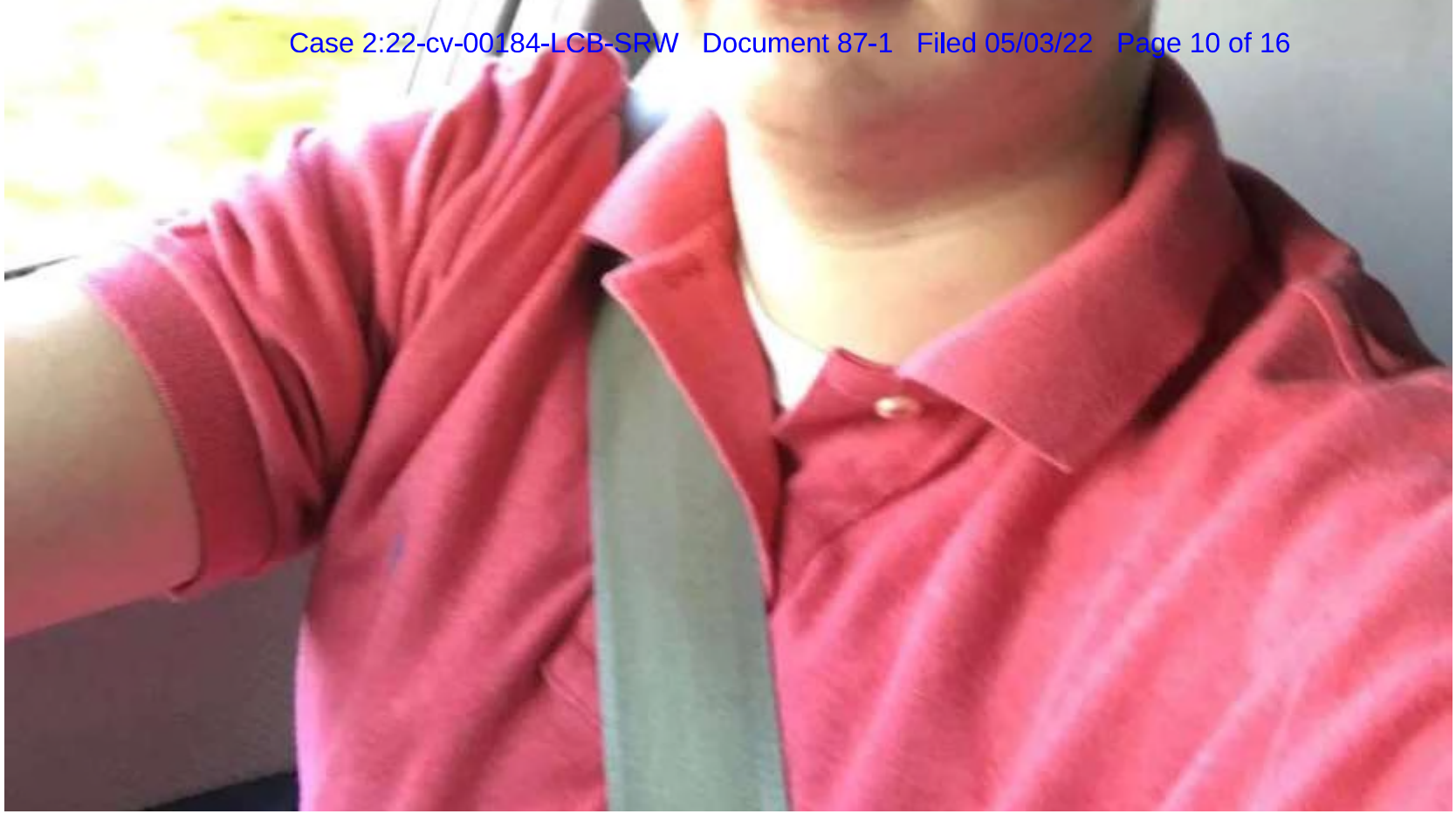
I started feeling regret.

Unfortunately, I was stuck: I had already declared to everyone that this was who I was. I had changed my gender, and I had forced people to play along with it and call me by a new name: Jaxson. At work, men had to be OK with their former female co-worker now using the same restroom as them.

Everyone was walking on eggshells around me—and people fell in line for fear of what might happen if they objected. (Employers are already being sued over this kind of thing, after all.)

Nobody could tell me what I was doing was wrong, or "Hey, wake up!" A few brave souls at work did quietly try to say, "Are you sure?" Or, "Why don't you think about it a little while?"

Meanwhile, my mom was crying daily about why I was doing this to myself, all the while blaming herself.



Sydney after one year on hormones. (Photo: Sydney Wright)

Finally, one day, my grandfather sat me down to talk about it. He was, and will remain the only person whose opinion I will ever care about. With tears in his eyes, he asked me to stop.

Everything in me wanted to keep going—not even because I wanted it anymore, but because of pride. “What will people think?” I thought. I had made everyone play along. If I suddenly stopped, what would I tell people?

Those questions ate at me. And yet, there was my grandpa, the man I respect most, pleading with me through tears. I just couldn’t tell him no.

That was a saving grace. I would have let this treatment kill me before admitting I’d screwed up. His intervention may have saved my life.

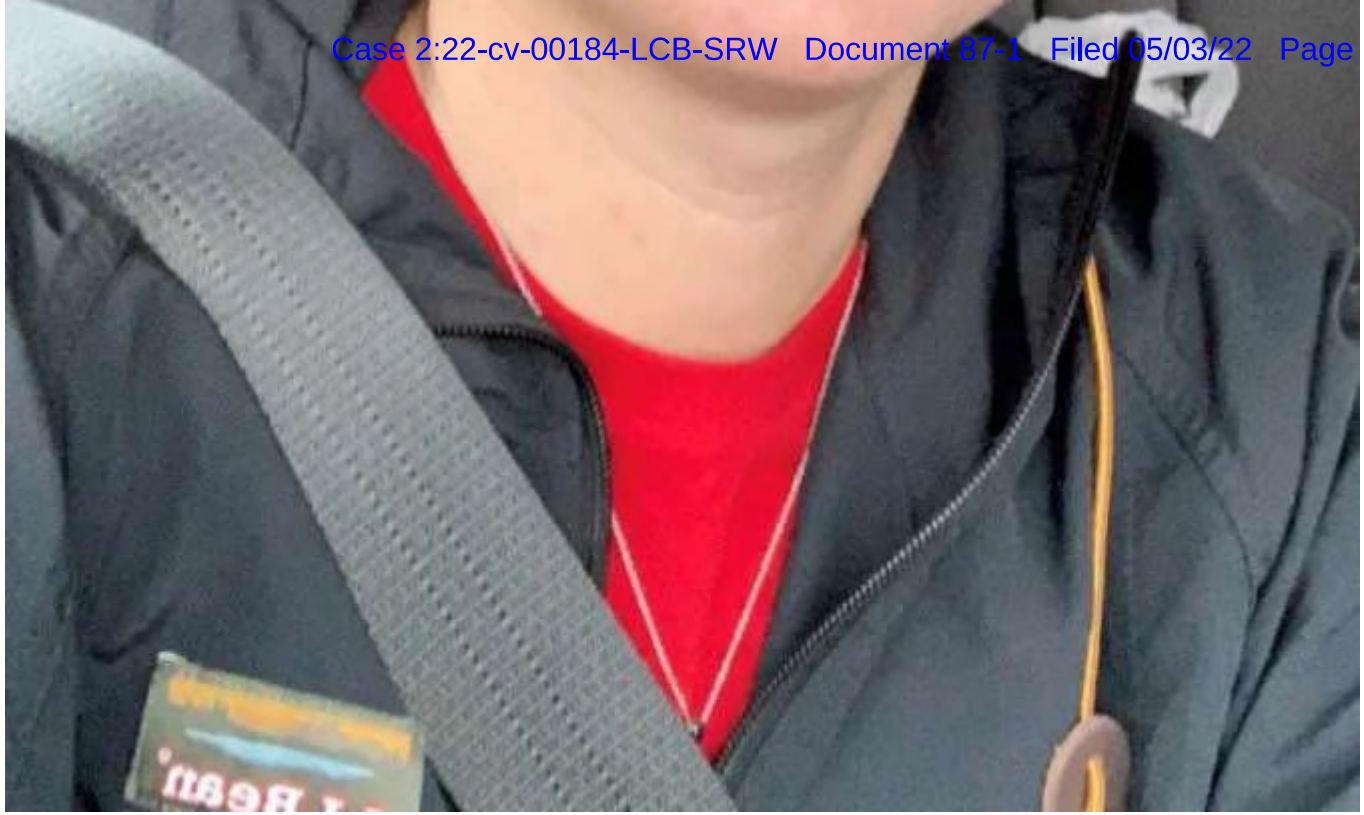
Sydney with her grandfather. (Photo: Sydney Wright)

So I decided to quit—and I quit cold turkey without seeing my doctor again.

Unfortunately, it wasn't that simple.

Not even two weeks after stopping hormone treatment, the withdrawals kicked in with a vengeance. I was soon on the floor groaning, crying, throwing up, not able to keep anything down, and not able to eat at all.

Getting sick every single day was exhausting. I went to the emergency room three times and had to have two procedures to figure out what was happening to me. My hormone balance was way off, and I was miserable.



Sydney while losing weight from withdrawals. (Photo: Sydney Wright)

The last time I went to the ER, I had been showering and suddenly went into withdrawals. I called my mom, who had to drive 30 minutes to come get me out of the shower and take me to the hospital. I didn't even think I would make it there alive.

Before the ER gave me medicine to sedate me, I begged my mom to make them admit me to the hospital. "I will die if I go back home or leave here," I said.

She and I both sat crying before I passed out from all the sedatives they gave me. I thought I wasn't going to make it.

Finally, Hope

After four long, exhausting months of being sick every day and losing the 50 pounds, I finally got back to a semi-normal life.

I'm now more stable, but my body bears the scars of gender therapy. My voice is still deep, and I look very masculine. I'm now $1,000 poorer due to the cost, though that's a fraction of what insurance paid.

And, because of that doctor's letter that said I'm irreversibly a male, my driver's license is now stuck with a "male" label. I'll have to appear in court to prove I'm a female again.

Nevertheless, I'm just thankful to have gotten off this horrible path alive, and before I had any body parts mutilated.

Sydney six months after quitting hormone treatment. (Photo: Sydney Wright)

It's insane to me that our society is letting this to happen to young people. At age 18, I wasn't even legal to buy alcohol, but I was old enough to go to a therapist and get hormones to change my gender.

This is happening to vulnerable kids much younger than I was, and the adults are AWOL.

When you walk into these clinics, you won't really see older people around. It's boys and girls playing dress-up, brought there by clueless parents, waiting for the appointment that could likely ruin their lives.

I hope I'm not the only one who sees a major problem with this. Our culture has set up a fast-track to gender transition that will only result in scarred bodies and ruined lives—and the medical community is complicit. I met with these doctors in person and gave them my own cash. I can tell you they did not care.

> ***At age 18, I wasn't even legal to buy alcohol, but I was old enough to go to a therapist and get hormones to change my gender.***

This is a public health crisis that our media and politicians are completely ignoring. More young people are being deceived every day, being told that the solution to their insecurity and identity problems is to get a sex change.

That's just about the worst path you can put a young person on.

Until we do something, until the medical community puts up serious guardrails and begins to do its due diligence—and until politicians grow a spine and step in—expect to see more young people scarred for life.

If anything, I hope my story can serve as a warning bell and save some other young teenager the misery and grief I've been through.

DOC. 92

**IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION**

REV. PAUL A. EKNES-TUCKER; BRIANNA BOE, individually and on behalf of her minor son, MICHAEL BOE; JAMES ZOE, individually and on behalf of his minor son, ZACHARY ZOE; MEGAN POE, individually and on behalf of her minor daughter, ALLISON POE; KATHY NOE, individually and on behalf of her minor son, CHRISTOPHER NOE; JANE MOE, Ph.D.; and RACHEL KOE, M.D. Plaintiffs, and UNITED STATES OF AMERICA, Plaintiff-Intervenor, v. KAY IVEY, in her official capacity as Governor of the State of Alabama; STEVE MARSHALL, in his official capacity as Attorney General of the State of Alabama; DARYL D. BAILEY, in his official capacity as District Attorney for Montgomery County; C. WILSON BLAYLOCK, in his official capacity as District Attorney for Cullman County; JESSICA VENTIERE, in her official capacity as District Attorney for Lee County; TOM ANDERSON, in his official capacity as District Attorney for the 12th	Case No. 2:22-cv-184-LCB-SRW Honorable Liles C. Burke

Judicial Circuit; and DANNY CARR, in his official capacity as District Attorney for Jefferson County.

Defendants.

AMENDED COMPLAINT IN INTERVENTION

Plaintiff-Intervenor, the United States of America ("United States"), alleges:

PRELIMINARY STATEMENT

1. This lawsuit challenges a state statute that denies necessary medical care to children based solely on who they are.

2. All people, including transgender youth, deserve to be treated with dignity and respect. And the Fourteenth Amendment demands that Alabama not "deny to any person within its jurisdiction the equal protection of the laws." U.S. Const. amend. XIV.

3. The United States accordingly files this complaint in intervention to enforce the Constitution's guarantee of equal protection, and to challenge Section 4 of Act No. 2022-289, Senate Bill ("S.B.") 184 (2022), the "Alabama Vulnerable Child Compassion and Protection Act."

4. S.B. 184 criminalizes certain forms of medically necessary care for transgender minors. Specifically, S.B. 184 makes it a felony to "engage in or cause" specified types of medical care for minors, if performed for "the purpose of

attempting to alter the appearance of or affirm the minor's perception of his or her gender or sex, if that appearance or perception is inconsistent" with sex assigned at birth.

5. S.B. 184 thus allows a minor to receive certain medical procedures or treatment only if they will be used to affirm the sex that the minor was assigned at birth.

6. The law discriminates against transgender minors by unjustifiably denying them access to certain forms of medically necessary care.

7. While criminalizing certain forms of medically necessary gender-affirming care for transgender minors, S.B. 184 permits all other minors to access the same procedures and treatments.

8. As a result of S.B. 184, medical professionals, parents, and minors old enough to make their own medical decisions are forced to choose between forgoing medically necessary procedures and treatments or facing criminal prosecution.

9. S.B. 184's felony ban on various forms of medically necessary gender-affirming care for transgender minors discriminates on the basis of both sex and transgender status in violation of the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution.

JURISDICTION AND VENUE

10. The Court has jurisdiction over this action pursuant to 28 U.S.C. §§ 1331 and 1345.

11. The United States is authorized to intervene in this action pursuant to 42 U.S.C. § 2000h-2. The Attorney General of the United States has certified that this case is of general public importance.

12. Venue is proper pursuant to 28 U.S.C. §§ 81(b) and 1391(b).

13. This Court has the authority to enter a declaratory judgment and to provide preliminary and permanent injunctive relief pursuant to Rules 57 and 65 of the Federal Rules of Civil Procedure, and 28 U.S.C. §§ 2201 and 2202.

PARTIES

14. Plaintiff-Intervenor is the United States of America.

15. Defendant Kay Ivey is the Governor of the State of Alabama. Governor Ivey is sued in her official capacity.

16. Defendant Steve Marshall is the Attorney General of the State of Alabama. Attorney General Marshall is sued in his official capacity.

17. Defendant Daryl D. Bailey is the Montgomery County District Attorney. Mr. Bailey is sued in his official capacity.

18. Defendant C. Wilson Blaylock is the District Attorney for the 32nd Judicial Circuit, which oversees Cullman County. Mr. Blaylock is sued in his

official capacity.

19. Defendant Jessica Ventiere is the Lee County District Attorney. Ms. Ventiere is sued in her official capacity.

20. Defendant Tom Anderson is the District Attorney for the 12th Judicial Circuit, which oversees Coffee County and Pike County. Mr. Anderson is sued in his official capacity.

21. Defendant Danny Carr is the Jefferson County District Attorney. Mr. Carr is sued in his official capacity.

FACTUAL ALLEGATIONS

22. Transgender people are individuals whose gender identity does not conform with the sex they were assigned at birth.

23. The American Psychiatric Association has stated "[b]eing transgender or gender diverse implies no impairment in judgment, stability, reliability, or general social or vocational capabilities."

A. Standard of Care for Treating Transgender Youth

24. According to the American Psychiatric Association's Diagnostic & Statistical Manual of Mental Disorders ("DSM-V"), an authoritative source for psychiatric conditions, "Gender Dysphoria" is the diagnostic term for the condition experienced by some transgender people of clinically significant distress resulting from the lack of congruence between their gender identity and the sex assigned to

them at birth.

25. As the DSM-V explains, to be diagnosed with gender dysphoria, the individual must experience the incongruence for at least six months and experience clinically significant distress or impairment in social, occupational, or other important areas of functioning.

26. The American Psychiatric Association recognizes that not all transgender persons have gender dysphoria. A diagnosis of gender dysphoria is currently required in order to receive many forms of gender-affirming care, including hormone therapy and surgery.

27. The DSM-V notes that medical treatment for gender dysphoria addresses the clinically significant distress created by gender dysphoria by helping people who are transgender live in alignment with their gender identity.

28. The precise treatment for gender dysphoria depends on each person's individual needs. According to clinical guidelines from the World Professional Association for Transgender Health ("WPATH"), the number and type of interventions to treat gender dysphoria may differ from person to person. The medical standards of care differ depending on whether the treatment is for a pre-pubertal child, an adolescent (i.e., minors who have entered puberty), or an adult.

29. The American Academy of Pediatrics agrees that gender-affirming care is safe, effective, and medically necessary treatment for the health and

wellbeing of some children and adolescents suffering from gender dysphoria.

30. Before puberty, the American Academy of Pediatrics recommends treatment for gender dysphoria that does not include any pharmaceutical or surgical intervention and is limited to "social transition," which means allowing a transgender child to live and express themselves in ways consistent with their gender identity.

31. As transgender youth reach puberty, puberty delaying therapy may become medically necessary and appropriate for some minors according to the Endocrine Society's clinical practice guidelines.

32. According to the American Academy of Pediatrics, gender dysphoria may emerge or worsen with the onset of puberty. For many transgender adolescents, going through puberty in accordance with the sex assigned to them at birth, can cause extreme distress.

33. According to WPATH, refusing timely and necessary medical interventions for adolescents may prolong gender dysphoria and lead to an appearance that provokes abuse and stigmatization; such gender-related abuse is in turn associated with psychiatric distress.

34. The Endocrine Society's clinical guidelines recognize that puberty delaying hormone treatment (also referred to as puberty blockers or puberty suppressing treatment) allows transgender youth to avoid experiencing heightened

gender dysphoria and permanent physical changes that puberty would cause. Before providing such therapy, pediatric endocrinologists work in close consultation with qualified mental health professionals experienced in diagnosing and treating gender dysphoria.

35. Under the Endocrine Society's clinical guidelines, transgender adolescents may be eligible for puberty-blocking hormone therapy only if the following steps have been taken:

- A qualified mental health professional confirms the adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria, gender dysphoria worsened with the onset of puberty, and any coexisting psychological, medical, or social problems that could interfere with treatment have been addressed, such that the adolescent's situation and functioning are stable enough to start treatment;

- The adolescent has sufficient mental capacity to give informed consent to this treatment, has been informed of the effects and side effects of treatment (including potential loss of fertility) and options to preserve fertility; and has given informed consent and the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process; and

- A pediatric endocrinologist or other clinician experienced in pubertal assessment agrees with the indication for treatment, has confirmed that puberty has started in the adolescent, and has confirmed that there are no medical contraindications to treatment.

36. According to WPATH, during puberty suppression, an adolescent's physical development should be carefully monitored, preferably by a pediatric endocrinologist, so that any necessary interventions can occur.

37. WPATH also recognizes that for some transgender adolescents, it may be medically necessary and appropriate to provide hormone therapy to initiate puberty consistent with gender identity.

38. Under WPATH's clinical guidelines, adolescents who are transgender may receive medically necessary chest reconstructive surgeries prior to the age of majority if they have severe gender dysphoria, provided they have been living consistent with their gender identity for a significant period of time.

39. According to WPATH, while some transgender individuals find comfort with their gender identity without surgery, for others surgery is essential and medically necessary to alleviate gender dysphoria. Surgery is often the last and most considered step in treatment for gender dysphoria.

B. Senate Bill 184

1. Bill Text

40. S.B. 184 was signed into law by Governor Kay Ivey on April 8, 2022. The law will become effective on May 8, 2022.

41. Section 2 of the bill includes various legislative findings suggesting that sex is an immutable characteristic that cannot be changed. The findings reject the need for interventions to treat gender dysphoria, describing such treatments as "unproven" and "experimental" and causing "numerous harmful effects." The findings characterize a "discordance between sex and identity" as a state that

resolves itself over time in most cases.

42. Section 3 of the bill defines "sex" as the "biological state of being male or female, based on the individual's sex organs, chromosomes, and endogenous hormone profiles."

43. Section 4 of the bill identifies a set of medical practices, including administering puberty blockers, administering hormone therapy, and surgical interventions (including the removal of "any healthy or non-diseased body part or tissue, except for a male circumcision"). It further provides that "no person shall engage in or cause any of" these practices to be performed on a minor for "the purpose of attempting to alter the appearance of or affirm the minor's perception of his or her gender or sex, if that appearance or perception is inconsistent" with sex assigned at birth.

44. Section 4 contains an exception for procedures "undertaken to treat a minor born with a medically verifiable disorder of sex development."

45. By its terms, the prohibition in S.B. 184 necessarily implicates parents of transgender minors as well as health care providers and other medical professionals. And because S.B. 184 prohibits any person from causing the prohibited treatment, a transgender minor may face prosecution for seeking out their own medically necessary care. *See* Ala. Code § 22-8-4 ("Any minor who is 14 years of age or older, or has graduated from high school, or is married, or

having been married is divorced or is pregnant may give effective consent to any legally authorized medical, dental, health or mental health services for himself or herself, and the consent of no other person shall be necessary.").

46. Violation of Section 4 of S.B. 184 is a Class C felony, which is punishable by up to 10 years of imprisonment and a fine of up to $15,000. *See* Ala. Crim. Code §§ 13-A-5-6(a)(3), 13A-5-11(a)(3).

2. Impact of S.B. 184

47. S.B. 184's felony ban on various forms of gender-affirming care prohibits transgender minors from accessing certain medical procedures or treatment if they will be used to affirm a gender identity inconsistent with the sex assigned at birth.

48. The law discriminates against transgender minors by unjustifiably denying them access to certain forms of medically necessary care. S.B. 184 prohibits transgender minors from obtaining care that is well recognized within the medical community as medically appropriate and necessary, while imposing no comparable limitation on medically necessary care by cisgender minors.

49. In addition, the law allows children to access the exact same medical procedures or treatment if they will be used to reinforce the gender they were assigned at birth.

50. With respect to medical care, S.B. 184 permits a doctor, for example, to prescribe testosterone for a cisgender male minor suffering from delayed pubertal development or a condition such as hypogonadism, but the law makes it a felony for the same doctor to prescribe the same testosterone to a transgender male youth to affirm his gender identity.

51. With respect to surgical procedures, for example, the law permits a cisgender girl to undergo a voluntary non-cancer related breast augmentation procedure to make her feel more accepting of her body, but forbids a transgender girl from receiving the same procedure even when recommended as medically appropriate by her physician. The law also permits a cisgender boy with gynecomastia to have excess breast tissue surgically removed to give him a more "male" physique, but does not permit a transgender boy to obtain the same treatment.

52. In other words, the sex a minor was assigned at birth determines the legality and availability of medically necessary treatments.

53. In restricting who may receive medically prescribed care based on the individual's sex assigned at birth, S.B. 184 threatens health care providers with criminal sanctions for exercising their independent medical judgment and expertise and threatens parents and others with criminal sanctions for acting on their judgment of what is in their child's best interest.

54. Further, the law prevents transgender minors from accessing gender-affirming care that is widely recognized within the medical community as the only effective treatment for some individuals diagnosed with gender dysphoria. S.B. 184 prevents healthcare providers from considering the recognized standard of care for gender dysphoria and from providing medically necessary gender-affirming care for improving the physical and mental health of their patients.

CAUSE OF ACTION

COUNT ONE
Violation of Equal Protection
U.S. Constitution, Amendment XIV
Plaintiff-Intervenor United States against All Defendants

55. The United States re-alleges and re-pleads all the allegations of the preceding and subsequent paragraphs of this Complaint and incorporates them herein by reference.

56. The Equal Protection Clause of the Fourteenth Amendment to the U.S. Constitution prohibits state and local governments from denying to any person within their jurisdiction the equal protection of the laws.

57. Section 4 of S.B. 184 discriminates both on the basis of sex and on the basis of transgender status, each in violation of the Equal Protection Clause.

58. Under the Equal Protection Clause, government classifications based on sex or on transgender status are subject to heightened scrutiny and are presumptively unconstitutional.

59. Section 4 of S.B. 184 cannot survive heightened scrutiny because it is not substantially related to achieving Alabama's articulated important governmental interests.

60. In the alternative, Section 4 of the statute could not survive any level of scrutiny because it is not rationally related to a legitimate government interest.

61. The above conduct of Defendants has been taken under color of state and local law.

PRAYER FOR RELIEF

WHEREFORE, the United States respectfully requests that this Court:

a. Enter a judgment declaring that Section 4 of S.B. 184 violates the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution;

b. Temporarily restrain, and issue a preliminary and permanent injunction restraining, Defendants from enforcing Section 4 of S.B. 184; and

c. Grant such additional relief as the needs of justice may require.

Dated: May 4, 2022

Respectfully submitted,

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DOC. 94

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

PAUL A. EKNES-TUCKER, *et al.*,	)	
	)	
Plaintiffs,	)	
	)	
UNITED STATES OF AMERICA	)	
	)	
Intervenor Plaintiff,	)	
	)	
v.	)	**Case No. 2:22-cv-184-LCB**
	)	
STEVE MARSHALL, *et al.*,	)	
	)	
Defendants.	)	

PROCEDURAL ORDERS & STATUS OF FORTHCOMING OPINION

This suit challenges the constitutionality of the Alabama Vulnerable Child Compassion and Protection Act. Before the Court are five procedural motions. First, the United States moves to intervene on behalf of Plaintiffs under Federal Rule of Civil Procedure 24. (Doc. 58 at 2). For the reasons given on the record during the motion hearing, the United States's motion to intervene (Doc. 58) is **GRANTED**.

Second, the States of Arkansas, Alaska, Arizona, Georgia, Indiana, Louisiana, Mississippi, Missouri, Montana, Nebraska, Oklahoma, South Carolina, Texas, Utah, and West Virginia move for leave to proceed as *amici curiae* and file a brief in support of Defendants. (Doc. 71 at 1). Third, twenty-two health organizations move for leave to proceed as *amici curiae* and file a brief in support of Plaintiffs. (Doc. 91

at 1–2). Because the proposed *amici* briefs are timely and offer relevant information, the motions for leave to proceed as *amici curiae* (Docs. 71 & 91) are **GRANTED**. The Court will consider the briefs in ruling on the motions for a preliminary injunction.

Fourth, Plaintiffs move for leave to file Exhibit 40 of their Exhibit List under seal. (Doc. 84 at 2). Fifth, Plaintiffs Megan Poe and Dr. Rachel Koe move to seal the preliminary injunction hearing while they testify. (Doc. 90 at 2). For the reasons given on the record during the preliminary injunction hearing, the motions to seal (Docs. 84 & 90) are **GRANTED**.

Finally, as the Court explained on the record, this is a complicated case that raises complex and important issues and consists of many hundreds of pages of briefing and exhibits. The Court has made very substantial progress toward crafting an opinion in this matter and expects to file the opinion by the end of this week, if not sooner.

DONE and **ORDERED** May 8, 2022.

LILES C. BURKE
UNITED STATES DISTRICT JUDGE

DOC. 104

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

REV. PAUL A. EKNES-TUCKER, et al.,	*	
Plaintiffs,	*	2:22-cv-00184-LCB
	*	May 5, 2022
vs.	*	Montgomery, Alabama
	*	9:00 a.m.
KAY IVEY, in her official capacity as Governor of the State of Alabama, et al.,	*	
Defendant.	*	

****

TRANSCRIPT OF PRELIMINARY INJUNCTION HEARING
VOLUME I
BEFORE THE HONORABLE LILES C. BURKE
UNITED STATES DISTRICT JUDGE

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I N D E X

P R O C E E D I N G S

(In open court.)

THE COURT: Good morning. Please be seated.

All right. Who is going to proceed on behalf of the plaintiffs today?

MS. EAGAN: Your Honor, I will be questioning the first two witnesses.

THE COURT: All right. Why don't you road map this for me today so I know how this day is going to go?

MS. EAGAN: Sure. So the first witness will be Dr. Linda Hawkins.

Our second live witness will be Dr. Morissa Ladinsky. And I will be doing the examination of those witnesses.

The third will be plaintiff Megan Poe. My colleague Mr. Doss will be questioning that witness.

Our fourth witness will be Rachel Koe, MD, and Brent Ray, who do I not believe that you have met from King & Spaulding, will be asking questions of that witness.

And then our fifth will be Reverend Eknes-Tucker, and he will be our last witness, and Mr. Doss will be conducting the examination of that witness.

THE COURT: All right. So how many of these witnesses can we get in before lunch?

MS. EAGAN: My hope, Your Honor, is that we could get Dr. Hawkins on and, depending on how long defendants' cross is,

I would hope we could get at least Dr. Ladinsky's direct on before lunch.

THE COURT: Are we on target that you believe you will finish today?

MS. EAGAN: Yes, sir. I believe we will.

THE COURT: All right. All right.

MS. EAGAN: That certainly is our goal, and we are going to be as efficient as we can to achieve that.

THE COURT: All right. All right. So State, road map tomorrow for me.

MR. LACOUR: Good morning, Your Honor. I believe we will lead with Dr. Cantor, who is our expert witness, and then we have Sydney Wright, fact witness, who will be testifying after Dr. Cantor.

THE COURT: All right. And what does that time look like?

MR. DAVIS: Your Honor, we are confident that we can get those two done in half a day.

THE COURT: Still half a day?

MR. DAVIS: Yes.

THE COURT: Okay. We're really on target. Okay. I looked back at that Arkansas hearing, and I was wrong. That entire preliminary injunction hearing was two hours and 53 minutes, so y'all are all way ahead of the game here.

Okay. The floor is yours.

MS. EAGAN: Your Honor, if I may approach.

First, I would like to take up an administrative matter.

Plaintiffs' Exhibits 1 through 44 for this hearing have been previously filed into the Court record as Document 78. It was filed on May the 3rd. And we have conferred with defense counsel, and if permissible from Your Honor's perspective, we would go ahead and offer Plaintiffs' Exhibit 1 through 44 into evidence for the hearing so that we're not having to do it with each witness.

THE COURT: By agreement?

MR. DAVIS: By agreement. We don't object, and we likewise move to admit Defendants' Exhibits 1 through 41.

MS. EAGAN: We agree to that.

THE COURT: Excellent. Excellent. Any other administrative issues? I know we still have -- I think there is still a motion hanging out there to remove Governor Ivey from this action.

MS. EAGAN: Yes, sir. We have conferred with counsel for defendants, and to streamline the case, and considering the stipulations that the defendants have made in regards to that, Governor Ivey will be bound by whatever injunction or decision Your Honor makes, and then also, of course, by appeal, whatever the outcome of that, if appeal happens. In light of that stipulation, we have agreed and filed a joint motion to dismiss Governor Ivey without prejudice.

THE COURT: Somebody enlighten me. What is the thought process -- I'm imperfectly fine and we'll do that. But enlighten me as to why that's happening.

MS. EAGAN: My understanding, Your Honor, is that when I conferred -- when the defendants first filed their answer, and they indicated that they plan to file a motion to dismiss on behalf of Governor Ivey, I conferred with defense counsel, and he explained to me that they would take the position that Governor Ivey would not have any independent authority -- enforcement authority over this Act. And maybe defense counsel could better explain the grounds, but after we conferred, and in light of the stipulations that we have reached, we have agreed to streamline the case and dismiss Governor Ivey.

THE COURT: Mr. Davis, do you want to chime in on that?

MR. DAVIS: Judge, she is not a prosecutor. The Governor doesn't prosecute. They're challenging a criminal law. She is not needed. We just wanted to simplify the case.

THE COURT: No problem. All right. Well, that motion is granted. And so it's yours again, Ms. Eagan.

MS. EAGAN: All right. Your Honor, Mr. Doss has one matter, as well.

MR. DOSS: With respect to our two plaintiffs who are testifying under a pseudonym, we have filed a motion to either have their examination in camera or in the courtroom, but clear

the courtroom.

I mean, it would seem -- we're happy to do whatever would be easiest for Your Honor, but we wanted to go ahead and ask about that so we know logistically what we should do with the witness.

THE COURT: So I know there was an agreement, correct, Mr. Davis, for that to either be sealed or whatnot. Have you conferred?

MR. DAVIS: We have talked, Judge. We are okay with however the Court wishes to handle that. As long as we can cross the witness, whatever means or place you want to do it is okay with us.

THE COURT: So your two choices are in camera or clear the courtroom?

MR. DOSS: Yes, Your Honor.

THE COURT: Doesn't matter to me. Whatever the two parties agree on, I will be happy with.

MR. DOSS: I'm okay with an in-camera examination, if that works for the State.

THE COURT: In camera will be easier logistically.

MR. DAVIS: Will there be room for more than one lawyer from each side to come? We probably don't have to bring everybody.

THE COURT: Absolutely. I think we will just go to the conference room.

MR. DOSS: Where should we have the witness go in the courtroom or in the courthouse to get to where the witness needs to be?

THE COURT: Deena, could somebody maybe meet the witness and the attorneys right there at that outer door before you go in the judge's conference room?

THE COURTROOM DEPUTY CLERK: Yes, sir. I can get a marshal or...

THE COURT: That's probably the easiest way to do it. When the time comes, give me 20 minutes' notice.

MR. DOSS: Yes, Your Honor. Thank you.

THE COURT: All right. Go ahead.

MS. EAGAN: Your Honor, plaintiffs are ready to proceed, if Your Honor is.

THE COURT: Go ahead.

MS. EAGAN: Your Honor, the plaintiffs call Linda -- Dr. Linda Hawkins.

LINDA HAWKINS, MD,

having been first duly sworn by the courtroom deputy clerk, was examined and testified as follows:

DIRECT EXAMINATION

BY MS. EAGAN:

Q Good morning, Dr. Hawkins.

A Good morning.

Q Could you please introduce yourself?

A Yes. My name is Linda Aline Hawkins.
Q Dr. Hawkins, what do you do for a living?
A I am the director of the Gender and Sexuality Development Clinic at the Children's Hospital of Philadelphia.
Q And what is -- are you a licensed professional counselor?
A I am.
Q Tell us a little bit about your educational background, please, Dr. Hawkins.
A My background includes Bachelor's of Science in speech and hearing science from the University of Washington. I have a master's in psychological services from the University of Pennsylvania, and a Ph.D. from Widener University in human sexuality and human development.
Q And, Dr. Hawkins, what is your area of specialty?
A My broader -- my broad area of specialty is LGBT children, youth, and their families, and more specifically, transgender children, youth, and their families.
Q And in your practice, do you actually work with children and adolescents who are experiencing gender dysphoria and their families?
A I do. I see anywhere from 10 to 15 families a week.
Q Could you please elaborate in your experience supporting the LGBT youth and their families?
A In my role as a mental health provider, I often am working with young people who are experiencing anxiety, depression,

coming to understand their identities, and also supporting the families that are part of that young person's system. Often there are young people who are experiencing profound mental illness in addition to their LGBT identities. So for trans children and youth, it is an important job to have a strong mental health background.

Q How long are have you been working in that area, Dr. Hawkins?

A About 22 years.

Q Okay. And what are the settings in which you have provided this support and counseling to youth?

A The majority of my time has been in the Children's Hospital of Philadelphia. So outpatient setting that is part of a specialty care center.

I've also had a private practice, where I saw transgender children, youth, and their parents, as well as mental health through a community mental health center in Philadelphia.

Q Over the 20-plus years that you have been doing this, how many transgender children and adolescents have you worked with over that time frame?

A Specifically transgender, over 4,000. If we look at LGBTQ and gender-exploring children, many more thousand.

Q Dr. Hawkins, up there with you, you should have a binder that are plaintiffs' exhibits that have been admitted into evidence.

If you could please turn to Plaintiffs' Exhibit Number 3.
A Yes.
Q Dr. Hawkins, what is Plaintiffs' Exhibit Number 3?
A My declaration.
Q Okay. And by your declaration, was this something -- was this under oath when you provided this and signed this?
A Yes.
Q Okay. And Exhibit A, if you could turn to Exhibit A of Plaintiffs' Exhibit 3.
A Yes.
Q What is this document?
A This is my updated curriculum vitae.
Q Does your curriculum vitae provide a detailed overview of your education, training, and experience in the area of transgender care of youth and adolescents?
A Yes, it does.
Q Dr. Hawkins, you mentioned that you work with the gender and sexuality development program at Children's. What is your role there?
A My role is to develop and oversee the entire program. We have two clinics -- one in Philadelphia, and one in Voorhees, New Jersey -- where we're currently supporting about 3,000 families. And that involves overseeing the mental health and medical care and choreography with all specialists who are part of this care, which involves eight to ten different

subspecialties. And then as I said earlier, I see -- I actually see families every week to provide the expert assessments.

Q When was the gender and sexuality development program opened at Children's in Philadelphia?

A We opened our doors in January of 2014. And prior to that date, specialists had been providing the work in different departments and different divisions. But in January of 2014, we all came under one umbrella for ease of patients and families to find our care.

Q And when you opened your doors in 2014, how many pediatric gender clinics were in the nation at that point?

A We were the fourth pediatric gender clinic to open in a major pediatric academic hospital.

Q Okay. Have you served as a director at any other gender clinics other than the one at Children's in Philadelphia?

A Yes. One thing that I'm able to do is travel to other children's hospitals and assist in their development of gender programs based on the exceptional style of work that we do and the standard of care that we've created at Children's Hospital of Philadelphia.

I spent two years at Rady Children's in San Diego helping to build up and improve their program with the methods that we use, as well as two years at John's Hopkins All Children's Hospital in St. Pete, Florida. I've also consulted with

Children's Denver and Children's Seattle to make sure everybody is doing the best work possible.

Q Dr. Hawkins, do you actually train other therapists to support transgender youth with gender dysphoria?

A Yes. In 2018, I founded a -- with colleagues, I founded a training program, a one-year training program for therapists to be able to learn how to better support and serve transgender individuals across the life span. My focus was children and youth and families. Other specialists focused on older transgender people.

Q Have you authored any peer-reviewed publications relating to transgender health issues?

A I have. I have collaborated on the publication from studies that were done by our medical fellows.

Q And are those publications, are those included in the publications that you have authored that are outlined on pages 5 through 9 of your curriculum vitae?

A Yes, they are.

Q And do these articles re -- do those articles include ones relating to the treatment of gender dysphoria in transgender youth?

A Yes.

Q Dr. Hawkins, do you belong to any professional organizations or associations that relate to the care of transgender children and adolescents?

A I do. I am a member of the World Professional Association for Transgender Health, often called WPATH. I'm also a member of USPATH, which is the U.S. version of that organization, as well as the mental health organizations that oversee my licensure.

MS. EAGAN: Your Honor, we would tender Dr. Hawkins as a mental health and counseling expert in the field of transgender health, including the treatment of gender dysphoria in children and adolescents.

MR. BOWDRE: No objection, Your Honor.

THE COURT: Be admitted for that purpose.

BY MS. EAGAN:

Q All right. Dr. Hawkins, let's take a step back. And I would like to talk about some terms that we're going to be using a lot over the next couple of days.

First, what is gender identity?

A Gender identity is the internal authentic hardwired sense of one's self as male or female. Every human has a gender identity. It's truly how we identify ourselves in our head, in our heart internally.

Q Is gender identity something that we as humans choose?

A No. It's hardwired. In opportunities to see where children are encouraged to try to be some -- like the opposite gender and that's not who they are, we see that that is not possible. It is not a choice. It is who somebody is.

Q When do children typically become aware of their gender identity?

A Typical gender development among all young people, given the opportunity to have a healthy developmental period in childhood usually occurs between the ages of three and five years old. Prior to three years old, children are absorbing lots of cues and rules and understandings about how gender works around them.

By three -- around three to five years old is when young people start to have the synapsis fusing in their brain to have them truly imagine and understand their gender identity. We don't always hear from three to five years old about differences in gender identity, but for some, we do.

That developmental period of time for gender identity is often when we see young people across the board having normative gender exploration or play, such as somebody who is a boy putting on a tutu at preschool, or a girl putting on a suit and tie and pretending to have imaginative play of being daddy.

So the majority of humans have gender play in childhood. The difference with somebody who has a long-lasting sense of that is where we move into a diagnostic level.

Q In most children, does their gender identity align with their birth sex?

A Yes. The majority of children go through a period of gender exploration or gender play. And it goes away. It --

the young person will feel and identify that they are aligned with their sex assigned at birth, so their gender identity matches what they were told in the hospital about who they are. And that's a term we use, cisgender. So somebody whose gender is on the same side of their sex assigned at birth. The majority of children will fall into that category.

Q Okay. As a mental health provider, how do you differentiate between nontrans children who may have gender nonconforming behaviors and then transgender children? How do you draw that distinction?

A That distinction really comes from the American Psychiatric Association's diagnostic manual that gives us criteria with which we follow to understand when somebody reaches a diagnostic threshold of gender dysphoria. Gender dysphoria is that distinct feeling of not -- not having a body that fits with your gender identity.

The diagnostic criteria for childhood clearly states that the feelings are significant of distress and that there's a specific duration of time that exceeds what would be typical in the average child exploring gender.

So the duration of time that's required is consecutive six months. Not just a few weeks of putting on a tutu, not just a month or two of putting on a tie. It's a long-term consecutive six months' minimum with identifiable clinical distress.

Q Is that time threshold different for adolescents than adults?

A That time -- the threshold is longer for adolescents and adults because that is a period of time where the treatment recommendation moves beyond just social support for the child and family, and psychological support to assess and assure that the young person is truly transgender.

The third component of care when you get into adolescents and adulthood includes medical care, which requires a more rigorous assessment and duration of time and evidence of distress.

Q Okay. Has there been advancements made in your area with the ability to differentiate between children or adolescents who have nonconforming gender behavior and then transgender children?

A Yes. We're always evolving as humanity is evolving. And the criteria continues to require that we look at, you know, higher levels of distress, different types of trauma that our young people are experiencing, to be able to assure that certain traumas, certain mental health conditions that are becoming more prevalent amongst teenagers and even amongst children are not falsely having us perceive a child as transgender when there's really something else going on. So we're always refining and expanding our assessment process to be as thorough as possible.

Q Okay. You touched on this a minute ago, but just to go back to this, what is gender dysphoria?

A Gender dysphoria is a diagnostic term that is given to us through the American Psychiatric Association, the American Psychological Association.

And it is -- it defines the distinct distress that an individual would feel between how -- their gender identity, their internal hardwired authentic sense of self differs from their sex assigned at birth. And specifically, the secondary sex characteristics that their body has produced as a result of that sex assigned at birth.

Q If gender dysphoria is not properly treated, what are the results in transgender children?

A The -- the effects of not -- the outcomes -- sorry -- of not treating young people and adults who have been diagnosed adequately with gender dysphoria, we see higher rates of depression, anxiety, suicidality, eating disorders, substance use and abuse, and other comorbid conditions that result from significant internalized distress.

Q When can gender dysphoria manifest itself in children and adolescents?

A I mentioned the first time of three to five years old, when there is the natural and typical onset of understanding one's gendered self, and that some young people share with us with their words, with their behaviors, with their actions.

Behaviors being anger, anxiety, actions, wanting to have hair cut short, wanting to have different clothing.

In adolescence or preadolescence is also a time where we will see young people who previously may have been seen as a tomboy or a more feminine boy and accepted in that type of identity start to exhibit significant distress as puberty is about to begin.

So there are really two -- two times in childhood and adolescence where we tend to see an increase in young people sharing distress, letting their parents know, and then coming to a clinic like mine.

Q And as far as puberty, what is -- why is it that that is a triggering event in transgender children with gender dysphoria?

A Because gender dysphoria is connected to the difference -- the incongruence is the diagnostic word. The incongruence between somebody's internal gender identity and their body and secondary sex characteristics, the diagnosis of gender dysphoria in adolescents and adults very clearly states that there is the added level of distress that occurs as body development begins.

So if somebody has spent from two to ten years old identifying as a male and being able to understand that they are male and have other people understand them as a male, the onset of breast development is devastating. The onset of menstruation monthly is devastating.

Q As a mental health counselor at Children's in Philadelphia, are you, Dr. Hawkins, involved with assessing children and adolescents for gender dysphoria?

A I am.

Q Could you please describe the assessment process?

A The assessment process is -- involves multiple visits and multiple professionals who are trained in this care.

The first portion of the assessment is all mental health and functioning. So developmental specialists, mental health specialists, including psychologists and psychiatrists, social workers get involved to look at school and community and home performance. And we call it a 360 assessment. So the -- we spend significant amounts of time with the young person alone, the young person with their family, parents alone.

Once we get outside of the family system, we look at all of the other systems that are part of a child's life. So that could include meeting with teachers, getting input from teachers about the amount of time and how they're presenting and behaving at school, feedback from the pediatrician, feedback from any community-based therapist, psychiatrist, or any systems that have been part of the child -- of the child's life.

At minimum, this takes a duration of several months. And for some children, it goes across years to really assure that we're providing the right care to the right kids.

Q In the assessment, are the potential of other -- or mental health issues analyzed? Is that part of the assessment?
A 100 percent. That's usually where we start. We want to really make sure -- we want to understand where these thoughts and feelings are coming from. And if there are any current mental health struggles or significant chronic mental health conditions that the child or youth has, that we're very clear that the distress with the body and the identity, their gender identity is not somehow a symptom of something else, or something else masking has gender dysphoria.

Oftentimes, that's where we start, to make sure that we don't move a child down the road of assessment into gender care when that's really not the right care.

Q What about trauma? If the child's had some trauma in their life, is that also part of the assessment?
A Absolutely. And that's within that first portion of potential for mental health distress or diagnosis is trauma. We look very closely at trauma, neurological development, our kids with autism or ASD, any type of childhood or youth mental health or neurological condition that could have them not really understanding who they are because of that trauma or mental health.

Q Dr. Hawkins, what are the potential outcomes of this assessment?
A In my work, we see that there is three typical outcomes.

And I like to simplify things, so I like three categories.

The first is the kid doesn't have -- the young person doesn't have gender dysphoria. There's something else going on. And for those kids, we move them into a treatment plan that's really going to focus on that concern or that issue.

And some of those young people are actually exploring gender. They may have come to a gender clinic because they've been sharing some gender exploration, but they don't meet criteria for gender dysphoria. They may benefit from other resources and services, but they're not going to go down the road of medical care.

The second category of young person is maybe somebody who's experienced trauma. So there's too much going on in the moment for us to make a really quick -- it's never quick, but a clear, like decision about how somebody is identifying that would lead to a medical care plan. Those young people have an extended assessment period to really carefully look further into what's going on.

If there's been a trauma, we would want to make sure that there's been sufficient unpacking mental health-wise through therapy, through potentially psychiatric medications, to assure that if we are moving a young person into the next group I will describe, that we have ruled out that the trauma could be causing the distress, and that it is truly just gender dysphoria.

The third category would be someone who after rigorous multiperson mental health assessment with the family and all the systems I described would be referring to our medical experts who would then begin their assessment. In younger years, it's nothing. There would never be a move to medical care.

As an adolescents moves into distress with puberty, that would be meeting with endocrinologists, fertility specialists, pediatricians, and trained experts who would then begin their assessment to ensure the best medical plan.

Q If the child is assessed and medical care is appropriate, are puberty blockers and hormones accepted, hormone treatments accepted to be too well-established, effective medications to be provided to transgender adolescents?

A Yes, they are, based on the guidelines from the leading mental health and medical experts.

Q And just to be clear, before a child enters puberty, do they -- are they given any of these types of medications?

A No.

Q Okay. Even if an adolescent is placed on puberty blockers or on hormones, does a mental health care provider still stay involved in their care?

A 100 percent. We're constantly assessing and reassessing the appropriateness of every treatment plan.

When transgender kids and youth have dysphoria, they

benefit from long-term support, whether that's helping their school be more supportive or helping parents and family members understand how to continue to support them in their communities.

So it is a constant assessment reassessment to assure that we're in the right category and on the right path.

Q The assessment process and then the potential use of medications such as puberty blockers and hormone treatments, if appropriate in an adolescent, do you believe that that is the appropriate care for gender dysphoria?

A When gender dysphoria is diagnosed very clearly, yes.

Q And why?

A Because the -- having been in this work for 22 years, prior to there being the addition of medical care for children and youth -- well, for youth, sorry. It doesn't apply to children.

Mental health providers were just trying to keep kids alive until they became older to get the access to those medications. And now what we're seeing is the opportunity for children and youth to not only survive, but thrive. And the fact that we are able to see more kids going to college and we're going to fewer funerals, and the recommendations are supported by all of the leading local and mental health leaders gives us the guidance that the medication is an important addition to the treatment plans.

Q Let's talk about the guidance by the medical leaders.

If you -- who are the organizations who have issued guidelines outlining that this is -- the regime that you have talked about is the appropriate care for adolescents and children with gender dysphoria?

A To name a few, the American Academy of Pediatrics, the American Medical Association, the American Psychiatric Association, American Psychological Association, just to name a few.

Q Okay. And are there -- if you could please turn in the notebook that you have in front of you --

A Uh-huh.

Q -- to page -- to Plaintiffs' Exhibit 17, Dr. Hawkins.

A Yes.

Q What is this document?

A This is the World Professional Association for Transgender Health Standards of Care for Health of Transsexual Transgender and Gender Nonconforming People published in 2012.

Q How does this interplay with the care regime that you have described as appropriate and accepted?

A Commonly called the WPATH standards of care. This provides a set of guidelines, recommendations for comprehensive care for transgender individuals. It outlines expectations of people who are considered gender experts, like myself, the training that we should have, as well as ways in which we may

best be able to support transgender folks across the life span.
Q I am going to direct your attention to Plaintiffs' Exhibits 14 through 29. And have you reviewed those exhibits before coming here today?
A I'm sorry.
Q Plaintiffs' Exhibits 14 through 29. And if you would like, there's actually a listing at the front of that book that may help you that's just got the articles or the different exhibits listed.
THE COURT: While she is looking at that, it occurs to me that nobody has invoked the rule. That may not be necessary. Does anybody want the rule or no?
MS. EAGAN: We do not.
THE COURT: Okay.
MR. LACOUR: We do not, Your Honor.
THE COURT: Okay. Just checking. Go ahead.
THE WITNESS: Yes. These are position statements and guidelines from nationally recognized and respected organizations that oversee the care of -- the mental health and medical care for children and youth and adults. Sorry.
BY MS. EAGAN:
Q All right. And do those organizations -- if you could just kind of -- let me ask you this: Do those organizations include the Endocrine Society, the American Academy of Child and Adolescents Psychiatry, the Pediatric Endocrine Society,

WPATH, the United States Professional Association for Transgender Health, the American Medical Association, the American Psychiatric Association, the American Psychological Association, and the American Academy of Pediatrics? Are those all included in the composite exhibits?

A Yes. I have seen them all.

Q And are all of those exhibits different endorsements of or support for the type of care that you provide to transgender children and adolescents, as well as the medical treatments if you refer the child out?

A Yes, they are.

Q Dr. Hawkins, I don't know if you have defendants' exhibits.

MS. EAGAN: May I approach, Your Honor?

THE COURT: Yes.

MS. EAGAN: I have a defense exhibit I would like to show the witness.

THE WITNESS: Thank you.

BY MS. EAGAN:

Q Dr. Hawkins, I have handed to you what has been marked as Defendants' Exhibit Number 2, the declaration of James Cantor.

Have you reviewed this declaration before?

A Yes, I have.

Q And if you'd turn to page -- excuse me -- paragraph 36 of his declaration. You'll see that Dr. Cantor states in this, he

asserts that with prepubescent children -- and those are children before they go into puberty, correct?

A Yes.

Q With prepubescent children who feel gender dysphoric, he says, the majority cease to want to be the other gender over the course of puberty, ranging from 61 to 88 percent desistance across large prospective studies.

How does that reconcile with the -- how does that data reconcile, if it does, with your clinical experience and what you know about studies?

A When -- when a study offers this elevated rate of what we call -- what's being termed as a desister or somebody who goes from gender behaviors, gender exploration that is opposite to their sex assigned at birth, what we tend to find is that the initial cohort that was given the diagnosis of gender dysphoria is actually false. And that is elevated.

So when I said earlier there is a very typical amount of gender exploration that is part of childhood and even adolescence, not all of those individuals should have been termed gender dysphoric or having gender dysphoria.

So what we see in general, once young people are coming to a clinic, some are still experiencing gender exploration, which is why we need a very thorough assessment. But if you go back to the preschool room with five year olds who are all exploring gender, that cohort would be a large group of kids who are

really not gender dysphoric and should not have been diagnosed with gender dysphoria.

So in natural -- yes, 80 percent of kids who put on a tutu are not transgender.

Q So I want to focus on once the child is not prepubescent, but when they actually have entered puberty, when they are adolescents, okay? Based upon your clinical experience, research, and expertise, do transgender adolescents, after they've reached puberty, usually grow out of their gender dysphoria?

A Not if they truly have gender dysphoria.

Q Okay. And do they generally grow out of their -- or does mere counseling, is that sufficient generally with youth who are -- adolescents, once they've reached puberty?

A If they truly have gender dysphoria and have been diagnosed as such from a major -- a comprehensive assessment, mental health support is only going to go so far.

Because the distress is specific to body changes, that is why the recommendations across the board for mental health and medical experts includes the three pieces -- social support, psychological support, and medical support.

Q In Dr. Cantor's declaration, going back to that, Dr. Cantor notes some recent findings that have been made in certain organizations -- in the UK and Finland and Sweden and France -- related to medical care for transgender youth.

Let me ask you this question: Have any of those countries banned the use of puberty blockers or hormones for gender dysphoria in transgender youth?

A No, they have not.

Q If you could also turn to paragraph 47 of Dr. Cantor's affidavit -- excuse me -- declaration.

I apologize. I wrote down the wrong number.

Let me ask you this: Are you familiar with Dr. Cantor's critiques in his affidavit about studies using observational data to prove the efficacy of transgender medical treatment? Are you familiar with his critiques of that?

A I am.

Q First of all, what does observational data mean?

A So the only way to study human behavior is by observation. It is how we assess for mental health concerns. It's how we assess for developmental and sometimes neurological assessments.

And so the only opportunity we have to assess -- we can't do a blood test right now or a brain scan right now to identify someone as transgender, so we have to rely on observational data.

And in particular, because the treatment of transgender children who have this gender dysphoria includes mental health and medical care, we can't do things like double blind studies and say, this kid is just not going to get this medication, or

this kid is not going to get this mental health care, and we will watch to see how poorly they do. That's unethical.

So what we do is observational studies to look at how do young people do when they are able to get the three pieces of care in a way that is best for them based on the assessment. And also we can look at what happens to kids that are waiting to get that care for some reason.

One addition I would make is that while the critique is about the rightness or validity of observational studies in human behavior, which that is the most appropriate, the majority, if not all of these studies include measured psychometric tests, which are also an objective way of looking at behavior.

So an example would be something like the CBCL or the Children's Behavior Checklist. That is done by the child, by the parent, and oftentimes by a teacher. So we are looking at multiple inputs.

And again, the psychometric measures that were utilized in these studies add another layer to the validity of the observations.

Q Dr. Hawkins, switching gears a little bit. Is mental health counseling to adolescents with gender dysphoria that encourages them to live in their birth sex, is that helpful to the child or youth -- excuse me -- the adolescent, or is that harmful?

A The history that we have of that type of therapy and counseling being utilized in the past and -- we can see the detriment that that type of therapy has caused. And in my -- even in my day-to-day work now, I see young people who are coming in who have experienced that for two months, two years prior to coming into our center. And it's not -- it's been proven to be detrimental to individuals. It's sometimes referred to as conversion therapy or reparative therapy.

Trying to convince somebody to live in a way that is not authentic to their identity is dangerous, if not unethical -- well, it has been determined unethical by most medical and mental health organizations.

Q Now, I want to turn to SB 184, which is the law that we're here about today. Are you familiar with that law?

A I am.

Q Dr. Hawkins, what impact psychosocially will the denial of medical treatment, a blanket prohibition of puberty blockers and hormone treatments, what impact will that have on transgender youth in Alabama who are currently receiving these treatments?

A It will be devastating. The benefit that young people are receiving from the medical care, medical and mental health care that has been identified as ideal for that patient would be like removing somebody's cancer treatment and just expecting them to be okay. This would be devastating.

Q What impact psychosocially will this law going into effect have on transgender youth in Alabama who may not yet be receiving these treatments, but suffer from gender dysphoria? What impact will it have on them?

A Having worked in Philadelphia and taken care of young people where that was the case just because we did not have medical providers under 18 -- our age of consent is 18 -- adult care is 18 -- I was seeing young people who were desperately waiting to a birth date to get the care that they needed.

And the number of young people who had suicide attempts, had exacerbated mental health distress, which results in inability to attend school, inability to have functioning healthy relationships with their peers and their family, it literally becomes a daily suicide watch that devastates people and families.

MS. EAGAN: Your Honor, may I consult with my colleagues?

THE COURT: Yes.

MS. EAGAN: Thank you, Dr. Hawkins. I have nothing further.

THE COURT: How long does the State believe their cross will be?

MR. BOWDRE: Probably about an hour. I will try to keep to it an hour.

THE COURT: All right. I suspect sometime in the

middle of that we will probably need to take a break, but go ahead. We will knock out some time.

MR. BOWDRE: Thank you.

CROSS-EXAMINATION

BY MR. BOWDRE:

Q Good morning, Dr. Hawkins. My name is Barrett Bowdre. I represent the State defendants.

A Good morning.

Q Thank you for being here.

I might jump around a little bit in my questions, but let me know if things get confusing. I will try and rephrase. If you don't understand the question -- I will admit I am a little sleep deprived, so I might not make all the most sense, so just let me know.

A We will work together.

THE COURT: Speak up just a little bit, Mr. Bowdre.

BY MR. BOWDRE:

Q One question I'm curious about. You mentioned in your report, and I think this is at paragraph 15, you say, because a person's gender identity is unknowable at birth, doctors assign sex based on the appearance of a newborn's external genitalia.

I guess my question is: Do you think that if a doctor did know the child's gender identity at birth, that the biological sex would therefore not -- would become irrelevant?

A In cases where there are medically unclear -- there's

visibly unclear genitalia or there is evidence of some other medical condition going on, medical providers do take pause.

Q I guess -- sorry. To clarify, I'm not really asking about the disorders and those sorts of things. I'm talking simply about gender identity. And in the vast majority of cases, either people align with their sex or they don't; is that right?

A Yes.

Q And you say that it is because we don't know the gender identity that we have to rely on external genitalia to determine the person's sex; is that right?

A Correct.

Q Okay. So if we did know the person's gender identity at birth, would sex become irrelevant?

A I think sex would be -- the sex assigned at birth meaning -- can you clarify what you mean by sex assigned at birth, specifically their genitalia and body?

Q Right. The biological sex that is -- I mean, let me ask you: Can you define what is your definition of sex?

A Sex is a bi -- for in my definition, sex is a biologically-based term that is achieved and understood by a combination of observed body parts and then additional assessment of chromosomes by -- that's the top of my medical knowledge in that.

Q And so would you agree that sex is binary? Biological

sex, not gender identity, biological sex, is sex binary?
A That's stepping outside of my medical purview.
Q Okay. I will move on.
In preparing -- I will admit I was having a little bit of trouble preparing to ask you in-depth questions, because as far as I could tell, you cite maybe five studies in your report. And I am just wondering why do you not cite many studies in your report to -- I mean, you make all these claims. Why do you not cite those studies to back up these claims?
A Given the opportunity to comment and meet and talk, I cited what I did at the time.
Q Okay. You testified earlier about that you are familiar with the international literature reviews; is that correct?
A Yes.
Q Have you reviewed them?
A Have I reviewed every single?
Q Let me be more specific. Have you reviewed the UK's literature reviews from the National Institute for Childhood Excellence, whatever NICE means? Are you familiar with that?
A Can you point to that in the --
Q Yes. Let's go to Defendants' Exhibit 9. Do you have a set of the defendants' exhibits?
A I am on 9, if you're wondering.
Q Okay. Sorry. Is that defendants or plaintiffs? Are you looking at --

A I am looking at the declaration of Kathy Noe.

MR. BOWDRE: May I approach the witness?

THE COURT: Yes.

MR. BOWDRE:

Q I'm sorry. I thought you had this, as well.

A That's okay. Thank you.

Q Okay. Can you identify this document?

A I'm looking at "Evidence reviewed: Gonadotropin releasing hormone analogs for children and adolescents with gender dysphoria."

Q Have you read this?

A I have not.

Q Are you generally aware of it?

A I have not. I am not.

Q You testified earlier that you -- well, maybe -- let me ask you this: Do you keep up with the medical literature in this field?

A I do. I keep up with the mental health literature most frequently, and I rely on the national medical organizations to review and synthesize the medical findings.

Q Okay. Are you -- I think you testified that you oversee a clinic; is that correct?

A Uh-huh.

Q And that clinic provides not only mental health counseling, but also, you know, helps people along the pathway

if -- if you determine it's necessary, they will get puberty blockers, cross-sex hormones; is that right?

A Yes. And I do not oversee the medical arm of medical care. That is overseen by -- we have nine medical experts who do that.

Q Okay. Well, you testified earlier that you believe in the efficacy of the medical care; is that correct?

A Can you just --

Q Yeah. I mean, you testified earlier that the psychological counseling alone is not enough, that these children need puberty blockers. Is that a fair assessment of your testimony?

A I -- I believe that I said, yes, that puberty blockers and hormones are part of the standard of medical care for children. I --

Q Okay.

A I want to stay in my lane of mental health and be clear that the assessment process then moves over to a physician.

Q Okay. You would recommend at some point a patient comes in, you diagnose that patient with gender dysphoria; is that right?

A Uh-huh. Yes.

Q And then at some point, you say, counseling is not enough for you, you need puberty blockers, or at least you need to go and be seen by endocrinologists for you to get puberty

blockers; is that right?
A For the child to be assessed for the appropriateness of puberty blockers.
Q Okay. And you are not aware of what kind of assessment they do?
A I -- I am -- I am aware of conversations they have that include discussing all of the risks, benefits, and limitations. I don't do those meetings because I am not a physician.
Q Okay. Are you aware of the risks, limitations that the informed consent -- or the things that might be necessary for informed consent to begin puberty blockers, for instance?
A Yes. And we do not practice informed consent. We do -- we do a more expanded evaluation and assessment to make sure that young people are aware of -- and parents are aware.
Q Okay. Are you involved in that informed consent process for puberty blockers?
A I am not involved in those meetings.
Q Okay. Are you involved in creating what that process might look like because you direct the clinic?
A In my director role, we then bring all of the assessments back into one room and make a collective determination about what would be the best medical mental health care for a child or youth.
Q Okay. So I just want to be sure I understand. Would you say that you're generally aware of the risks and the benefits

in that calculus for beginning puberty blockers?
A I think generally is a fair word. And especially where it affects psychosocial impacts versus medical impacts.
Q Okay. But is it fair to say that you have not done a deep dive into the literature of whether puberty blockers are actually effective in treating gender dysphoria?
A To that extent, I rely on our medical leaders to be aware of what that is, and that's --
Q Okay.
A Yeah.
Q Would you agree that there's a difference between literature reviews and relying on, you know, a single study? Is that -- are those two different things?
A By construct, they're two different things. And I would say that all research in this field is needed and valued, whether it's a literature review, a single case study, or prospective assessment.
Q Okay. But you have not read -- I just want to make clear -- you have not read, even skimmed the literature reviews done by the UK, National Institute for Health Care -- whatever the CE is. I'm sorry -- I have missed that.
A I have not done a review such that I would be able to sit here and give witness on that.
Q Okay. Would it concern you at all if this evidence review surveyed nine -- the nine longitudinal studies of puberty

blockers that existed in 2020 when the review was done, and came to the conclusion that there was not sufficient evidence to support their efficacy?

A That would definitely be concerning.

Q Okay. Let's look at a couple of just -- I don't want to spend too much time more on this, but I want to look at a couple of the specific findings and get your reaction to them.

A Uh-huh.

Q So if you could flip -- one question -- are you familiar -- you have plaintiffs' exhibits -- you have the plaintiffs' exhibit binder before you?

A Yes.

Q Okay. Sorry to keep making you flip, but I just want to make sure.

Plaintiffs' Exhibit 42.

A 42?

Q Yes, ma'am.

A My binder goes to 41.

Q Sorry. Are you looking in the plaintiffs' binder?

A The one that you just handed me?

Q No. I'm sorry. The one that you had from the plaintiffs.

A Oh. Sorry. Sorry.

Q Sorry about that.

A No, no, no. That was my mistake. Thank you for clarifying. Now I see a 42. Thank you.

Q And what is that?
A This is the Longitudinal Impact of Gender From an Endocrine Intervention on the Mental Health and Wellbeing of Transgender Youth Preliminary Results published in 2020 in the International Journal of Pediatric Endocrinology.
Q Who is the main author?
A Achille.
Q Okay. And then just one more. Are you familiar with that setting, by the way?
A I haven't reviewed the study.
Q Okay. Can you turn to Plaintiffs' Exhibit 35 in that same binder?
A Sorry. Yes.
Q Okay. And is that the study by Lopez de Lara?
A It is Psychosocial Assessment and Transgender Adolescents published in 2020 in -- I'm not familiar with this journal.
Q Okay. Do you see the author?
A Yes.
Q And is it Lopez de Lara?
A Yes.
Q Okay. All right. So now I think this is the last time I will make you switch between binders, but if you could go back to the other binder, the defendants' exhibit, and go back to the study that we were looking at, which is Defense Exhibit 9.
A Yes. I got them both.

Q Sorry. Just one second. Yeah. I flipped it. I'm sorry. Could you move on to one more exhibit, Exhibit 10? It's just the next one this that same binder.
A Oh, okay.
Q I'm sorry this is taking a while. I will move on pretty quickly. Have you seen that before?
A No.
Q Okay. Would you agree that that is -- the evidence review entitled Gender-Affirming Hormones For Children and Adolescents With Gender Dysphoria?
A I see that exhibit.
Q But, again, you have not reviewed this literature, have you?
A No.
Q Okay. Could you go to page 16 of that?
A Uh-huh.
Q And this is a listing of the specific studies that this literature reviewed. And do you see the study that we just looked at by Achille 2020, the one that you said that you were familiar with?
A On page 16, yeah, I see where that's under a Table 1 Summary of Included Studies.
Q Yes. And then could you flip to page 20, and do you see the listing of the Lopez de Lara study that we just looked at, that we just identified? We didn't look specifically at it.

A I see what looks like a summary of that, as well.
Q Okay. Okay. And then could you flip to page 13 with me of the same document? And then would you read along with me? This is in the discussion section of the literature review.
A Uh-huh.
Q And the authors state, The key limitation to identifying the effectiveness and safety of gender-reforming hormones for children and adolescents with gender dysphoria is the lack of reliable comparative studies. And it says, All the studies included in the evidence review are uncontrolled observational studies which are subject to bias and compounding and were of very low certainty using modified grade. A fundamental limitation of all the uncontrolled studies included in this review is that any change in scores from baseline to follow up could be attributed to regression to the mean.

And skipping down a paragraph, it says, Most studies included in this review did not report comorbidities, physical or mental health, and no study reported concomitant treatments and details. Because of this, it is not clear whether any changes seen were due to gender-affirming hormones or other treatments that participants may have received.

And then the last part that I will read is on the top of the very next page. It is difficult to draw firm conclusions for many of the effectiveness and safety outcomes reported in the included studies because many different scoring tools and

methods were used to assess the same outcome often with conflicting results.

Then the next paragraph, Any potential benefits of gender-affirming hormones must be weighed against the largely unknown long-term safety profile of these treatments in children and adolescents with gender dysphoria.

Did I read all that correctly?

A Yes, you did.

Q Okay. Do these findings give you pause?

A I don't feel like I can speak to the conclusions that are in a document that I have not reviewed and the summaries of an author that I haven't read.

Q Okay. You mentioned earlier when my friend on the other side asked you about other countries and whether any other countries were banning, you know, puberty blockers or cross-sex hormones. Do you recall that?

A Yes, I do.

Q You said no other country is banning it; is that right?

A Uh-huh.

Q Are you aware in Sweden if someone has gender dysphoria, are puberty blockers and cross-sex hormones for an adolescent, are those available to that adolescent?

A Off the top of my head, I am not sure what Sweden's age requirement is.

Q Okay. So you don't know if those treatments are

effectively banned in Sweden or not?
A To my understanding, they are not banned.
Q Okay. Can we go to Defense Exhibit 11, which is --
THE COURT: Mr. Bowdre, I would say when you reach a stopping point, let me know, and we will take a break.
MR. BOWDRE: Yes, Your Honor.
THE WITNESS: Care of children and adolescent with children with gender dysphoria?
BY MR. BOWDRE:
Q Yes. Have you seen this document before?
A No.
Q When you testified earlier that you were familiar with what all these other countries were doing, what was your basis for that testimony?
A I'd like to correct that. I didn't say that I am aware of everything that's going on in other countries, that I -- to my knowledge, this care has not been banned. That is what I said.
Q How did you come to that conclusion?
A Reviewing what countries have and -- the fact that the countries are not banning this care as a conclusion.
Q I guess my question is: What research did you do to figure out whether they're banning that care provided that you have never seen this document before?
A The over -- looking at summaries.
Q Okay. Could you turn to page 3 of this document?

A Uh-huh.
Q And under the heading, Recommendations and Criteria For Hormonal Treatment, it says, For adolescents with gender incongruence, the NBHW -- which is the National Board of Health and Welfare of Sweden -- deems that the risks of puberty-suppressing treatment with GnRH analogs, those are commonly referred to as puberty blockers; is that right?
A Yes.
Q Okay. And gender-affirming hormonal treatment currently outweigh the possible benefits, and that the treatments should be offered only in exceptional cases.

This judgment is based mainly on three factors: The continued lack of reliable scientific evidence concerning the efficacy and safety of both treatments, the new knowledge that detransition occurs among young adults, and the uncertainty that follows from the yet unexplained increase in the number of care seekers and increased particularly large among adolescents registered as females at birth.

Did I read that correct?
A You did.
Q First, do those findings give you any pause about the treatment that you were providing in your clinic?
A Any review of care should give us all pause to make sure that we are abiding by the expectations and the needs of children. I don't feel like I can speak to this particular

piece, because I have not reviewed it.
Q Okay. Could you go to the next page with me? And then I think we will be ready for a break.
This is page 4 of that document.
A Uh-huh.
Q Okay. And about halfway through that paragraph -- sorry. Halfway through the second full paragraph of that document, beginning with, Until a research study is in place.
So it says, Until a research study in place, the NBHW deems that treatment with GnRH analogs and sex hormones may be give in exceptional cases in accordance with the updated recommendations and criteria described in the guidelines.
A Uh-huh.
Q And then a couple of sentences before that, is that, To ensure that new knowledge is gathered, the NBHW further deems that treatment with GnRH analogs and sex hormones for young people should be provided within a research context, which does not necessarily imply the use of randomized controlled trials.
Okay. So my question is: Are you aware of any ongoing trials in Sweden in which a child or adolescent with gender dysphoria could receive these treatments?
A Not the medical trials, no. I rely on our medical providers to be aware of the information.
Q Okay. Okay.
MR. BOWDRE: Your Honor, I think now would be a good

time for a break.

THE COURT: Okay. Good. All right. Let's all be back in the courtroom at ten minutes until 11:00.

(Recess.)

THE COURT: I didn't mean to take that long of a break. I have just realized this clock is way off from the regular time. So breaks will be shorter. That was my fault.

So go ahead, Mr. Bowdre.

MR. BOWDRE: Thank you, Your Honor.

BY MR. BOWDRE:

Q Dr. Hawkins, I think I would like to move to and focus more on your treatment of the gender dysphoric children and youth that you treat.

How long on average are these patients in your care?

A The youngest patient I've met with is four to five years old, and we see folks until they're 21, at which point they transition to adult care providers. So it can be 5, 10, 15 years.

Q Do you keep up with them once they transition out at age 21?

A We do, especially for those who are working with the local medical providers, and as much as possible with ongoing research, yes.

Q What does that research look like?

A Keeping track of the outcomes and looking at how young

people are doing as they age out of the clinic.
Q Okay. And at what point -- are you publishing this research?
A Not at this time. We're still in collection.
Q Okay. And what are the long-term -- at what ages are you asking the patients? Does that make sense? Like they leave your clinic at age 21. And then you're conducting research as they progress through life. What ages are they at now?
A I would have to hypothesize that based on -- so we started in 2014. I recall having touched base again with a patient who is nearing 30, who came to us when they were 20 -- or nearing 30, yeah, so in the late 20s. Late 20s is about where the majority of our aged-out patients are right now.
Q Okay. And when you say that you keep in touch with them, is that something -- I mean, do you send them surveys? Do you send them -- do you just call them? Do they call you? What does that look like?
A We have a research director that's part of the Children's Hospital of Philadelphia that does ongoing -- ongoing assessments and ongoing research. It is not myself.
Q Okay. Do all of your patients continue to stay in touch? If you send them a survey or whatever, do they -- how many drop out?
A I can't speak to that. I'm not the research director.
Q Okay. Do you know if any of your patients have gone

through a transition and then detransitioned and aligned with their biological sex?

A For -- for young people who have gone through the complete thorough assessment and have received medical care from our teams, we have not had somebody desist with regret.

Q What does that mean for young -- I mean, I think you had a qualifier at the very beginning. Could you explain that?

A The qualifier was for individuals who have gone through our full assessment and as a result ended up in that third category that I described of young people who will benefit from ongoing medical care for their gender dysphoria, we have not seen anybody to date desist with regret.

Q Okay. And that assumes that you have 100 percent response rates to your surveys or follow up with them once they leave your clinic; is that correct?

A I don't -- I can't speak to the percentages or the follow up --

Q So how do you know that you have not had a detransitioner if you don't know how many drop out of the follow-up studies?

A From the reports back from the research director, we have not seen that yet.

Q Okay.

A That --

Q Are you aware -- at least according to one survey, only a quarter of detransitioners ever tell their doctors -- their

gender clinic doctors that they have detransitioned?
A I had not heard that.
Q Okay. So you have not read Lisa Littman's Survey of Detransitioners?
A I actually have read Lisa Littman's work.
Q Okay. Have you read that specific survey? I mean, as far as I know -- I will just stop there. Have you read that specific survey?
A Yes.
Q Okay. And you just did not pick up on her finding that only a quarter of detransitioners ever told their doctors that they have detransitioned?
A I apologize. I do not recall that from that study.
Q Okay. Does that concern you -- assuming that it's true, does that concern you?
A All the research around transgender children and individuals with gender dysphoria concern me. And it is important to, as a director, hire leaders in each field of medical care, mental health care, and research to lead that.
Q On direct I think you said that your standards of care are exceptional. Did I get that right?
A Yes.
Q Does that mean -- would you agree does that mean that other clinics might not have exceptional care?
A I wouldn't -- I wouldn't speculate to presume that.

Q Okay. Is it your understanding that all providers who prescribe puberty blockers or cross-sex hormones to treat gender dysphoric youth have the same exceptional standards that your clinic does?
A I don't think it's -- I don't think I can say that everybody has to have the same standards. We don't -- we are -- our type of care is incorporating all of the recommendations from every organization. So I'm not sure that I could say that -- in a great world, I would hope that everybody would have the same standards. I don't -- I can't set that as a standard as an individual from Children's Hospital of Philadelphia.
Q Okay. So I guess there's two different questions here. One is: What should the standard be? And then the other question is: What is the standard that everyone's using? And I just want to make sure I'm breaking that down. And your testimony is that the standard that you use is exceptional, but might not be the only way to treat gender dysphoric children; is that right?
A I would agree.
Q Okay. And then the second question is: You would agree that not all clinics or not all pediatrician offices or not all pediatric endocrinologists are using the same standards that you are using to treat gender dysphoric children; is that correct?

A I don't think I could make that speculation about what other people are doing.
Q Okay. I just want to make sure. You testified -- we touched briefly on the informed consent process that your clinic uses. And I believe you said that you are not directly involved in that process, at least for the puberty blockers and cross-sex hormones; is that correct?
A That's completed by a physician.
Q Okay. And you could not testify about what is in that process, what risks are given to the patient or the patient's parents?
A Not the medical risks, no.
Q Okay. So you don't know if the patients are given and are told about the long-term effects that being on puberty blockers might have for them?
A The medical leaders in the clinic are following the expected guidelines that are put out by the medical associations and has been -- have been approved by the Children's Hospital of Philadelphia as best care practice. I can guarantee that.
Q Okay. But I guess -- you don't know -- I guess to go back to my question. You don't know what specific risks the children or their parents are told about being on puberty blockers; is that right?
A Medical risks?

Q Medical risks, psychological risks, whatever the risks are.
A I don't sit in those meetings. My job is to determine that a young person is ready to have those conversations with the medical providers. The medical providers are staying on top of the best practice and the best information to be sharing with the parents and the child -- and the adolescent.
Q Okay. How do you determine when a patient is ready to start that process for medical treatment?
A When psychosocially there is confirmation of the diagnosis of gender dysphoria, and that the distress that a young person or an adolescent is experiencing meets criteria psychosocially or mental health-wise for the distress to be reduced or stopped.
Q And so what is the youngest patient that you have said has met that criteria and was ready to go meet with an endocrinologist about puberty blockers?
A We don't do a lot based on age. We do it based on Tanner staging.

And so the -- I would say the youngest would be conversations with folks in the 14-year-old age range.

And we look at two variables. One is the physical distress that's being described that the breast development, the menstruation is highly distressing and/or the anticipation of those body changes. And for kids who are assigned male at

birth, that would be deepening of the voice and increasing of the genital size.

Q What Tanner stage are you looking for?

A The physicians are looking for Tanner Stage 2.

Q Okay. And I'm correct that there are five Tanner stages?

A From what I have read, yes.

Q Okay. And the Tanner Stage 2 is really the first stage of pubertal changes; is that correct?

A From what I understand from sharing from medical providers, yes.

Q And do you know if -- if a person at Tanner Stage 2, is that person fertile?

A I can't speak to that level of medical knowledge.

Q Okay. So then does that also mean that you are not aware of whether the patients are told that if they start on cross sex -- if they start on puberty blockers and then move on to cross-sex hormones at Tanner Stage 2 that they might be permanently infertile?

A We have on our team fertility specialists who are part of the University of Pennsylvania hospital system, and they are part of the multidisciplinary medical team that does a comprehensive sharing of information and review of systems with every patient and their family. So I have the experts on the team that provide that information.

Q Okay. And they tell the patient that she might end up

permanently infertile?
A I can't speak to that.
Q Okay.
A They provide all the information needed.
Q Okay. Let's move on to diagnosis.
A Uh-huh.
Q And I think you testified earlier that the gender dysphoria is a psychological diagnosis based on the DSM-5; is that right?
A Yes.
Q And as I understand it, the two criteria are gender incongruence and a clinical level of distress about that incongruence; is that fair?
A Correct.
Q Okay. And I think you also said this, that at present there are no brain studies or blood tests that we can do to figure out whether someone has gender dysphoria or not?
A Correct.
Q It's based on patient report and what the family tells you?
A Patient report, what the family tells us, as well as the 360 evaluation of the other people who are involved in the young person's life, including pediatricians, other mental health providers. So...
Q Would you agree that --

THE COURT: Mr. Bowdre, I am not getting in the middle of your case, but I would be interested to have some practical knowledge of what exactly does that clinical level of distress look like.

MR. BOWDRE: Okay.

THE COURT: And maybe that's a better one for their redirect. So I will just aim that at both parties.

MR. BOWDRE: Thank you, Your Honor.

BY MR. BOWDRE:

Q Just to follow up on that there are no brain scans that can identify gender dysphoria or blood tests or any of those sorts of biological tests. Would you agree that that is different than diagnosing precocious puberty, for instance?

A I don't diagnose precocious puberty, so I can't speak to that diagnostic process for a medical provider.

Q Okay. Can you -- do you have any idea whether precocious puberty is based on -- is a psychological condition or something that can be found in, you know, blood work, for instance? Do you have any idea?

A As a nonmedical provider, I can't answer that.

Q Okay. So you testified that most -- that gender identity begins to form between ages three and five, and that that is really when we start to see gender dysphoria being manifest. And I think you put in your declaration that it is insistent, persistent, and consistent in the cross-gender identification;

is that right?
A Correct. For some children, that is when we start to hear their proclamations of their gender identity.
Q Okay. Would you agree that that is -- the traditional or classic case of childhood onset gender dysphoria is around three to five?
A I would agree with that.
Q Okay. Am I correct -- and do you want to explain at this point what the distress -- part of the diagnosis of the three to five year old, what that second component, the distress, what that looks like?
A Yeah. For a kiddo -- I'm sorry. For children that age, oftentimes we will see the manifestation of that distress in difficulties sleeping, excessive tearfulness, nighttime is that time at bedtime where you hear what's really upsetting a kiddo -- child, sorry. And it also comes out in desires not to go to school, where preschools and kindergartens are very gender separated. So opportunities for that child to be repeatedly misgendered because they're being told to line up in one line or another.

We have had five year olds who say that they want to throw themselves out of a moving car, end their life. More commonly, we see that the bellyaches, the GI distress, the headaches, and overall significant -- and it's not just a little bit. We're looking at significant distress.

Q I understand that the DSM-5 requires this finding of distress. Wasn't that also true for the DSM-IV?
A Yes. Under the diagnosis of the DSM-IV that was gender identity disorder, the distress was also needed as part of that diagnostic criteria.
Q Was that also true for DSM-III?
A Yes. Also as gender identity disorder. The terms changed with the DSM-5.
Q But they all required this level of significant distress, right?
A Correct. The one word that I would like to add is that in the DSM-5 there became flexibility for the understanding that perceived distress in childhood also warrants significant distress. So in that regard, if a child is fearful of future body changes, that qualifies as a diagnosis of dysphoria.
Q Okay. Thank you.
I want to address desistance for a moment. And my understanding is that the most likely outcome for this cohort of gender dysphoric children who present at age three to five is desistance. Is that true?
A Going back to what I said earlier about is -- if the child is actually diagnosed with gender dysphoria, through a multidisciplinary longitudinal systemic assessment process, we do not see desistance at the rates that were identified.
Q Okay.

A By --
Q Would you agree that the DSM-5 has a contrary statement?
A What statement would you be referring to?
Q Okay. Let's look at it. Could you go to defense Exhibit 17?
A I see the Diagnostic and Statistical Manual of Mental Disorders, DSM-5.
Q Could you go to the internal pages 455, or if it's ECF stamped, it's page 7 of the ECF document.
A Sorry. That print's small. 455?
Q Yes.
A Uh-huh.
Q And then under the heading, gender dysphoria without a disorder of sex development, the second full paragraph begins, Rates of persistence of gender dysphoria from childhood into adolescent or adulthood vary and, in natal males, persistence has ranged from 2.2 percent to 30 percent. In natal females, persistence has ranged from 12 percent to 50 percent.
Did I read that correctly?
A Yes, you did.
Q Okay. And so that would indicate that somewhere, what, between 97.8 and 70 percent of boys, and between 50 percent and 88 percent of girls with diagnosed gender dysphoria, the dysphoria will desist by the time they become adults, according to the DSM-5?

A You said 80 percent?
Q In natal females, persistence has ranged from 12 to 50 percent, so that would mean desistance would be between 88 percent and 50 percent; is that right?
A Oh, I'm sorry. Thank you for clarifying that. I see that.
Q Okay. Can we also go to -- if you flip over to Defense Exhibit 19.
A The Endocrine Treatment of Gender Dysphoric Gender Incongruent Persons by the Endocrine Society.
Q Yes. Are you familiar with this document?
A Yes.
Q Does your clinic use this document to treat gender dysphoric youth?
A Yes. It is used as a guideline and recommendation.
Q Okay. Can you go to internal page 3879? And then do you see under the heading, Evidence?
A Uh-huh.
Q It says -- Defense Exhibit 19.
Quote, In most children diagnosed with GD or gender incongruence, it did not persist into adolescence. The percentages differed among studies probably dependent upon which version of the DSM clinicians used, the patient's age, the recruitment criteria, and perhaps cultural factors. However, the large majority -- about 85 percent -- of

prepubertal children with a childhood diagnosis did not remain GD/gender incongruent in adolescence.

Did I read that correctly?

A Yes.

Q Okay. And then it goes on to note that social transition is associated with the persistence of GD and gender incongruence as the child progresses into adolescence; is that correct?

A Uh-huh.

Q Okay. And then I want to look at one more exhibit, which is Defense Exhibit 18. So just flip one to the left.

A Standards of care.

Q Yes. What are these?

A I'm sorry?

Q I'm sorry. What is this document?

A This is the World Professional Association for Transgender Health standards of care for the health of transsexual transgender and gender nonconforming people.

Q These are the WPATH standards that you talked about earlier?

A Correct.

Q Okay. Could you go to internal page 11?

A Yes.

Q Okay. And then that first full paragraph beginning with the second sentence. Gender dysphoria during childhood does

not inevitably continue into adulthood. Rather, in follow-up studies of prepubertal children, mainly boys, who were referred to clinics for assessment of gender dysphoria, the dysphoria persisted into adulthood for only 6 to 23 percent of children. And then I will skip the citations.

And it says, Boys in these studies were more likely to identify as gay in adulthood than as transgender. Newer studies also including girls showed a 12 to 27 persistent rate of gender dysphoria into adulthood.

A Uh-huh.

Q Did I read that correctly?

A Yes, you did.

Q So my question is: You testified earlier that you don't believe these statistics because you believe that -- I don't want to put words in your mouth. So let me see if this is a fair characterization.

My understanding of your testimony was that these statistics are all wrong because it might be that everyone was diagnosing people with gender dysphoria who, in fact, did not have it; is that correct?

A The care with which we look at the research findings needs to include the appropriateness and accuracy of a diagnosis. And that is why the DSM has continued to improve and modify the diagnosis so that we can be more clear, based on what we're understanding about gender dysphoria in children, especially as

it relates to medical care, to keep an eye on the knowledge we're gaining.

Q Okay. Well, you testified -- earlier I asked you, does the DSM-IV, does the DSM-III, they both require clinical levels of distress for the diagnosis of gender dysphoria, correct?

A Uh-huh. Yes.

Q Okay. And so I guess my question is: Why do you think all these statistics, all these studies from WPATH, Endocrine Society, DSM-5, how are they all wrong?

A I'm not saying that they're all wrong. They're guiding us to really carefully take a look at the diagnostic process. And the benefit of the care that's provided would follow children for several years and never activate medical care.

So if a child were to, as you say, desist prior to adolescence, there is no harm.

Q I guess -- all right. So what do you think the rate of desistance in childhood dysphoria is?

A I -- I would -- I don't feel comfortable giving a rate or a percentage based on that question.

Q Okay. And so on this harm aspect, wouldn't you agree that if you start someone on medical interventions and it turns out that that person would have been in the vast majority, according to the DSM-5, Endocrine Society, WPATH, of people who would have desisted but for the medical interventions, isn't that a harm?

A Potentially it could be a harm. I -- the statement I was making earlier was about the importance of not having medical care occur under puberty and being able to watch and then assess and reassess.
Q Okay. And so how do you tell if one of your patients, if his or her gender dysphoria will persist, and so that he or she is a good candidate for medical treatments?
A The duration of time, which is what -- one of the areas of diagnosis that has changed is the requirement for there to be -- you used the words insistent, persistent, and consistent evidence of the child or the young person's identity as male or female opposite to their sex assigned at birth for a significant duration of time with significant mental health improvement or stabilization when receiving medical and mental health care for their gender dysphoria and experience significant distress when not able to receive medical or mental health for their gender dysphoria.
Q Okay. And what's -- what -- I guess my question is: If -- if it is true that by adulthood the vast majority of the childhood gender dysphoric youth, their dysphoria will have desisted, but we have medical interventions before adulthood, how can you be confident that the person sitting in front of you is a persister rather than a desister?
A The comprehensive assessment that we do with the children, the parents, all of the providers leads us to that confidence.

Q Okay. Would you say that you are -- you have -- using your diagnostic criteria, that you would be 100 percent sure that the person in front of you is a persister rather than a desister?
A The assessment -- it's interesting you say 100 percent. The assessment process we use, we try to assure we are 180 percent sure that the right kids are getting the right medicine.
Q Okay. And which studies can you point to that show 180 percent chance that you have the right person in front of you, that it is a persister and not a desister?
A Hopefully soon we will have one from us. I can't point to one as you said.
Q So there are no formal studies as of this time that tell us whether -- what criteria you can use to determine whether someone desists or is a persister in front of you?
A Sorry. Can you repeat that question?
Q Yep. There are no formal studies at this time that can tell you what diagnostic criteria to use to make sure that you are confident and accurate that the person sitting in front of you is a persister and not a desister?
A The assessment process that includes longitudinal assessments with multidisciplinary team of the multi-systemic areas of a child is the ideal assessment process to determine that, to determine the appropriateness of what medical and

mental health care a child or an adolescent with dysphoria experiences.

Q Okay. Can you point to a study that provides an accuracy percentage of, you know, these children were diagnosed, and they were -- they ended up persisting, and we got it right, versus these children were diagnosed, and they were part of the majority and desisted, and we got the diagnosis wrong? Are there any studies like that?

A I would lean to Tordoff, our colleagues in -- at Seattle Children's who did a one-year longitudinal study following children who were -- youth -- sorry -- who were receiving medical and mental health care.

Q Okay. So that study showed -- those children got the intervention, right? They got the puberty blockers?

A Uh-huh.

Q And then we're saying, well, this shows that we got it right where it could also show, as the Tavistock vs. Bell decision showed, that once you start them on puberty blockers, then they're likely to persist. Isn't that also likely?

A Correct me if I'm wrong. What I heard you say was that the puberty blockers would make somebody persist. Youth persist because they're getting the right care.

Q How do you know that?

A Because they continue to do well, to have baseline of the same mental health challenges that their cisgender peers do,

and continue to thrive.
Q Can you go back with me to Defendants' Exhibit 19?
A Yes.
Q This is internal page 3876. At the very top. And these are the Endocrine Society guidelines, right?
A Yes.
Q At the very top, With current knowledge, we cannot predict the psychosexual outcome for any specific child.
Did I read that right?
A Yes.
Q Do you disagree with that?
A In general, that's an accurate statement.
Q Okay. What is -- I think -- okay. Thank you.
THE COURT: No rush, Mr. Bowdre, but tell me how long you think this cross is going to continue.
MR. BOWDRE: Your Honor, I'm sorry. At least another 30 minutes. Maybe not at least. I will do my very best to get done within 30 minutes.
THE COURT: Is there going to be some amount of redirect?
MS. EAGAN: At this point, Judge, I anticipate a short redirect.
THE COURT: Five minutes?
MS. EAGAN: Yes, sir.
BY MR. BOWDRE:

Q Just one clarifying question. When you say that in general you agree with that statement, is the -- your hesitancy to fully agree with that, is that based on the Tordoff study?
A No. It's based on the fact that we -- we can't predict any child's psycho -- psychological well-being based on human variables in life.

So if there is a trauma, if there is a challenge that occurs in someone's life, if there is additional reasons for anxiety or depression, that's why I'm saying I would not uniformly say that.
Q But I guess going back to the statistic earlier. If it's true that children are between, you know, 50 percent and 90 percent, 95 percent likely to desist, then we can predict that it is at least more likely than not that any individual child is -- will desist. Isn't that correct?
A I don't know that I would agree with that.
Q Okay. So far we've been talking about the children ages three to five. My understanding is that there is -- in recent years, the patient profile has changed to become predominantly adolescence and often adolescent girls presenting with gender dysphoria. Do you agree that?
A I would agree that there are more youth coming in who are in the 13 to 15 year old range than in the past, yes.
Q Okay. And have you seen that at your clinic?
A Yes.

Q And these -- these youth were -- are not considered the traditional gender dysphoric childhood onset class; is that true?

A There's -- there's two categories that we're seeing. The additional youth who are coming into clinics, one is teens who are identifying in adolescence that they did have an identification and -- in childhood or in earlier years that as they start to go through puberty, they realize qualified as gender dysphoria, though they didn't speak on it in the past. And there is -- right now the young people around the United States are enjoying a lot of developmental exploration around gender and sexuality, and thus increasing our needs to do very careful assessments about what type of care each child gets in its youth.

Q Okay. Let's address those in turn. What studies do you rely on for the idea that you would treat someone who identifies as an adolescent as gender dysphoric -- or as diagnosed as an adolescent with gender dysphoria for the first time, what studies do you rely on to say that the treatment, the cross-sex hormones, the puberty blockers are appropriate for that class of children?

A I -- I would lean back on some of the colleagues who have published the Achille, as well as Tordoff and the medical leaders that then guide this information and the mental health leaders.

Q Okay. One of the studies that you cite in your report is the 2014 Dutch study. Are you familiar with that?
A Uh-huh.
Q Is the one by Dr. de Vries and others from the Dutch gender clinic?
A Yes.
Q Would you agree that that is a leading study on the treatment of gender dysphoric children?
A Yes.
Q Would you agree that that study only looked at the classical onset, childhood onset age three to five for gender dysphoria?
A Yes.
Q Okay. It did not look at people whose gender dysphoria came to light when they were adolescents; is that true?
A From my recollection.
Q Okay. And so you would agree that treating adolescent onset gender dysphoric youth with those same interventions is at least not supported by the Dutch study itself; is that true?
A I wouldn't come to that summary.
Q Why not?
A Because the research and the findings they have are continuing to evolve, so I think making a definitive statement like that is not something I would do.
Q Okay. You also mentioned that you are seeing an

increasing number of people with different gender identities; is that right?

A Describe what you mean by different gender identities.

Q I'm sorry. I forget the exact wording that you used. But would you agree that gender -- that you are seeing nonbinary identifying youth?

A We are seeing an increase in youth across the sex spectrum and gender spectrum who are exploring gender, yes.

Q Okay. Would you agree that gender can be fluid?

A I see gender presentation as fluid. That's what somebody puts on themselves to express who they are. And that is -- that is something that is gaining popularity right now.

Q Okay. Does -- is there an age at which gender identity becomes set?

A Given the opportunity for typical childhood development, meaning no traumas, no challenges, no deficits in nutrition and support, we see that there is a point around six that a sense of understanding that gender is permanent in society is part of natural and normal gender development.

For many individuals, where there are challenges to healthy and typical development, whether that's from just neurological differences, family and stress differences, the understanding and solidification of gender identity can emerge at other different times, later different times in life.

Q Okay. So are the adolescents that are coming to your

clinic for the first time identifying as trans or showing signs of gender dysphoria, are you saying that those -- their gender identities were not set at the normal age; is that right?

A No. I'm saying that there's a difference between somebody who has gender dysphoria and is transgender and somebody -- a teen who is exploring their gender identity.

Between our two clinics in Philadelphia and New Jersey, we're seeing about -- we're supporting about 3,000 kids and teens. Only two-thirds of those folks are on any type of gender-affirming medical care.

So a third that are exploring their gender are in kind of those first two categories I spoke of today, either gender -- something else is going on that is not gender dysphoria, or we're in a place of continued assessment before any type of medical recommendation is made.

Q Okay. Thank you.

What studies do you rely on for the proposition that only puberty blockers and cross-sex hormones and not therapy alone would reduce suicide rates in gender dysphoric use?

A Can you say that again?

Q What studies do you rely on for the proposition that only puberty blockers and cross-sex hormones and not therapy alone can reduce suicide rates in gender dysphoric youth?

A I rely on the medical and mental health guidelines that are prepared by the professionals that review all those

studies.
Q Okay. So you testified earlier that it is your understanding that without the medical interventions, suicide rates go up; is that fair?
A For the kids who are diagnosed with gender dysphoria.
Q Okay. And your basis for saying that is just that you rely on the professionals?
A The professional organizations, yes. And, yes, I do read the research, and the Tordoff, and Olsen, and Achille, and -- and, again, look at the synthesis of each of those studies collectively and how the collective understanding that we gain from those studies are brought into guidelines and expectations for our care.
Q Okay.
MR. BOWDRE: May I have a moment to consult with my co-counsel?
Okay. Thank you, Dr. Hawkins.
THE WITNESS: Thank you.

REDIRECT EXAMINATION

BY MS. EAGAN:
Q Dr. Hawkins, after an adolescent is placed on -- an adolescent with gender dysphoria is placed on puberty blockers, do you continue to treat that adolescent?
A Yes. We continue to assess and reassess continually, checking in with family, parents, the youth, and checking on

any changes in functioning at school with any mental health.
Q In your clinical practice, have you personally observed improvement in those patients with gender dysphoria, adolescents who have been placed on puberty blockers?
A I have.
Q Describe that, please.
A The symptomology of distress, the anxiety and depression, the fear of their bodies changing can reduce greatly. And what we see -- what we've witnessed with our work with over 2000 kids is that, you know, that opportunity to have their bodies stop going in the direction that it shouldn't be going in is incredibly relieving.
Q Same question for hormones. You continue to treat those adolescents after they begin hormone treatments?
A Yes. We have continued visits.
Q And in your clinical practice, what have you observed, in regards to improvement in their psychosocial condition?
A Significant improvement.
Q Mr. Bowdre asked you about what does distress look like in a young child ages three to five with gender dysphoria?
A Uh-huh.
Q I am going to ask the question tying it to an adolescent, who is about -- who is going into puberty when medication can be started with these children that is banned by this law.
What does the distress look like, Dr. Hawkins, in an

adolescent with gender dysphoria who is being considered for medical treatment?

A In addition to all the distress that I described in childhood, the fact that adolescents can have access to more ways of harming themselves means that we often will see an addition of cutting behaviors, missing school, similar to the younger age, but it gets bigger. The consequence of missing school, the lethality of an adolescent's ability to take their own life is significantly different than a five year old. Not to minimize the importance of what I shared about a five year old. And the addition of substance use, substance abuse, as in eating disorders. Those are the layers that are added to the distress categories that we see in adolescents, all of which increase the significant lethality of not doing this care.

Q Turning to when Mr. Bowdre was asking you about Sweden. In Sweden -- and he showed you the paper -- were you aware that in Sweden that -- that -- or you saw it then. I can pull it back up -- that treatments are allowed in exceptional circumstances for children?

A Yes.

Q Or for adolescents, correct?

A Uh-huh.

Q And Sweden, in fact, has -- adolescents who are 16 can get the treatments, correct?

A Yes.

Q Okay. Alabama, unlike Sweden, their law has no exception?
A Uh-huh.
Q Correct?
A From my read of it, yes.
Q It's a blanket ban, regardless of exceptional circumstances?
A Correct.
Q Now, Mr. Bowdre also walked you through some literature from the UK. Let me ask you this just to wrap this up. Has any of the data that he reviewed with you, has any of that data changed the position of any major medical association in the United States regarding the appropriateness and the efficacy of these medical treatments for adolescents with gender dysphoria?
A Not to my knowledge. The -- what the research has advised is stronger and better assessments of the mental health to assure that the right kids are getting the right medicine at the right time.
Q Mr. Bowdre asked you about the standard of care that you described as exceptional that y'all practice with your clinic at Children's. Let me ask you this: Does the standards that are used by Children's Hospital in your practice, do those standards, the ones -- do -- does that follow recognized protocols for best care practices, the same protocols that we talked about earlier that's endorsed by every major medical association?

A I just want to clarify. I'm sorry.
Q Sure. My point is this: He was asking you, well, you don't know what other folks, what other practices do, so I can't speak for a specific practice, but you know what your practice does.

Are the practices that you follow, are those in compliance with what are the recommended practices for best treatment for children, transgender youth with gender dysphoria that's recognized by the guidelines that we talked about earlier?
A Yes. Thank you for clarifying that.

It incorporates -- the care provided incorporates the highest standards from endocrine, from adolescent medicine, from psychiatry, from psychology, all of those together, yes.
Q Okay. Mr. Bowdre asked you, Dr. Hawkins, he talked with you about some statistics that he phrased as desistance for children, which would be young children up to adults or children to adolescence, okay?
A Uh-huh.
Q When gender dysphoria, however, has persisted from childhood into adolescence, when medical treatments are being considered, what has been your experience regarding later realign -- what he's called desistance? What has been your experience on that once they have had that persisted dysphoria?
A In my experience, when a child has expressed insistent, persistent, and consistent cross-gender identity or cross-sex

identity for a significant amount of time, they persist.
Q Okay. Stated differently, if they have persisted and been consistent and insistent from being a young child up until the point of puberty and have entered puberty, in your experience, those children continued to experience gender dysphoria and continued to -- they're transgender children; is that fair?
A Correct. And they continue to require medical and mental health in support of addressing the distress from their gender dysphoria.
Q Doctor, I am going to -- let me see if I can put this up on the Elmo.
This is from plaintiffs -- excuse me -- Defendants' Exhibit 19, if you want to turn in your book.
And just to identify, these are the endocrine treatment guidelines for gender dysphoria, the clinical practice guidelines, correct?
A Yes.
Q Okay. Sorry. I was making notes on this. This is my only copy.
All right. I want to turn you to the language or some of the language that I believe that Mr. Bowdre was referring to you. And he pointed out just the first sentence, which says -- this is on -- Natural History of Children With Gender Incongruence or Gender Dysphoria.
The sentence he directed you to is, With current

knowledge, we cannot predict the psychosexual outcome of any specific child.

Do you remember him asking you about that sentence?

A Yes.

Q Let's go on into that, that section.

And I am going to start where I started outlining. And this is where they're talking about combining all outcome studies to date, the GD/gender incongruence of a minority of prepubertal children appears to persist into adolescence?

A Uh-huh.

Q Okay? And then it talks about in adolescence, a significant number of these children whose -- who identify as homosexual or bisexual. And then it goes on to say this: It may be that children who only showed some gender nonconforming characteristics have been included in these follow-up studies.

Is that the phenomena that you were talking about earlier that children are being wrongfully grouped in this that don't really have gender dysphoria?

A Yes, that was what I was referring to.

Q And then it goes on to say this: That they may have been included because the DSM-IV text revision criteria for a diagnosis was rather broad?

A Uh-huh.

Q And DSM-IV criteria, that's an older way of doing things; is that fair to say?

A Yes. Yes.
Q Okay. It's not what we use today or not what you use today?
A Correct. We use the DSM-5.
Q Okay. And then it says -- goes on to say, However, the persistence of gender -- GD, and that stands for gender dysphoria; is that right?
A Correct.
Q The persistence of GD/gender incongruence into adolescence is more likely if it had been extreme in childhood, and then it says, With the newer, stricter criteria of the DSM-5, persistence rates may well be different in future studies?
A Correct.
Q And the DSM-5 criteria, is it a more robust criteria than what DSM-IV was?
A I would say it's -- I would say one of the best editions is the duration of time and the -- just the additional layers, yes.
Q And in your clinical experience and also with the study that y'all are undergoing with -- is it your experience that with the DSM -- or in the clinical experience with DSM-5 criteria, you're seeing much higher or you're seeing high persistence rates?
A Yes. And what I would add to that is that there are more professionals who are trained in how to clearly assess

individuals for gender dysphoria or not.

Q Okay. The final thing, Dr. Hawkins, is I would like to direct your attention to Plaintiffs' Exhibit 33. These large notebooks are a little bit unwieldy.

And Mr. Bowdre asked you about a de Vries study. And I believe he said that -- he couched it as, Dr. Hawkins, do you agree that the de Vries or de Vries study is a leading study in the area of analyzing the outcome of puberty suppression and gender reassignment in young adults?

A Correct. I recall that.

Q Okay. And he -- it was his words that he said a leading study, correct?

A Correct.

Q Is Plaintiffs' Exhibit 33, is this the findings from the de Vries -- is it de Vries or de Vries?

A I say de Vries.

Q Okay.

A Sorry.

Q Is this Plaintiffs' Exhibit 33, that's a summary of the -- or the findings from that study?

A Yes.

Q Okay. And first, I would like to direct you to the background of this study. It explains puberty suppression by means of gonadotropin releasing hormone analogs has become accepted in clinical management of adolescents who have gender

dysphoria, and that's referring to puberty blockers; is that correct?
A Correct.
Q And then it says, The current study is the first longer-term longitudinal evaluation of this effectiveness in this approach.
What does a longitudinal evaluation mean, Doctor?
A This is following the youth who have been part of her clinic in the Netherlands.
Q And in this assessment, what was it that they were looking at in this longitudinal evaluation?
A They -- I mean, they were following young transgender folks who were receiving -- who had received puberty suppression and then cross-sex hormones in adolescence.
Q And in this study they then, as they aged into adults, they looked at things such as their psychological functioning, depression, and anxiety, basically how they were doing both function-wise both mentally and in life, correct?
A Correct. In particular, they utilized many psychological measures in addition to self-report.
Q All right. And then if you turn to the conclusions section on this.
A Uh-huh.
Q This was the conclusion of the study: A clinical protocol of a multidisciplinary team with mental health professionals,

physicians, and surgeons, including puberty suppression, followed by cross-sex hormones and gender reassignment surgery, provides gender -- let me back up. The gender reassignment surgery for the student -- or the people that were the subject study, that was gender reassignment surgery that was performed in adulthood, correct?

A Correct.

Q Okay. So let's go back to the conclusion. A clinical protocol in the multidisciplinary team with mental health professionals, physicians, and surgeons, including puberty suppression, followed by cross-sex hormones, and gender reassignment surgery, provides gender dysphoric youth who seek gender reassignment from early puberty on the opportunity to develop into well-functioning young adults.

Did I read that right, Doctor?

A Yes.

Q And was that the findings of the study that Mr. Bowdre called a leading study?

A Yes.

MS. EAGAN: Thank you, Doctor.

THE WITNESS: Thank you.

THE COURT: All right, Ms. Eagan. It's Conn Law 2, and we are going to see if you can book the class.

Had Alabama adopted this statute but with Sweden's exceptions, would you be here today? Does that pass

constitutional muster?

MS. EAGAN: If they --

THE COURT: If Alabama had passed this law but with Sweden's exceptions for 16 years old and for exceptional circumstances, would you be here today asking me to enjoin the enforcement of this Act?

MS. EAGAN: I will -- I -- I can't claim to be a constitutional scholar, Judge. I would anticipate -- I will say this: The way to have -- to tailor this to whatever the justification of the State is -- is not a blanket ban. That is not reasonably tailored to any liable justification. So to --

THE COURT: Would the Swedish rule be nearly tailored? I'm not going to let you off the hook here.

MS. EAGAN: Can I refer with my much brighter colleague?

THE COURT: You certainly can. Absolutely.

Let me go ahead and warn the United States. You're next.

MS. EAGAN: All right. Mr. Doss is --

MR. DOSS: I mean, I think the issue would be what are exceptional circumstances. I mean, for example, we take the position that untreated gender dysphoria would be exceptional circumstances for the reasons that we just heard from Dr. Hawkins, that if you have no medical intervention, then it can lead to increased suicide rates and depression, anxiety. We do think those are exceptional circumstances.

And so if there was no definition to the Alabama law about exceptional circumstances, or there was a definition that allowed for physician judgment in consultation with parents, and a clear assessment and a clear weighing of the risks by the parents with input from the doctors, and that was sufficient to satisfy exceptional circumstances, I'm not sure that we would be here, Your Honor. Because it would like -- it would allow room for those difficult judgments to be made.

If exceptional circumstances is something that could never be obtained as a practical matter under current medical outlooks, then maybe we would be here because it would not be narrowly tailored. There would be no narrow tailoring in the event that it categorically always and repeatedly overrode parental judgment and doctor judgment.

So as long as there's some room for discretion within that definition, it would be a different scenario, we think.

THE COURT: All right. General Garland, what do you say?

MR. CHEEK: Your Honor, I most certainly am not General Garland. I am just a lowly assistant United States attorney.

What we would say is, of course, that would still require intermediate scrutiny. And so there would have to be a substantial relation to an important government interest.

Is protecting children an important government interest?

Of course. But here -- and we'd have to look at the law and the circumstances surrounding a law that Your Honor is proposing -- is that a legitimate basis or is it pretextual or a post-hoc rationale? I think those questions would matter and potentially be material.

THE COURT: All right. I'm not going to let you off that easy.

MR. CHEEK: Sure.

THE COURT: So, I am speaking in general. If the Alabama law had Sweden's exceptions, what's your gut? Would you be here today? That's my question.

MR. CHEEK: I'm not sure, Your Honor. I mean, I have not pondered that specific scenario.

THE COURT: So you might well be here even with Sweden's exceptions? Is that what I'm hearing?

MR. CHEEK: Absolutely. That's a possibility. Sure. Sure.

THE COURT: Fair enough. All right. Thank you.

MR. CHEEK: Thank you.

THE COURT: Anybody from the State want to be heard on this?

MR. LACOUR: Your Honor, just very briefly, I will point you back to Gonzales vs. Carhart, which we cited yesterday.

In areas of medical uncertainty, the State has tremendous

ability to regulate. So I don't think the Constitution has empowered federal courts or private plaintiffs to require the State to get it absolutely just right, much less defer to the AAP or the AMA whenever we are trying to protect public health in the state.

THE COURT: All right.

MR. CHEEK: Your Honor, can I add just one additional thought?

THE COURT: Why not?

MR. CHEEK: The fact -- if it were a felony in Your Honor's hypothetical, I think absolutely we would be here.

THE COURT: Okay.

MR. LACOUR: And, Your Honor, I don't see why it would make any difference whether it's a felony or it's a physician losing their license. It's still banned, and there's not any constitutional provision they've cited that makes the question turn on the punishment that attaches to the ban.

THE COURT: All right. Are we still on track time-wise?

MS. EAGAN: I had hoped to get Dr. Ladinsky on before now, but I know it's noon, Your Honor. I mean, I could -- I would expect Dr. Ladinsky would be about the same length as my direct was with Dr. Hawkins, which I think was right at around between 30 and 40 minutes. I would expect probably about the same for Dr. Ladinsky.

THE COURT: All right. All right. I will see everybody back here, then, at 1:25. No. That clock is wrong. 1:15.

MS. EAGAN: 15?

THE COURT: 1:15.

(Recess.)

THE COURT: All right. Well, I detect that we are off track on time and that we need to get back on track.

So I will ask everybody to tighten up, and everybody knows how to do that, I'm certain.

One way of tightening up might be -- are you going to offer Dr. Ladinsky for certain purposes, I assume?

MS. EAGAN: Yes, Your Honor.

THE COURT: And those purposes will be?

MS. EAGAN: We are going to tender her as an expert in pediatric transgender care in the state of Alabama.

THE COURT: Is there going to be an agreement by the State for that tender?

MR. LACOUR: No objection, no, Your Honor.

THE COURT: No objection?

MR. LACOUR: No objection.

THE COURT: Gotcha. I realize you have to make your record, but, you know, to the extent we can get a foundation laid in lightning speed...

MS. EAGAN: Yes, sir. We are -- we have put her CV

into evidence, and so I can probably just refer to it on a couple of quick points and get moving with it.

THE COURT: Excellent. All right.

One other thing I will say before we start is the same thing that I did yesterday with evidence, I'm going to do to you again tomorrow when we give closings, which, obviously, I don't need cases. You have given me your cases.

But in your closing argument, I will want whoever is going to give those to cite me back to specific evidence that has come in through testimony or otherwise that you think would be in your top ten list on each issue.

Okay. Then are we ready for Dr. Ladinsky?

MS. EAGAN: Yes, Your Honor.

THE COURT: Okay.

MS. EAGAN: Plaintiffs call Dr. Morissa Ladinsky.

MORISSA LADINSKY, MD,

having been first duly sworn by the courtroom deputy clerk, was examined and testified as follows:

THE COURT: And you think you're 30 minutes? And, Mr. Bowdre, are you doing cross again? No. Mr. LaCour?

MR. LACOUR: I will be doing cross, Your Honor. I will try to keep it 30 to 45.

THE COURT: All right. Here we go.

DIRECT EXAMINATION

BY MS. EAGAN:

Q Good afternoon, Dr. Ladinsky.
A Good afternoon.
Q Could you please give us your full name?
A Sure. Morissa Jean Ladinsky.
Q Dr. Ladinsky, what do you do for a living?
A I am an associate professor of pediatrics. As such, I am a faculty attending physician, UAB Pediatrics, in the division of general peds.
Q Okay. And what is your area of specialty, Dr. Ladinsky?
A I am a primary care pediatrician and also a clinician educator, as such. I lead our primary care clinic team, educate the residents within that space. I colead our regional NICU follow-up clinic, and then I also colead our multidisciplinary gender health team.
Q I want to focus on the multidisciplinary gender clinic. Is that a clinic that you founded?
A It is.
Q And if you could -- I am going to mark as -- actually, there's a notebook up there, Dr. Ladinsky, that's plaintiffs' exhibits. Do you see that? There's a lot of notebooks up there.
A I'm guessing it's this one. Yeah.
MS. EAGAN: Your Honor, may I approach and help her?
THE COURT: Yes.
BY MS. EAGAN:

Q Dr. Ladinsky, could you please turn to what's been marked as Plaintiffs' Exhibit 7?
A Yes, ma'am. Okay.
Q Dr. Ladinsky, is this your curriculum vitae?
A It is.
Q And does your curriculum vitae provide a detailed outline of your background, training, education, and experience?
A It does.
Q All right. Dr. Ladinsky, are you a board certified physician?
A Yes, I am.
Q In what field?
A In pediatrics, American Board of Pediatrics.
Q All right. Dr. Ladinsky, let's talk about the gender clinic at UAB hospital. You said that it is a multidisciplinary gender clinic. What do you mean by multidisciplinary?
A Indeed it is. The clinic is held within the pediatric endocrinology space, UAB Children's. However, an entire team consisting of a pediatric endocrinologist, myself, a primary care pediatric in adolescent medicine, as well as peds to psychologists, social worker, a pediatric and adolescent gynecologist, as well as our chaplain are in that space together and work in an interdisciplinary way to make decisions and deliver the best care at each visit to our patients and

families.
Q Dr. Ladinsky, when did the UAB gender clinic open?
A Dr. Latif and I opened our doors in that space in the late fall of 2015.
Q How many gender clinics like UAB's are there in the state of Alabama?
A There are none, to my knowledge.
Q Okay. Are there any -- are you aware of any such clinics in the state -- adjacent state like of Mississippi?
A There are none.
Q Okay. About how many gender clinics like yours are there in the country?
A Approximately 55, these team-based clinics that are located in pediatric academic centers.
Q At UAB, have you treated transgender young people with gender dysphoria?
A I have.
Q How many would you estimate?
A Since our clinic's opening, we have touched the lives of some 400 to 450 youth.
Q And from where do your patients come, Dr. Ladinsky?
A Our patients come from every corner of Alabama, Mississippi, the Florida Panhandle, and occasionally the sort of southern border of Tennessee, western border of Georgia.
Q So describe the path of how a pediatric patient ends up at

your -- in your care at UAB, please.
A By all means. So about 80 percent of the patients for whom we provide care were referred to us.
This is a multi -- this is a subspecialty referral level of care. And these youth have been identified by their primary care pediatrician or family doctor in community. Many have also been seeing a mental health professional in community. They are referred to us.
The other 20 percent are youth who we first meet in consultation in the pediatric emergency center inpatient psychiatry or on the inpatient medical floors. And these are transgender youth who have entered the health care system due to suicide, severe eating disorders, or suicidal ideation.
Q So let's talk -- let's briefly focus on guidelines for the treatment of gender dysphoria and transgender youth.
Dr. Ladinsky, are you familiar with the standards that provide guidance for treating physicians for the diagnosis and the treatment of gender dysphoria in youth?
A I am.
Q And please elaborate on that.
A So standards of care by an international body of experts known as WPATH, in addition -- and does touch on -- has many -- the revised version has a lot of guidance around pediatrics. Those are standards of care. The Endocrine Society's guidelines, again, consensus bodies of high-level endocrinology

experts, digesting and continually looking at literature to prescribe the guidelines, all of this is again incorporated into a policy statement by our organization, the American Academy of Pediatrics issued in 2018.

So these provide excellent guardrails for the care that we provide.

Q These guardrails and policies and procedures that you've just mentioned, are those endorsed by every major medical association in the United States?

A Absolutely.

Q Okay.

A Especially those who touch the lives of children.

Q And do those guidelines support the use of puberty blockers and hormone treatments in pediatric -- excuse me -- in adolescents with gender dysphoria?

A They do, with very critical, you know, parameters and diagnoses.

Q Now, you were in here for Dr. Hawkins's testimony this morning?

A Yes, ma'am.

Q And you heard me when I went through and just had her identify numerous of our exhibits that are the various policies for some organizations and procedures, correct?

A That's correct.

Q All right. I'm going to focus you on one that I did not

ask her about, and that is Plaintiffs' Exhibit 32, if you could please turn to that, Dr. Ladinsky.

A Okay.

Q Dr. Ladinsky, what is this document?

A There is the 2018 American Academy of Pediatrics' policy statement that provides guidance to pediatricians throughout the nation.

Q And does this document endorse the guidelines for care that y'all follow at UAB?

A It does.

Q And very quickly, what is the American Academy of Pediatrics?

A The American Academy of Pediatrics is a body about 70,000 pediatrician members throughout this entire continent that does two things: It advocates for pediatricians, as well as for policy around the health and welfare of women and children. It also, through its expert subspecialty teams, is continually vetting the latest, most well-validated and most important research to impact the care of kids issuing guidelines and recommendations along those lines.

Q Are you a member of that academy?

A I am.

Q Is there also an Alabama chapter?

A There is.

Q And are you a member of that, as well?

A Yes, ma'am, I am.
Q All right. So let's talk about the process that y'all use at UAB, Dr. Ladinsky, for assessing a pediatric patient for gender dysphoria. Can you walk us through that, please?
A I can. And remember, patients are going -- it's individualized care based on patients' ages, physical stages, and physiology.

However, our -- most of the patients coming to us have been followed longitudinally in community by a mental health professional. Most have already been diagnosed with gender dysphoria, and together with their pediatricians have elevated a level of dysphoria warranting subspecialty insight. It's about a six-month wait to be seen.

But in that first visit, again, the assessment of mental health dysphoria underlying mental health conditions is made by our psychology team, along with information coming from their psychologist. And then all of the members of the team meet with youth and family to assess where they are and what levels of dysphoria and concern they manifest in that visit.
Q And then once you have assessed whether they have gender dysphoria and the level of dysphoria, then where do you go from there?
A Well, it is a very robust team. And there will be a good bit of this focused on support for the family, where are the parents, the household, and what concerns do they have and

share. There are resources that we provide, and mental health, if that needs to be escalated. And then the physical health for each patient.

We also look at what will be needed going forward and when we will see them again.

Q As far as the type of care that is needed, is that impacted by the age and life stage of a youth with gender dysphoria?

A Oh, absolutely.

Q Can you elaborate on that a little bit more, please, ma'am?

A For youth before puberty, our younger and elementary age kids, there is no medical treatment indicated ever for gender dysphoria in that young population. It's more about how to best address that dysphoria, and making sure that all of the different spaces and places and households where this youth navigates are coming to places of support for them.

For youth just into puberty, when immense dysphoria can ratchet up, and we are seeing severe -- we are seeing anxiety, depression, academic decline, grades plummeting, withdrawal, and parents saying, what's -- this is not my child, that's when we talk about what is needed to alleviate that dysphoria.

If putting a pause on puberty at that point is medically indicated, as well as mental health, to, you know, to uphold their mental health, and then for our older teens who have

manifested, you know, gender dysphoria for a long period of time, along with a lot of support, are they eligible and ready for hormonal therapy.

Most of our youth are with us for one to three years before any medical therapy is initiated.

Q Dr. Ladinsky, why is it that the recommended practice is to wait until a child begins puberty before you consider any type of medications for the child?

A That's critically important. We know there are some youth who may have a gender diverse or gender questioning identity during childhood that may return to align with their sex assigned at birth as puberty happens. Puberty is a very sentinel event for transgender or youth experiencing gender dysphoria.

Youth whose dysphoria is not just present, but increased in severity with the onset of a natal puberty, we know very well that those youth may -- they are most likely to contend with dysphoria life long, and they are most likely to maintain that identity life long, and they may very well merit medical therapy.

Q If -- as far as when a -- sorry.

When a patient has been determined that puberty blockers or hormones is appropriate medical treatment for them, what is the interplay of medical health providers at UAB? Do they continue to stay involved in the adolescent's care?

A They do, absolutely. Oh, goodness, yes.
Q Dr. Ladinsky, do you believe that if you support a child with their gender identity that differs from the birth sex, do you believe that then you're setting them on a path for blockers and for hormones?
A I don't.
Q Can you please explain?
A Our younger youth who manifested gender questioning or transgender identity with significant levels of dysphoria need that robust management in their identity, but they're evaluated at each -- each page and each stage.

At each visit, we're always telling our families, we're here for you. You are not here for us.

We always discuss that exit ramps are available at each age, each stage.

And then we look at where we are with dysphoria at that point in time.

Q Okay. So let's first talk about puberty blockers. Could you just explain to us an overview of what puberty blockers are?
A Sure. It's a sort of umbrella term for a family of medications known as GnRH agonists. But what these medications do functionally, especially as they're used in pediatric and adolescent care, is to place a short-term pause on the continued development of the secondary sex characteristics

aligned with puberty.

Q And how are those generally administered to your patients at UAB?

A So they are administered by injection once every three months. So that's what we call a depo preparation.

That injection needs to be administered by a trained medical professional -- a nurse, a physician assistant. And that usually once you have reached that point, the medication is usually administered by those personnel in their local pediatric office or space.

Q Okay. Are puberty blockers used only with transgender youth?

A No, ma'am.

Q What are other reasons that puberty blockers are used in pediatric patients?

A The most common, I believe, is in pediatric endocrinology for a condition called central precocious puberty, or premature puberty, when puberty begins too early. That affects about one in 5,000 kids. And they are used in the same way.

They've been used for, gosh, over 30 years for that indication with an enviable record of safety and reversibility.

Q And that was my next question, actually.

A Oh, okay.

Q So are puberty blockers considered to be safe for use in pediatric patients?

A Absolutely. For patients just into initial puberty, absolutely.
Q And are they considered to be reversible?
A They are. When the medication is stopped, puberty aligned with the natal sex will restart.
Q And when you say the natal sex --
A Uh-huh.
Q -- what do you mean by that?
A Physical puberty in line with their sex assigned at birth.
Q Dr. Ladinsky, what steps are taken at UAB before a transgender adolescent is prescribed puberty blockers?
A There will be, first of all, a robust assessment of the information coming to us from their pediatrician, their mental health provider, and in-depth time spent with their family and them, a physical examination to assess and confirm that Tanner 2 staging by our pediatric endocrinologist, as well as the input from everyone on the team.
Q Okay. And as part -- before an adolescent is prescribed puberty blockers -- let me ask you this: What are the benefits of puberty blockers for a transgender adolescent with gender dysphoria?
A The benefit is that pause button. And that just putting a hold on continued physical maturation, aligned with the sex assigned at birth, meaning for a youth whose internal sense of gender is not at all aligned with what that body is doing, that

is horrific for some gender dysphoric adolescents, and the improvement in mental health for them by freeing them up from that concern can be transformative.

Q Are there also risks?

A There are risks with any medication.

Q What are some of the recognized risks of puberty blockers?

A There may be weight gain, mood changes. There may be local reactions at the injection sites, or pain. And there is a mild, but potential brief kind of decrease in the rate of bone mineral acquisition, or the rate at which the developing bones acquire their strength.

That is short lived. And excellent data show us, though, that long term, when a hormonal puberty fills in and completes, that bone strength will unquestionably approximate youth at that same age and stage.

Q How -- I'm sorry?

A Go ahead.

Q Were you done?

A Oh, yeah.

Q Okay. Dr. Ladinsky, at UAB, how long do y'all use puberty-blocking medication with your patients?

A We view puberty-blocking medication as a short-term pause. So one or two years for most of our patients.

Q Okay.

A Two and a half at the most.

Q In your practice, have you had occasions with patients where they begin taking puberty blockers and then their gender dysphoria stops and as a teenager they align their gender ID with their birth sex? Have you had that happen at UAB?
A We have seen two or three patients with that trajectory, yes.
Q Okay. Would you describe -- how would you describe -- is that rare?
A It's uncommon, yes.
Q Okay.
A But it does underscore the whole point of using that pharmacologic intervention. It's completely reversible and gives youth time to explore that gender identity. And really feel if it innately aligns with who they are.
Q So in those rare occasions, those -- that you just described, I mean, what did y'all do?
A The blockers -- they're discontinued. Puberty aligned with their natal sex fills in.

But we ensure that they continue with their ongoing mental health therapy, and make sure that their pediatricians have great communication with us.
Q I hope -- I can't remember if I asked you this or not. I apologize.

You talked about the risks and the benefits. Before a child goes onto puberty blockers, do you have a discussion with

the parents and with the child about those risks?
A We do. Absolutely. It's a pretty lengthy discussion. And it's well documented in the medical record.
Q Let's now move to hormone therapy, Dr. Ladinsky.
A Okay.
Q What is that?
A So hormone therapy is a potential pharmacologic initiative or intervention that is undertaken with older adolescents who have manifested gender dysphoria continued over a long period of time. They have been what we call living in their identified gender, expressing with their name, pronouns, hair, their expression for a long period of time at school, at home. They have also had long-term mental health over time.

We request a written letter from their mental health provider attesting to not just their capacity to assent to hormones and to the potential risk-benefit analysis, but as well as a decision that's made by the entire team, as well as lengthy informed consent documents that are reviewed longitudinally and must be signed and agreed upon by any and all parents or guardians with legal custodial medical decision making.
Q Okay. And I am going to turn to the consent document a little bit. We have those marked as exhibits. Before I go there --
A Uh-huh.

Q -- why is it that hormone treatment is beneficial for older teenagers, transgender teenagers with gender dysphoria?
A They are finally at a point where they can further align some of the physical elements of their body with their internal sense of gender.
Q If you could turn to Plaintiffs' Exhibit 41, Dr. Ladinsky, in that notebook.
A Uh-huh.
Q You got it?
A Yes, ma'am.
Q Could you identify for us what Plaintiffs' Exhibit 41 is?
A These are the informed consent documents that are used in our clinic space for the initiation of hormones.
Q I believe there are two different forms here. If you could just identify what those are, please, ma'am.
A One is Feminizing Medications for Transgender Clients. The other is titled Testosterone for Transgender Clients.
Q How do these forms compare to what is generally used at academic-based clinics like yours, gender clinics?
A They're virtually identical.
Q And how do you use these forms?
A These forms are given to families, as well as kids -- to families and kids as they are getting closer to the time of initiation of hormonal therapy. So they have a lot of time to review them, read about them, digest them, and share them with

other family members who may not have been present at that visit. They have ample opportunity to ask questions and to make decisions together as a family and as a team.

Q Okay. And then once the -- if once they've weighed the risks and the benefits before starting them, do they actually sign the forms?

A They do. They must be signed in multiple places by all legal parents and guardians, as well as assent by those kids.

Q What about a situation where parents are divorced, but both have some level of custody over the child, or joint custody or custodial rights? How does that work with consent for these treatments?

A If parents are divorced or not together, but they have shared legal medical decision making, both parents must not only sign the forms, but be offered time and space and opportunity to ask questions of us.

Q If both parents do not consent, what happens?

A Hormonal therapy is not initiated.

Q Dr. Ladinsky, what are the hormones that you generally use for these hormone treatments in these older teens?

A For our trans ladies, those assigned male at birth with a female identity, primarily estrogen, which is taken orally. For our trans men, our trans guys assigned female at birth, testosterone.

Q Is testosterone and estrogen prescribed to nontransgender

adolescents?
A Absolutely.
Q For what purposes?
A So estrogen is used in pediatric endocrinology for -- well, both for genetic and/or metabolic congenital challenges where the body may not produce ample amounts of either hormone. It's quite common in pediatric endocrinology.
Q And what about testosterone?
A The same.
Q And how long has that been the practice, Dr. Ladinsky?
A Decades and decades.
Q Are puberty blockers and testosterone and estrogen you use in your practice, are those FDA approved medications?
A They are FDA approved medications, yes.
Q Okay. For the -- how they are used in your clinic, is that considered to be what's called an off-label use?
A It is. And off-label use of medications is very, very common in the medical profession.

In fact, the FDA recognizes that its approval gives the medical profession the peace of mind we need, that rigorous safety and efficacy trials have been done in this age group. We have that, along with 35 years of such for GnRH agonists.

But the FDA allows physicians clinical judgment and leeway to use medications in similar clinical entities.

Q Okay. And are there other examples that you can think of,

of use of medications that may -- hormones for off-label uses that's a common practice?

A That's quite common in medicine.

Estrogen in what we know as a combined birth control pill is used frequently among teenage girls, teenage young ladies to manage acne, to deal with very, very difficult, very, very heavy periods, polycystic ovary syndrome, which can induce that. Progesterone alone can be used to cease menstrual migraines. It's very, very common.

Q Dr. Ladinsky, based on your clinical experience, research, clinical experience and research in your field, what is the -- let me back up.

Let's talk about your clinical experience with your patients. What have you observed to be the benefit in your parents with the use of hormonal therapy?

A Oh, my gosh. To see gender dysphoria averted, abated, you will see a radiance, a self-confidence, but most importantly, we see teenagers who have been sullen, withdrawn, failing academically, not interested in the activities and peer groups they used to be in, join the world in ways they hadn't before.

Academic prowess soars. We see graduation. We see higher education. But most importantly, we also see youth who manifested severe anxiety and depression sometimes even self-harm and cutting to see that long gone is incredible.

Q In your clinical experience, Dr. Ladinsky, for those

patients of yours who have undergone hormone treatments, either past patients or present patients, how many of those patients have expressed regret or retransitioned to their birth sex?

A In our clinic population, those who have received medical therapy and gone on, we have seen none. It doesn't mean it doesn't happen. But in our clinic population, none.

Q Dr. Ladinsky, the use of puberty blockers and hormone therapy in transgender adolescents and teens with gender dysphoria, are those experimental treatments?

A Oh, no, ma'am.

Q Are those types of treatments, is that taught to the future doctors in medical schools as recommended care?

A Oh, it is. It is --

Q Is the -- I'm sorry. Go ahead.

A Absolutely. It's part of the standard curriculum in American medical schools per the AAMC since at least 2014.

Q Is the topic of transgender medicine, do you find that on state board exams for doctors?

A You do. You find it on -- you will find a few questions for students in graduating on their licensure exams, and it will absolutely be on the board certifying exams in several medical specialties.

Q Okay. I want to move just very briefly to the topic of gender transition-related surgeries.

Dr. Ladinsky, are any type of gender transition-related

surgeries performed here in the state of Alabama on transgender minors?

A Not to my knowledge.

Q Do the established guidelines for the treatment of gender dysphoria recommend gender transition-related surgeries for minors?

A The established guidelines recommend waiting until the age of legal majority for gender-related surgeries.

Q Okay. Dr. Ladinsky, you were here again for Dr. Hawkins's testimony this morning, and you heard Mr. Bowdre ask Dr. Hawkins about some reviews and recommendations coming out of the United Kingdom. Are you familiar are those reviews and recommendations coming out of the UK?

A I am aware of them. I'm not familiar with them in intimate detail.

Q Why don't you follow those recommendations and reviews more closely?

A Recommendations coming out of the UK and some of the other countries are quite applicable to refining best practices, selecting patients appropriately and judiciously within the health care systems of those nations.

The health care system in the United States is very, very different from the United Kingdom. Our decentralized system of health care allows for those 55 very high level subspecialty pediatric academic settings to evaluate and manage gender

dysphoria.
Q And just to make sure it's clear, when you're talking about the system being decentralized and 55 treatment centers, I believe you said the United Kingdom -- were you referring to the United States?
A I meant the United States, yeah. The United Kingdom has one.
Q Okay. Dr. Ladinsky, based on your general understanding, what do you know about the efforts to either narrow or expand access to blockers or hormones in the United Kingdom?
A I know that the United Kingdom is not just formally recommending, but working very hard to design and implement wider-spread subspecialty centers of excellence to expand access to that care appropriately.
Q All right. Dr. Ladinsky, are you familiar -- I will just say you're familiar with SB 184 which was the law, of course, that we are here about today?
A Yes, ma'am, I am.
Q Has the American Academy on Pediatrics taken a position on SB 184?
A They have.
Q Has the Alabama chapter taken a position on SB 184?
A Oh, indeed they have, and both have condemned it.
Q Okay. And if you could look Plaintiffs' Exhibit 30 in the plaintiffs' exhibits, is that actually the written position

statement by the American Academy of Pediatrics and the Alabama chapter on this law?

A I'm getting there. It is.

Q If you could turn also, Dr. Ladinsky, to Plaintiffs' Exhibit 31?

A Okay.

Q Have other state medical associations' chapters taken a similar position to the American Academy of Pediatrics opposing SB 184?

A Absolutely. This exhibit portrays the formal statement made by the Alabama Psychological Association. They were also very active with us --

Q Okay.

A -- in, you know, advocating against this bill of the Legislature. As well, I don't see it here, but the Alabama chapter of the American Academy of Family Practice.

Q Okay. If you could turn to Plaintiffs' Exhibit 19, please, Dr. Ladinsky.

A Okay. I think I got it. There you go.

Q You there?

A I think so. Yep.

Q Okay. Dr. Ladinsky, are you familiar with this document, Plaintiffs' Exhibit 19?

A This is the Yale, yes, ma'am.

Q What is this document?

A So this document was released very recently by a compendium of three mental health and medical professionals in front line care who provide the same gender care that we do, as well as an attorney, to analyze point by point, aggregate all of the data and evidence in this nation to sort of illustrate and articulate how the evidence-based standard of care practices are contradicted and -- by both the Alabama VCCAP law, as well as the Texas Attorney General's opinion.

Q And you said that there are three mental health care providers. So were there three other medical doctors, pediatricians, endocrinologists?

A Correct.

Q So six --

A There are six.

Q -- there are scientists, and doctors, and MDs, and Ph.D.s total?

A Six clinicians, scientists, medical providers, and one attorney.

Q Okay. In this document, do the authors also cite a number of peer-reviewed studies that contradict some of the supports or the principles that the State articulated as the reasons for SB 184?

A They do. A considerable compendium of them.

Q All right. Dr. Ladinsky, if SB 184 goes into effect, what impact will that law have on medical providers in Alabama who

treat transgender youth?

A For the medical providers, which is myself, my teammates, this will force us into a place of risking a felony conviction for providing evidence-based standard of care medicine, or turning our backs on our Hippocratic Oath and literally doing harm.

Q Dr. Ladinsky, what impact will this law have on transgender youth here in Alabama who suffer from gender dysphoria?

A For those who are not yet receiving medication, but one day live in that hopes of doing so, or of their families knowing that there is care for them, if that becomes needed, you will see an escalation of mental health challenges, and you will see families with levels of stress that are inexplicable and unfair.

For youth who are already receiving these medications, this would be an unprecedented ask of us to abruptly stop that care and treatment, which is medically contraindicated, especially in the place with testosterone. That is a medical contraindication. No matter the use. You don't just stop that. That will take these youth to very dark places. And we are fully aware of many of those places from which they came.

You will have colossal mood swings, mental health decline, the potential for self-harm, and possible suicidality. This is not even a hypothetical.

One year ago, when the Arkansas Legislature enacted this law over the Governor's veto, in the seven days following that override, my counterpart there had five of her youth show up at that emergency room with severe suicide attempts. The final one, that young man was in an operating room for ten hours with two different teams of surgeons to save his life.

We're Alabama. We're better than this.

Q Thank you, Dr. Ladinsky.

CROSS-EXAMINATION

BY MR. LACOUR:

Q Good afternoon, Dr. Ladinsky. My name is Edmund LaCour. I am here on behalf of the State defendants.

A My pleasure.

Q It sounds like you are strongly opposed to SB 184; is that fair to say?

A It is.

Q Why did you drop your challenge to that law on April 15th, 2022?

A Under advisement of counsel, I did so.

Q And -- okay. Do you still oppose the law even though you're not challenging it?

A Yes, sir.

Q All right. And do you know who Jeff Walker is? Jeffrey Walker?

A I do.

Q In full disclosure, I am not asking you to disclose anything that's not already in the public record. Did you appear on a YouTube video with him on April 8th, 2022, for a livestream press release run by the human rights campaign in response to SB 184?
A I'm not aware of that.
Q All right.
A I would be happy to see it.
Q One moment. Let me -- we may get to that in a moment.
A Okay.
Q So you were here for Dr. Hawkins's testimony; is that correct?
A I was, yes.
Q She was unable to define sex for us. Do you recall? She was asked to define sex and said she was not able to do that?
A I don't recall that.
Q Okay. Well, would you be able to provide your definition of sex just so we can be working with the same definitions?
A In the context of the youth with whom we're talking about and this law is directed to, we talk about sex assigned at birth, which is a combination of physical attributes when a baby is born, as well as, if needed, what we call the genotype, the genetic makeup of that individual.
Q Okay.
A As far as sex chromosomes, XX/XY.

Q Okay. And those are not things that can be changed, are they, the genotype?
A No.
Q Okay. Now, we've talked a little bit today about what's experimental, perhaps. What would -- in your view, what would you say constitutes experimental medicine?
A In a center such as the one where I practice?
Q Just generally.
A Just generally. An experimental treatment would be a drug or an -- a medical intervention that is part of a very, very tightly controlled clinical trial, a trial that has been granted, you know, granted a yes or no -- granted the ability to do so by an institutional review board, which strictly upholds the ethical rights of human subjects. So to us, an experimental treatment is a treatment that is being studied in a very tightly controlled clinical trial.
Q Would one reason you would be studying this type of treatment would be to determine what the risks might be of the treatment course?
A Possibly. But generally it's more about efficacy.
Q Okay. But with any drug, right, I mean, there are going to be benefits and there are going to be risks, correct?
A That's a fair statement.
Q And so whether it should be made available or prescribed to someone would turn both on the potential benefits and the

potential risks, correct?
A Correct.
Q Would you consider a medical treatment to be well established if its risks are unknown?
A I think there are many, many, many medical treatments that are well established with a long track record of critically studied safety and efficacy, but there may still be long-term effects that are not completely known.
Q Okay. So there can be well-established treatments with unknown risks?
A I feel there can, yes. And that's all information that is discussed with -- in my situation as a pediatrician -- parents and families, you know, if that -- if the choice is to consider that medication, yes.
Q Okay. Now, you submitted a declaration in this case, did you not?
A I did.
Q You didn't cite any research in that declaration, did you?
A That I have personally been a part of?
Q Any studies or research whatsoever in the declaration?
A I don't believe so.
Q Okay. Did you review any studies or literature reviews or other research in putting together the declaration?
A We're continually doing that. It's part of our job.
Q Okay. I think you did reference one study a moment ago

when Ms. Eagan was questioning you, the -- from the AAP. It's their policy; is that correct?

A Oh, yeah. We did touch on that. It's an exhibit.

Q Yes. I think Plaintiffs' Exhibit 32.

Could you turn with me to Defendants' Exhibit 2?

A Do I have --

Q Probably --

A Is that it?

Q That might be it. Ours had a blue piece of paper on the front. So if you see blue --

A It's blue. Yep. Defendants' exhibit list.

Q Thank you.

A Which one, sir? I'm sorry.

Q Number 2.

A Number 2?

Q Yes, ma'am.

A Gotcha. Okay.

Q So if you will turn to page 100, going by the blue numbers at the very top of the page.

A Okay.

Q Okay. So are you looking at an article by James Cantor entitled Transgender and Gender Diverse Children and Adolescents, Fact Checking of AAP Policy?

A It appears to be.

Q Great. And I will put this on the Elmo, as well.

A Oh, great.
Q The highlighting is mine.
A Okay.
Q But if you see that first sentence, the American Academy of Pediatrics, AAP, recently published a policy statement entitled Ensuring Comprehensive Care and Support For Transgender and Gender Diverse Children and Adolescents.

Is that the same study you were referencing when you were talking to Ms. Eagan?
A Yes, sir, it is.
Q I will continue. Skipping a couple of lines.
A Okay.
Q Although almost all clinics and professional associations in the world use what's called the watchful waiting approach to helping transgender and gender diverse GD children, the AAP statement rejected that consensus, endorsing only gender affirmation. That is, where the consensus is to delay any transitions after the onset of puberty, AAP instead rejected waiting before transition.

With AAP taking such a dramatic departure from other professional associations, I was immediately curious about what evidence led them to that conclusion. As I read the works on which they based their policy however, I was pretty surprised, rather alarmed, actually. These documents simply did not say what AAP claimed they did. In fact, the references that AAP

cited as the basis of their policy instead outright contradicted that policy, repeatedly endorsing watchful waiting.

Did I read that correctly?

A You did.

Q Are you aware of whether AAP ever responded to this article?

A I am not, sir. I have not seen this before.

Q Okay. Now, Dr. Ladinsky, are you aware of Sweden's National Board of Health and Welfare and the statement they put out in February of 2022?

A I am not intimately apprised of that.

Q Okay. Could we turn to Defendants' Exhibit 11? Specifically to page 3.

A Okay.

Q I will put it up here again. You see the part that I marked with my pen. I will represent to you that this is that document from Sweden's National Board of Health and Welfare.

It states, For adolescents with gender incongruence, the board deems that the risk of puberty-suppressing treatment with GnRH analogs and gender-affirming hormonal treatment currently outweigh the possible benefits, and that the treatments should be offered only in exceptional cases.

Did I read that correctly?

A You did.

Q And are you aware of this position out of Sweden?
A I confess that I am not intimately associated with the position statements of other nations. Their health care systems, as I've said, are very different than ours.
Q Uh-huh.
A But I'm acquainted with ours.
Q So I mean, based on the statement, would you conclude that the Swedish Board of Health and Welfare would deem puberty blockers cross-sex hormones to be well-established treatment for gender dysphoria in youth?
A I could not comment on the truth or falsity of that statement based on what I'm seeing.
Q Thank you.
So you said earlier that treatment with puberty blockers and cross-sex hormones for gender dysphoria youth is well established; is that correct?
A Yes.
Q When did it become well established?
A Well, tell me what you -- give me your definition of well established so I can make sure we're --
Q Perhaps --
A -- the same.
Q -- the definition you used earlier.
A Sort of becoming evidence-based guideline-driven standards of care.

Q Sure.
A Okay. So this work has been done in pediatric academic centers in the U.S. since 2006. The guidelines issued by the pediatric endocrine societies around, you know, specific to pediatrics really fine tuned what we call the guardrails or the standards of care along with WPATH probably by about 2010.
Q Okay.
A Roughly.
Q Did you hear the discussion earlier about the WPATH guidelines? And would you say that they are well established when the WPATH guidelines were released, I believe it was 2011 or 2012, the current version?
A The current version standards of care. I think they were, you know, getting to that place, but I'm still -- you know, the term well established is very relative.
Q Would they have been experimental back then?
A No.
Q No. Okay.
A Okay.
Q But they were established enough even though at the time they found rates of desistance of as high as 80 percent. Is that your position?
A That 80 percent figure applied to youth before entrance to puberty. That's my -- that's my recollection of that.
Q You talked about some of the positions AAP has taken,

particularly SB 184. Do they wade into other potentially controversial issues sometimes?

A I'm not aware of what you mean by that.

Q Are you aware of whether AAP has taken a position as to whether adolescents should have access to abortion without having to inform their parents?

A I am not aware of that. I do know that the American Academy of -- the American Academy of Pediatrics absolutely views itself as a non-political physician association. And I'm not aware of that stance.

Q Do you think they represent the views of all pediatricians?

A I don't think anyone can represent the views of everybody who's a member of their association or group. I think they do a phenomenal job in refining and prescribing evidence-based standards of care.

Q So I think you said earlier that you've treated about 450 patients for gender dysphoria; is that right?

A I think.

Q Correct me if I'm wrong.

A We've touched the lives of about 400 to 450 patients referred to us or who we've met in the hospital and followed since we opened in 2015.

No more than a third of them, though, have received medication relative to gender dysphoria, at least the type that

are discussed in SB 184.

Q Okay. What's the youngest age for which you have prescribed puberty blockers?

A Remember that it is relative to the age at which that youth, with persistent dysphoria, et cetera, is at a physical Tanner 2 staging with definitive entrance to puberty.

For someone assigned female at birth, that's going to happen earlier. And there may be, I think, 11 years, is probably the earliest.

Q Okay. What percentage of children who you have prescribed and who have taken puberty blockers have gone on to take cross-sex hormones?

A The majority of them.

Q Would you say it's sort of in the 75 percent range, or the 90 percent range, or the 50 percent range?

A I'm going to have to estimate for you, and I will tell you why in just a second. But I would estimate it's more like 85 percent.

In the state of Alabama, the majority of youth presenting to our clinic, especially in our early years, really having not had the opportunity to take advantage of this and also given some of our more Alabama norms, et cetera, have realized at later ages, or have not had the chance to access this medicine.

So the vast majority of our patients initially presented to us as older adolescents. We now have kind of the first

cohort of younger youth who are eligible for blockers and who are transitioning over. It's at least 85 percent, if not higher, considerably, yeah.

Q That's helpful.

THE COURT: Mr. LaCour, when you get to a stopping point, we will take a ten-minute break.

MR. LACOUR: I will be looking for one, and I will try to take one shortly, if that's okay.

THE COURT: All right.

BY MR. LACOUR:

Q Has UAB clinic performed double mastectomies on any transgender youth?

A Before the age of legal majority?

Q Correct.

A Absolutely not.

Q Okay. So and why not?

A It is not -- it is not indicated per the guidelines of our profession that surgical procedures are taken before the age of legal majority. It is also not covered by the major insurers in the state of Alabama. But it is the best care for these youth, we feel, in our clinic setting that surgical interventions are not undertaken before the age of legal majority.

Q And why is that?

A Youth must be at a level of maturity. And their families

would agree that they need to be at an age where they consent legally to their own care before a very permanent intervention is undertaken.

We agree with the guidelines recommendation in waiting until the age of legal majority.

Q Because there are potentially permanent and irreparable harms that could occur from a transition surgery?

A That's a fair statement.

Q Are there any potential irreparable harms that could occur from starting a child on puberty blockers and then continuing them on cross-sex hormones?

A There are side effects to any medication regimen, but we do not see these medical initiatives in that way. They're small side effect risks.

Q What about fertility?

A We don't see them in the same way at all.

Q What about permanent loss of sexual function?

A Great question. Puberty-blocking medications, when introduced at Tanner Stage 2 and used in a short-term way, there's excellent longitudinal data to bare out that loss of sexual function is not part of the long-term picture.

Q What do you mean by short term?

A One to three years.

Q And you said you had some kids who were taking it for up to two-and-a-half years?

A One to three years, yes.
Q What if they then move from puberty blockers to cross-sex hormones?
A Correct. Then, you know, there are -- we get -- we go from puberty blockers to cross-sex hormones.

So they will only go through one puberty. And their mental health in our estimate, after rigorous, rigorous time and work, will be absolutely enhanced by it.

Could there be longer-term risk, potential risks to fertility? It is possible. They're mild. But long discussions are held around this. The informed consent process is huge.
Q And what about sexual function? If a child never goes through natural puberty and goes through the puberty of the opposite sex --
A Uh-huh.
Q -- I mean, how does that affect their ability for sexual pleasure, for intimacy, for example?
A We do not see longer term problems with that. It may not happen in the conventional ways, but there is, you know, the presence of tissue that underscores that, that is not harmed.

And, you know, the majority -- all of our youth basically enjoy age-appropriate developmentally healthy relationships because their mental health allows it. We have not seen long-term problems in this.

Q Is it your position that there is no risk of fertility loss?
A That is not my position. My position is especially in the use of estrogen for a trans woman, someone assigned male at birth, there is a small risk of, you know, like lessening or possibly impairing future fertility.
MR. LACOUR: I apologize, Your Honor. If I could have a few more minutes, I think we will be at a stopping point.
THE COURT: I'm not trying to end your cross. I was just going to take a break and let you continue. But you define your own stopping point.
BY MR. LACOUR:
Q If you would turn to Plaintiffs' Exhibit 41. I think we talked about this earlier. This is the informed consent form from your clinic, I believe. Please confirm that for me.
A I have to get there. It's all the way at the back.
Okay. 41 is -- 41 is not this. It's Sydney's essay.
Q Plaintiffs' - I think you have the defendants' binder. You can look at the plaintiffs' binder.
A Okay. I will look at this. I'm sorry. I was in the other one.
Okay. I can see it right here.
Q Great.
A Uh-huh.
Q Does this look familiar to you?

A It does.
Q If I represented that this was --
A Yes.
Q -- the informed consent form?
A Uh-huh.
Q Let's look at some of the highlighted portions.
A Yeah.
Q First, I know that my body will make less testosterone, androgen, or male hormone. This may affect my sex life in different ways and future ability to cause a pregnancy.
Did I read that correctly?
A You did.
Q The options for sperm banking have been explained to me?
A Correct. Yes.
Q Let's go down a couple more lines.
A Okay.
Q I know I may not be able to achieve or maintain an erection for penetrative sex.
Finally, I know this treatment may but is not assured to make me permanently unable to make a woman pregnant.
A Correct.
Q So there are risks of infertility from these treatments, is that correct?
A There are, correct.
Q Permanent irreversible damage, correct?

A Correct. And you see it right there in the informed consent form. These are difficult discussions, but they're lengthy, and they're had over time.
Q If a natal female who is 17 --
A Uh-huh.
Q -- cannot provide informed consent to a mastectomy, how could a 14-year-old boy who is maybe just beginning puberty consent to giving up his ability to ever have sexual intercourse?
A We would not be starting -- in our clinic and in how we do what we do in Alabama, we're not starting these medications on a 14 year old. But to get to the larger question, which is an excellent one, for the initiation of hormonal therapy, regardless of that patient being 17 or 15, parental informed consent is actually what this form requires legally, and then the youth will assent.
Q Why couldn't a parent consent to her natal female child's double mastectomy?
A I suppose she could if she wanted to, but she would not find that care in my institution.
Q Okay. Well, how, then, is it that a mother could consent to her natal son, her natal 15-year-old child's potential loss of ability to ever father a child of this person's own?
A So, first of all, you have highlighted the options for sperm banking have been explained to me. And many of our young

ladies do elect that option. And we help facilitate that care for them. So they can bank gametes.

If they one day want that potential to be there and, you know, realize -- and then we have, you know, significant discussions about this.

Q Do you think a child is able to fully comprehend what it might mean to not have sexual intimacy if that child has never had sexual intimacy, they've never been through puberty even because they have been put on puberty blockers?

A I think it's individualized. But remember that in this nation, and remember that the care that we're giving is a very, very robust risk-benefit analysis.

These are some of the risks. They are not 100 percent guaranteed to happen.

And then that has to be weighed with this family, the entire team, mental health, around the gravity of that person's gender dysphoria relative to their incongruence. That's the decision that's being made in a very longitudinal robust way. It's a risk benefit.

Q You had a 16-year-old girl who came to your clinic, natal female, cisgender, every female in her family has received female circumcision, and she is greatly distressed because she is the only one who is not.

A Uh-huh.

Q She is convinced that receiving this procedure would

alleviate these concerns and allow her to fit in better with her family and her peers. Could she consent to that procedure?
A In the United States, no.
Q Through a medical ethical sense, could she provide informed consent to that procedure?
A She could only provide informed assent. Youth under the age of legal majority for any surgical procedure in the United States requires the consent of their parents or legal guardians.
Q If the parents were also on board with this procedure from a medical ethical perspective, could that consent be provided for female genital circumcision?
A Regardless of whether the consent was provided or not, that procedure in the United States is contrary to the standards of care for pediatric surgeons, or urologists, or plastic surgeons. That procedure is not performed in this nation.

It is judged that the harm outweighs the benefit. And that is how the American system, the American surgical associations have judged it.
Q It's also how the federal government has judged it, correct?
A I'm not informed on the federal government's stance to female genital mutilation. I'm sorry.
Q Are you aware have any states have banned the procedure?

A I'm sorry. What?
Q Are you aware of whether any states have banned that procedure?
A I am not. I would believe it's banned throughout the United States. It's not standard-of-care medicine.
Q All right.
MR. LACOUR: I think this is a good stopping point, Your Honor.
THE COURT: Excellent. All right. Let's take a ten-minute break.
(Recess.)
THE COURT: Let's pick back up. Where are we on time?
MR. LACOUR: I will probably be done in about ten minutes.
THE COURT: Okay.
BY MR. LACOUR:
Q Thank you, Dr. Ladinsky, for being back with us.
A Of course.
Q So I wanted to touch very briefly on something you discussed with my colleague from the other side.
If you could turn to Defendants' Exhibit 1, it's in the defense booklet.
A In your booklet, correct?
Q Yes.
A Okay.

Q Or if you would like to wait, I can put it on the big screen for you.
A Can we do both? SB 184, correct?
Q Yes. Specifically, page 6, Section 4(a).
A Section 4(a).
Q Yes. And let me explain why we're turning here.
A Sure.
Q You stated earlier that if SB 184 went into effect, then youth who are on testosterone would have to stop immediately. Is that your understanding of the law?
A That is my read from Section 4, number 1, testosterone is administered by injection. So...
Q So can I draw you to some language in 4(a) that I underlined here, where it says paraphrasing a little, but --
A Okay.
Q -- for the purpose of attempting to alter the appearance or affirm the minor's perception of his or her appearance -- of his or her gender or sex, if that appearance or perception is inconsistent with the minor's sex as defined in this Act.
A Okay.
Q So, Dr. Ladinsky, if you were tapering one of your patients off of testosterone, would that be for the purpose of attempting to alter the appearance or affirm the minor's perception? Or would that be for a different purpose?
A I'm assuming that -- are you assuming that the

testosterone is being prescribed to address gender dysphoria?
Q If it had been prescribed to address gender dysphoria --
A Uh-huh.
Q -- but that course of treatment can no longer continue, and you were then trying to responsibly taper the patient off of the testosterone?
A Okay.
Q Would that be for the purpose of attempting to alter the appearance, or would that be for a different purpose?
A It was initiated for the purpose described in the law, so I would assume that administering the medication would thus be against the law.
Q Thank you.

So I mentioned earlier a livestreaming press conference from April 8th, 2022, the day the law went into effect. And you said you did not recall being a part of this human rights campaign organized press conference from just a month ago?
A I don't recall being part of a press conference, no, sir.
Q Do you recall being part of any sort of livestreaming event or videoconference call with the human rights campaign with attorneys from the National Center for Lesbian Rights or with Mr. Jeff Walker?
A I don't.

MR. LACOUR: Your Honor, at this time, I would like to admit Defendants' Exhibit 42. It's not on our list, but it is

a YouTube video of this press conference.

I believe it will show, Dr. Ladinsky, at this -- whether you define as a press conference, a livestream event. I'd like to just confirm that this is her and that it's Jeff Walker.

THE COURT: Any objection?

MS. EAGAN: I haven't seen the video, but I don't think so, Judge.

THE COURT: All right. It will be admitted.

MR. LACOUR: It will be short.

BY MR. LACOUR:

Q So, Dr. Ladinsky, does that appear to be you?

A That is a not flattering picture of me.

Q None of us have loved the Zoom age.

MR. LACOUR: Christopher, if you could hit play.

(Whereupon, Defendants' Exhibit 42 was played in open court.)

BY MR. LACOUR:

Q Does that refresh your recollection?

A It does. I'm not sure -- I don't recall it being -- anyway.

Q Sometime earlier this year?

A Evidently.

Q Okay.

A Ooh.

Q Unplug for now.

A Yeah. Thank you. Thank you.
Q I apologize for that.
A No apologies needed. That was me.
Q So you do know Jeff Walker, correct?
A I do.
Q Okay. And are you aware that he filed a lawsuit around the same time that you did challenging SB 184?
A I believe so.
Q Do you know why he dropped his lawsuit around the same time you dropped your lawsuit on April 15th?
A I do not. And I have not spoken with him in a very long time.
Q Okay. After you dropped your lawsuit, did you recruit any patients, colleagues, or doctors to join the present lawsuit?
A No. How do you mean recruit?
Q Did you reach out to any of them and suggest that they should file suit instead of you?
A No.
Q I will represent to you that yesterday your attorney, Mr. Doss, stated that the four patient plaintiffs in this case are patients of yours or have been treated by you at some point. Is that accurate?
A One of them, I believe, is on a wait list to be seen.
Q Okay.
A The others I do believe so.

Q Okay. Thank you.

Changing gears just a little?

A Sure.

Q Back to the science.

What is a normal testosterone range for a 12-year-old boy?

A It depends where that boy is in puberty.

Q Uh-huh.

A Some are at the very, very beginning. Some have not even entered. And then there are other 12 year olds who may be well into puberty. So that would be hard for me to actually say.

Q A boy who's entered puberty, what would be the normal range for him?

A I have to say I am not a pediatric endocrinologist. And I am not encyclopedic as to normals. I would know exactly where to find it.

Q Okay. I think you discussed earlier there are some natal males who suffer from testosterone deficiencies; is that correct?

A That can be, yes.

Q Okay. And would you prescribe a boy suffering from that condition testosterone if it would bring his levels up to a normal range?

A That -- so youth with this myriad of clinical challenges, or, for example, side effects secondary to medications they took for or for chronic illnesses, like inflammatory bowel

disease, Crohn's, or cancer, that work would be undertaken by our pediatric endocrinology team. I, as a general pediatrician, would absolutely refer that youth there if he was not already being seen by them.

Q Okay. With the understanding he would likely receive testosterone to bring his levels up to the levels of a normal boy?

A They would undertake the initiation of that as their clinical practice dictates.

Q Okay. If --

A That is what they do.

Q If there was a second boy who came to with you normal levels of testosterone who wanted the same dose as that first boy for purposes of raising his testosterone to abnormal levels because he's in body building and feels his muscles are too small, would you send that kid to the pediatric endocrinologist for the purpose of obtaining testosterone treatment?

A That would not be an indication for referral. And, in fact, that would be un -- I mean, that would be an unideal use of that medication, not be clinically indicated.

Q That would be a different treatment altogether, wouldn't it?

A It would.

Now, if a parent demanded to see the endocrinologist for such, as a primary care physician, I would say, I will -- I

will order that referral and allow you that consultation.
Q Okay. And similarly, using puberty blockers to treat precocious puberty --
A Uh-huh.
Q -- is also a different treatment than using puberty blockers to treat gender dysphoria, correct?
A Well, it's the same treatment given to youth.
Q How -- sorry. Go ahead.
A It's the same treatment that is given to youth at similar physiologic ages. However, the clinical entity for which it is being initiated is different.
Q I thought -- I mean, isn't it true that some children are started on puberty blockers because they're starting puberty around age four or five, if they are -- if they're suffering from precocious puberty?
A That would be, if they met the, you know, endocrinologic indications, yes.
Q So it's a very different treatment to prescribe a child suffering from precocious puberty a puberty blocker to move them into the normal range for beginning puberty than it is to prescribe a puberty blocker to a child who's starting puberty at the normal age and push him to a later age than normal for puberty; is that right?
A When both scenarios, center precocious puberty and significant gender dysphoria, both of your theoretical youth

would be at roughly a Tanner Stage 2 physiology. And they would both have medical indications for that pause button.

Q All right. And you discussed earlier the importance of parental rights, correct, or parental input in the process of informed consent and ensuring that these children are able to properly balance the risks and the benefits of puberty blockers and cross-sex hormones, correct?

A I did. Yes, that's correct, sure.

Q Now, your gender clinic also has social workers, correct?

A Correct.

Q What role do they play?

A Social workers, the biggest role they play is in working with not just the youth and family around the supports that they may need and helping them align with resources throughout the state and in their community for support when raising a transgender or gender dysphoric youth.

Q Okay.

A And all the administrative things that they do.

Q Have your social workers ever worked with a child to terminate a legal guardianship relationship between the child and his or her guardian?

A In our clinic setting, no.

Q Dr. Abdul Latif works with you, correct?

A Correct.

Q Did you participate with him on September 14th, 2021, in

on online program for the American Medical Women's Association?
A That was -- within our institution at UAB?
Q Yes.
A Yes.
Q Do you recall him -- do you recall him recounting how there are children who are transgender who do not have supportive parents who start communicating more with our social workers trying to find what is a path for them to go? One of them was actually very successful that the child made a case of changing who their guardian is and ended up coming to the clinic because of their child's advocacy?
A I recall that, and I recall that very unique case. That was the case of a young teen who actually was in a very abusive relationship within his family. I mean, he was -- if I recall, under -- he was the victim of physical abuse in that household.

He himself contacted our social worker at the time via e-mail to dialogue and to understand what supports might be available to him. As time went on, if I believe, and the abuse worsened, for I'm certain reasons that transcend this youth's gender identity and dysphoria, custody of the young man was awarded to an older sister who, as I recall, was over the age of 21.
Q Okay. And then it was with his sister's consent that he was able to begin these treatments?
A I believe so.

Q Okay.
A But there was a -- I mean, there were years in between.
Q Okay. Is that the only circumstance you can remember where a social worker helped to have a legal guardianship terminated and then the clinic treated that patient?
A That's the only situation I'm aware of. But I'm not sure, sir, to what extent.
Our social worker actually -- and I would beg to differ with the term facilitated because such reassignments is under the purview of the Alabama Department of Human Resources. Social workers don't have that power.
Q Okay. Thank you.
And once again, you are not a plaintiff in this case?
A Correct.
Q So you are not seeking injunctive relief?
A That's correct.
Q Okay. And if injunctive relief is not extended -- is extended only to the plaintiffs in this case, is it your understanding that would apply to you, as well, and you would be able to continue to prescribe these medicines?
A I'm sorry. Can you define injunctive relief?
Q Basically, the plaintiffs in this case are asking the Court to order the defendants not to enforce the law against them. You are not asking the Court to not enforce the law against you, though, correct?

A I believe that the plaintiffs are asking the Court to keep the law from going into effect. That was my understanding.

Q Okay. All right.

MR. LACOUR: I think that might be it for me, Dr. Ladinsky. Thank you for your time.

THE WITNESS: Oh, my goodness. Thank you very much.

MS. EAGAN: No questions, Your Honor.

THE COURT: All right. All right. May the witness step down?

All right. Thank you.

THE WITNESS: Of course. Thank you, sir.

THE COURT: Are we ready for the minor witness?

MR. DOSS: Yes. We will call Megan Poe, Your Honor.

THE COURT: Ladies and gentlemen, at this time, the parties have an agreement that this testimony would be heard in camera, which would mean only the attorneys and myself. And for the reasons that were put forward in the motions to proceed under pseudonym, I have granted that agreement.

So at this time, I'd ask everyone please to step out into the hall. And then the marshals will let you know when you can come back in.

Thank you.

(In camera:)

(THE FOLLOWING PORTION OF THE RECORD IS FILED UNDER SEAL AT THE DIRECTION OF THE COURT)

No. 22-11707

UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

PAUL A. EKNES-TUCKER, et al.,
Plaintiffs-Appellees,

&

UNITED STATES OF AMERICA
Intervenor-Plaintiff-Appellee,

v.

GOVERNOR OF THE STATE OF ALABAMA, et al.,
Defendants-Appellants.

On Appeal from the United States District Court
for the Middle District of Alabama
Case No. 2:22-cv-184-LCB

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July 5, 2022

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(continued)

(End of in-camera examination.)

(Recess.)

THE COURT: All right. Did I hear 15 or 20 minutes?

MR. DOSS: That is my aim, Your Honor.

THE COURT: All right. Let's proceed.

MR. DOSS: Your Honor, plaintiffs call Pastor Paul Eknes-Tucker.

PAUL EKNES-TUCKER,

having been first duly sworn by the courtroom deputy clerk, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. DOSS:

Q Would you mind stating your name for the record, please, sir?

A Paul Eknes-Tucker.

Q What's your occupation?

A I am pastor of Pilgrim Church in Birmingham.

Q And sometimes people all you Pastor Paul?
A They call me Pastor Paul, yeah.
Q How long have you been a pastor at Pilgrim Church?
A Seven years.
Q What kind of church is it?
A It's part of the United Church of Christ denomination.
Q For how long have you been a pastor?
A I've been a pastor for 45 years.
Q Did you grow up in Alabama?
A I was born in Alabama, grew up here until I finished college at Birmingham-Southern.
Q Did you obtain any education after Birmingham-Southern?
A Moved to Atlanta to go to seminar at Candler School of Theology at Emory University.
Q Have you always been with United Church of Christ?
A No. I started out as a United Methodist. That's my birth denomination.
Q All right. And were you always United Methodist before you became United Church of Christ?
A No. I was part of the Metropolitan Community Churches for the interim part between those two.
Q Over the course of your 40-plus year career as a pastor, have you had occasions where parents have come to talk to you about their child who is transgender?
A In every congregation I have served in those -- the last

40 of the 45 years, there has been either persons in my congregation that were transgender, or people in the community I served at that sought me out about issues around their transgender children or relatives.

Q And those sorts of circumstances when folks are coming to you to talk to you about their transgender children, what kind of concerns are the parents voicing to you?

A All kinds of things. Primarily, there would be religious issues. Often parents felt they could not talk to their pastors of their home churches because they weren't sure exactly how to -- this would play in their home churches, how they would feel about their child identifying this way.

THE COURT: Mr. LaCour, just to give you fair notice, I am likely to ask you the same question at the conclusion of his testimony that I asked at the conclusion of Dr. Koe.

MR. DOSS: Thank you, Your Honor.

BY MR. DOSS:

Q When parents come to you about these issues, Pastor Paul, what kind of advice do you give them?

A I try to talk about their questions, particularly around religious issues. Those are the things I feel like I can talk about. And then I try to connect them to resources in the community to whatever kinds of things they are looking to find, we try make sure they can get those resources.

Q Those resources sometimes include medical help?

A They do.
Q In the past, Pastor Paul, have you helped connect parents with transgender minors to doctors who provide gender-affirming care for patients?
A I have.
Q And generally speaking, do you understand that gender-affirming care for minors can include, for example, puberty blockers and hormone treatments?
A Yes.
Q Are you familiar with UAB's gender clinic for children?
A I am.
Q And since becoming aware of the UAB gender clinic, if you had a parent come to you telling you I have a transgender minor, would you consider recommending to that parent that the parent take the kid to that clinic?
A I would.
Q Having seen the law that we're here about today, do you have concerns that doing what you just described would run afoul of that law?
A I do. Having read the part that says that anyone who is accused of having a cause for connecting someone with a medical professional could be criminalized through this law. And that could include someone like me.
Q Have you had an occasion over your years of being a pastor to see kids who have been transgender and have received medical

help and who have flourished?
A Yes.
Q Are you aware of other clergy in the state of Alabama who share your concerns that you have expressed to me today about this particular law?
A Yes. In fact, after I was contacted to be a part of this case, I told other clergy friends and colleagues in Birmingham area, and word began to spread. And we created a letter for other clergy to sign on to about this issue, about supporting families with transgender members. And as of today, there are over 80 clergy from across Alabama who, if I couldn't have been here today, would have been willing to step into my place.
MR. DOSS: One moment, Your Honor.
All right. I appreciate your time here today, Pastor Paul. Attorneys for the State defendants may have some questions for you now.
THE WITNESS: Thank you.

CROSS-EXAMINATION

BY MR. MILLS:
Q Good afternoon, Pastor.
A Good afternoon.
Q My name is Christopher Mills, and I represent the State defendants. I thank you for being here today.
Could an individual obtain from you a puberty blocker medication?

A No.
Q Could they obtain a cross-sex hormone?
A No.
Q Could they obtain a surgery for gender transition purposes?
A No.
Q Have you advised minors or their parents that a minor should submit to any of those specific procedures?
A No.
Q Have you advised minors or their parents that their religion requires them to submit to any of those specific procedures?
A No.
Q Your medical advice is limited to suggesting that those you counsel seek professional help; is that right?
A I don't give medical advice. I try to connect folks to where the resources are.
Q You mentioned just a minute ago, when I was contacted before this lawsuit. What did you mean?
A When the attorneys asked me if I would be interested in being a part of this lawsuit.
Q And when did that happen?
A The Monday after Easter.
Q That was April 18th; is that right?
A That sounds right. I think so.

Q And before you were contacted by the attorneys, had you considered filing a lawsuit against this law?
A I was not sure how in the world to be -- to make a difference. So this was a great opportunity that I felt honored to be a part of.
Q Before you were contacted by them, you didn't think the law criminalized your ministry, did you?
A I didn't know.
Q And when the attorneys called you, what did they say?
MR. DOSS: Your Honor, I am going to object, to the extent this calls for privileged communications between counsel and him. It is privileged, attorney-client communication.
MR. MILLS: Your Honor, there was no attorney-client relationship at this point.
MR. DOSS: Communications in anticipation of creating that relationship.
For example, if I go meet with an attorney and discuss generally my problems, that can include privileged communications.
MR. MILLS: But this client wasn't seeking an attorney. The attorneys contacted him.
THE COURT: From what I have heard right now, we have got privilege. If you want to voir dire him some more and see, but from what I see, we have got privilege.
MR. MILLS: That's fine, Your Honor. I will move on.

BY MR. MILLS:

Q So after they contacted you, you agreed to become a plaintiff in this lawsuit; is that right?

A Yes.

MR. MILLS: Thank you. No further questions.

THE WITNESS: Thank you.

MR. DOSS: Nothing further, Your Honor.

THE COURT: All right. And does that conclude your witnesses?

MR. DOSS: It does, Your Honor.

THE COURT: The United States has a witness; is that correct?

MR. CHEEK: Your Honor, if I may.

THE COURT: Uh-huh.

MR. CHEEK: Throughout today, we have been trying to streamline our presentation. And so we may not have a witness. We just need to go over the evidence from today and confer with our group, if that's okay, and then make that determination. So...

THE COURT: If you are telling me you are speeding my trial up, that's always going to be okay.

MR. CHEEK: Can we have at least 30 minutes, or do we want to...

THE COURT: Is that a decision you just want to make in the morning?

MR. CHEEK: That's fine with us. Whatever the Court prefers, obviously.

THE COURT: And y'all correct me if I am wrong. It does seem like we're back on track with time. Everybody agree with that?

You know, if I take 30 minutes and then you say, no, we've waited here 30 minutes. If I take 30 minutes, and then we do call a witness, then we're here at 6:00 o'clock. I'd say it's a better use of everybody's time.

We'll call it a day today. Come back at 9:00 o'clock in the morning.

I appreciate what you have said, and that will give you plenty of time to make your mind up.

MR. CHEEK: Thank you, Your Honor.

THE COURT: So I know we have had just up and down and off and on air conditioning today. And so Judge Thompson has graciously offered to let us use his courtroom tomorrow. On the off chance that GSA gets this normalized by 8:00 o'clock in the morning, we will come back here. If they don't, we are going to go to 68-degree air and not have to suffer anymore.

So stand by, and I'm sure that my courtroom deputy will find a way to get the word out if we decide to change things in the morning.

MR. CHEEK: That is a welcome change.

MR. DAVIS: May I ask one thing?

THE COURT: Absolutely.

MR. DAVIS: If the United States does not call a witness, we are certainly prepared to begin with Dr. Cantor at 9:00 in the morning. I do not know that he will last all morning. He very well may. I think probably would.

If he doesn't, our next witness, I do not expect to be here before about 12:30. We had anticipated it would be later in the afternoon.

She's driving. She is the individual, Sydney Wright, who detransitioned. She's driving from her home near the Georgia line. I don't think I could get her here any earlier.

I'm asking the Court if it would be okay if there happens to be a gap between Cantor and this next witness of -- it should not be long.

THE COURT: How long a witness do you think that your last witness would be?

MR. DAVIS: I think my direct will be probably about a half an hour.

THE COURT: Okay. So, yeah, if you -- if we're leaving room for the United States in the event they do have a witness, and then your first witness, I think that probably works out about right, and we're still finished by 1:30 or 2:00 o'clock.

MR. DAVIS: It sounds like if the United States does call a witness, there is zero risk -- we are great with time

with both of our witnesses going tomorrow.

If the United States does not call a witness, when Cantor finishes, our second witness may not be here, but it won't be long before she does arrive.

THE COURT: That's okay. We can always slide lunch up a little bit if we need to.

MR. DAVIS: We appreciate the courtesy.

THE COURT: Absolutely.

Any other procedural matters we ought to take up today in anticipation of tomorrow?

MS. EAGAN: No, Your Honor.

THE COURT: Okay. All right. Excellent.

Well, then, I will see everybody at 9:00 o'clock again in the morning.

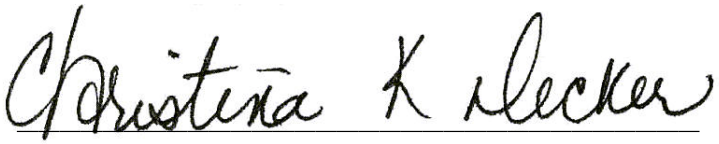
We will make the decision early about moving courtrooms. We won't make that decision at 8:59.

All right. Anyway, thank you. Have a good day.

(Whereupon, the above proceedings were concluded at 4:50 p.m.)

CERTIFICATE

I certify that the foregoing is a correct transcript from the record of proceedings in the above-entitled matter.



05-08-2022

Christina K. Decker, RMR, CRR — Date

Federal Official Court Reporter

ACCR#: 255

DOC. 105

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

REV. PAUL A. EKNES-TUCKER, et al.,	*	
Plaintiffs,	*	2:22-cv-00184-LCB
	*	May 6, 2022
vs.	*	Montgomery, Alabama
	*	9:00 a.m.
KAY IVEY, in her official capacity as Governor of the State of Alabama, et al.,	*	
Defendant.	*	

****

TRANSCRIPT OF PRELIMINARY INJUNCTION HEARING
VOLUME II
BEFORE THE HONORABLE LILES C. BURKE
UNITED STATES DISTRICT JUDGE

Proceedings recorded by OFFICIAL COURT REPORTER, Qualified pursuant to 28 U.S.C. 753(a) & Guide to Judiciary Policies and Procedures Vol. VI, Chapter III, D.2. Transcript produced by computerized stenotype.

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I N D E X

P R O C E E D I N G S

(In open court.)

THE COURT: Good morning. Please be seated.

All right. I am going to aim my question at you, Mr. LaCour.

You heard the testimony of Pastor Eknes-Tucker. What, if anything, in his testimony would trip the Alabama statute?

MR. LACOUR: Your Honor, we don't think anything in his testimony would trip the statute, as you said. The key language is does he engage in or causing the prescription or administration of puberty blockers? Is he engaging or causing the prescription or administration of the cross-sex hormones?

Clearly, he is not under the plain text of the statute, so we don't think he has standing, which I think is probably good news and bad news for him. But the good news is he is not going to be prosecuted. The bad news is he doesn't get to -- in his words -- make a difference by continuing in this case.

But that's the State's answer.

THE COURT: All right. Since he has addressed standing, anybody want to touch on that from the plaintiffs' side?

MR. DOSS: Yes, Your Honor.

Our concern remains that under this Act's language, it does capture speech for referrals, for actions by people who are counseling patients, or people who are counseling anyone to

put them in touch with medical providers knowing full well what those medical provisions may or may not be.

I think this does also feed into the void for vagueness argument, Your Honor, because the State is making these post-hoc decisions about when the statute does apply, despite its plain language and when it does not apply.

So we still think that the statute on its face is triggered. We appreciate the State's statement on the record that it doesn't think that the statute is triggered.

On the other hand, it shows just how vague the statute is, that we can't know just by reading it, which violates the Fifth Amendment rights' notice.

THE COURT: All right. One other thing that I will put the parties on notice about when we get to closings.

So I assume everybody has read the Arkansas order and transcript. Would that be a correct statement?

All right. So I would like everybody to be able to address at the conclusion of these proceedings what parts of that order, if any, that they disagree with, why, and to what degree those -- that legal reasoning is applicable here. And I know that we do have some differences in that statute.

So just put that in your back pocket, and let's be prepared to talk about that.

Okay. So I understand the United States has a witness this morning; is that correct?

MR. POWERS: Yes, Your Honor.

Before we get started, I have a quick bit of housekeeping. The United States moves to admit United States Exhibit Numbers 1 through 12.

09:11:36 MR. BOWDRE: No objection, Your Honor.

THE COURT: Be admitted.

MR. POWERS: Thank you. Now, the United States would like to call Dr. Armand Antommaria to the stand.

THE COURT: All right.

09:11:47 ARMAND ANTOMMARIA,

having been first duly sworn by the courtroom deputy clerk, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. POWERS:

09:12:15 Q Good morning.

A Good morning.

Q Doctor, could you please introduce yourself for the Court?

A My name is Armand Herbert Matheny Antommaria. I am a pediatrician and bioethicist. I am employed by Cincinnati 09:12:32 Children's Hospital Medical Center where I direct its ethics center. I'm the Lee Ault Carter chair of pediatric ethics and an attending physician in the division of hospital medicine.

THE COURT: Mr. Powers, I neglected to ask you how long you think this witness will be.

09:12:51 MR. POWERS: Well under half an hour.

THE COURT: Okay. All right.

BY MR. POWERS:

Q Doctor, do you hold an MD from the Washington University School of Medicine?

09:13:01 A I do.

Q Do you hold a Ph.D. from the University of Chicago Divinity School?

A Yes.

Q Doctor, what are your areas of specialty?

09:13:09 A As a physician, my area of specialty is pediatric hospital medicine. So I take care of general pediatric patients, patients with asthma or pneumonia, who are admitted to the hospital. And I'm also a bioethicist and specialize in pediatric clinical ethics.

09:13:31 Q Thank you.

Can you please explain what a bioethicist is?

A Bioethics is a multidisciplinary field that addresses the ethical issues that arise in medicine and the life sciences.

Q Doctor, are you board certified?

09:13:48 A I am. I am board certified in pediatrics and in pediatric hospital medicine. And I'm also certified as a health-care ethics consultant.

Q Are you part of a multidisciplinary team that provides treatment to adolescent patients with gender dysphoria?

09:14:07 A Yes. Cincinnati Children's has a clinic that provides

care for children and adolescents with gender dysphoria, and I participate in their monthly multidisciplinary team meetings, as well as consult on an as-needed basis when special ethical issues arise in the care of the patients that they treat.

09:14:34 Q And are the sorts of ethical issues that do arise when you're consulted regarding the care of transgender patients?

A At times, there are issues regarding who is able to provide informed consent, whether adult patients have medical decision-making capacity or ethical issues when there are

09:14:55 unusual risks or benefits involved in the care of a particular patient.

Q Are you involved in the development of treatment protocols related to treating adolescent patients with gender dysphoria?

A Yes, to the extent that they have ethical issues in

09:15:10 particular. I participated in the development and the periodic review of the clinic's informed consent documents.

Q Thank you, Doctor.

As part of your duties, do you consult with medical providers on the treatment of infants and children with

09:15:28 differences in sex development?

A Yes. Cincinnati Children's also has a clinic that provides care to individuals with differences of sex development. And I participate in similar ways in that multidisciplinary's team meetings both in terms of patient care

09:15:50 and in terms of gender policies.

Q Thank you.

MR. POWERS: Your Honor, the United States moves to have Dr. Antommaria qualified as an expert in bioethics and treatment protocols for adolescents with gender dysphoria.

09:16:05 MR. BOWDRE: No objection, Your Honor.

THE COURT: All right. He will be accepted for that purpose.

MR. POWERS: Thank you.

BY MR. POWERS:

09:16:11 Q Dr. Antommaria, is a diagnosis of gender dysphoria made by physicians and other medical professionals, or is it made by the patient or the parents?

A A diagnosis of gender dysphoria is made by clinicians.

Q And are there external indicators that can be evaluated as

09:16:29 part of that process?

A Yes. There are patient behaviors that can be observed that support the diagnosis such as, you know, missing school or other behaviors which can be observed that support that diagnosis.

09:16:48 Q Doctor, as part of your work, are you familiar with research studies, systematic reviews, and clinical practice guidelines in a variety of areas related to pediatric care?

A Yes, I am.

Q And are you familiar with studies, reviews, and guidelines

09:17:06 regarding treatment specifically for adolescents experiencing

gender dysphoria?
A Yes.
Q And what is the difference between research and clinical care?
09:17:17 A Research and clinical care are differentiated both in terms of their goals and their methods. So the goal of research is to generate generalizable knowledge. And the methods are the use of a protocol that defines the steps in a study.
09:17:36 Clinical care's goal is to provide benefit to individual patients, and its procedures are individualized decision making.
Q And what is the difference between observational studies and randomly controlled trials?
09:17:51 A So the two big categories of studies are observational and experimental.
In observational studies, the investigators don't control who's exposed to the intervention. The most -- one of the common forms of an observational study would be a prospective
09:18:15 observational study in which individuals who receive a treatment are followed over time to see the effects of that treatment.
In experimental studies, the investigators control who receives the intervention. Commonly in a randomized controlled
09:18:31 trial, neither the participant nor the investigator controls

who receives the treatment or the intervention or the control. People analogize randomization to a coin flip in terms of determining who receives which.

Q And, Doctor, do you have an opinion about the viability of conducting randomly controlled trials testing the use of treatment, like puberty blockers and hormone therapy, for adolescents with gender dysphoria?

A Yes, I do. I would have concerns that randomized controlled trials of these interventions would be unethical, and even if they could be ethically performed, they would have substantial methodological limitations.

Q And what are the ethical concerns first?

A In order for a research study to be ethical, particularly a randomized controlled trial, there must exist something called equipoise. The investigator must believe that the intervention and the control are each likely to be equally efficacious. And many investigators in this field would believe that there is sufficient evidence of the benefit of the use of puberty blockers or gender-affirming hormone therapy that a randomized controlled trial would not be ethical.

In addition, you would need to be sure that the study could be completed. For example, that you would have enough participants sign up to be in the study to make exposing them to the risks of the study to be beneficial. And there would be concerns that not enough participants could be recruited to

such a trial to be ethical.

Q And do you have any additional methodological concerns regarding randomly controlled trials?

A Yes. One of the key factors in a randomized controlled trial is they're what's called blinded, but neither the participants nor the investigators know whether the participants is receiving the intervention or the control.

And in a randomized control trial of this nature, it would be -- not be possible to blind investigators that are participants because they would know which -- what's called an arm, which arm the participant is in by the development or lack of development of secondary sexual characteristics. So such a randomized controlled trial would be of substantially less value.

Q Thank you.

Now, what's the difference between a systematic review of the literature and a clinical practice guideline?

A So in a systematic review of the literature, the individual will collect all of the evidence and -- relevant to a particular outcome and grade the quality of that evidence.

Systematic reviews of the literature, however, do not make treatment recommendations. Just because the level of evidence for intervention might be low doesn't mean that that intervention should not be used.

A clinical practice guideline both evaluates the quality

of the evidence, makes treatment recommendations, and grades the quality of those recommendations, because there are many other factors rather than in addition to the quality of the evidence that need to be considered in making treatment recommendations.

09:22:09

Q Doctor, can a clinical practice guideline be based on the results of observational studies?

A Yes, they can. And frequently in pediatrics, clinical practice guidelines are based on observational studies, because unfortunately there are fewer randomized controlled trials available in pediatrics than in adult medicine.

09:22:27

So other Endocrine Society guidelines for other pediatric conditions like congenital adrenal hyperplasia or obesity are largely based on observational studies. And even treatment guidelines for important crucial things, such as the American Heart Association's guidelines for performing CPR in children, are largely based on observational studies.

09:22:50

Q I think you might have mentioned one of them already, but what guidelines help establish the standard of care when treating adolescents with gender dysphoria?

09:23:08

A The two predominant clinical practice guidelines for treating adolescents with gender dysphoria would be the Endocrine Society's and WPATH's.

Q Thank you.

09:23:23

Is the level of evidence supporting these puberty blockers

and hormone therapy in these guidelines comparable to the level of evidence for other treatments in pediatrics?

A Yes.

Q Doctor, are you familiar with the European policies, with respect to treating adolescents diagnosed with gender dysphoria?

A I am.

Q And could you please summarize your understanding of that?

A So in part, particularly reference has been made to the Swedish policy. That policy is only available in an official English translation of a three-page summary.

So it's difficult to fully evaluate these policies, given the limited amount of material that's available in official English translation.

But my understanding of the policies are that they have reviewed the literature, but they use less robust methods than the Endocrine Society, because they neither grade the evidence nor the strength of their recommendations, and that none of the policies instantiate a ban on gender-affirming health care, the use of puberty blockers or gender-affirming hormone treatment.

Q Thank you.

Doctor, are you familiar with the provisions of Senate Bill 184?

A I am.

Q Are the provisions of Senate Bill 184 consistent with the

guidelines issued by any country in Europe?
A No.
Q Doctor, once a diagnosis of gender dysphoria has been made, how does the informed content process work in the pediatric context?
A In the pediatric context, parental consent is required -- in general, parental consent is required for treatment.
Adolescents should participate in medical decision making to the extent that it is appropriate, and for adolescents, their assent should also be sought.
And the informed consent process requires a discussion of the potential benefits, risks, and alternatives of the treatment.
Q Doctor, do you have an opinion as to whether puberty blockers and hormone therapy treatments have benefits to some adolescents diagnosed with gender dysphoria that outweigh the potential risks?
A Yes. That for some individuals with gender dysphoria the benefits of treatment outweigh the risks.
Q And what role does desistance play, or what our friends have referred to as desistance play in your analysis?
A So in evaluation of the risk, if treatments are discontinued, there may be effects of those treatments, which are only partially reversible. But that is only one of the factors that needs to be weighed in the risks and benefit

analysis. And that the evidence about the current rates of desistance are that it is sufficiently low, that that would not be in general a reason not to proceed with treatment.

Q Thank you.

09:26:43 Is there high quality evidence supporting the alternative of psychotherapy alone, so without the assistance of puberty blockers and hormone therapy? Is there high quality evidence supporting that as a treatment for gender dysphoria in adolescents?

09:27:03 A I am not aware of any randomized controlled trials of psychotherapy alone for the treatment of adolescents with gender dysphoria.

Q As an ethicist, do you have an opinion regarding parents and adolescents' ability to adequately understand the potential

09:27:23 cause and benefits in giving informed consent to the provision of puberty blockers and hormone therapy?

A Although this decision involves a complex set of risks, benefits, and alternatives, it is comparable to other decisions that parents and their children make in pediatric health care

09:27:42 on a frequent basis.

Q And in the instance that there was a medical provider who violated their ethical obligations to their patients with respect to obtaining informed content, are there forms of oversight in place?

09:27:57 A There would be multiple mechanisms to address those

potential shortcomings. If that provider worked for a health-care institution, they would be credentialed by that institution. The institution would have a responsibility for oversight of their practice.

09:28:14 The state medical board could review their practice and potentially discipline them or withdraw their license.

And although I am not a lawyer, it's my understanding that there would be the potential for malpractice claims for inadequate informed consent.

09:28:32 So there are multiple mechanisms that exist to address the case in which somebody obtained inadequate informed consent.

Q So there are other mechanisms in place other than a direct ban on the treatment itself?

A Yes. I'm sorry. You're correct.

09:28:48 Q Doctor, I would like you to consider a circumstance where adolescents no longer have access to puberty blockers or hormone treatments. Are there any equally effective alternative medical treatments for adolescents with gender dysphoria?

09:29:03 A There are not.

Q Is there an ethical basis for distinguishing the provision of treatment to minors experiencing precocious puberty, from transgender minors experiencing gender dysphoria?

A There is not.

09:29:19 So in particular, the type of evidence for both treatments

are the same. The evidence supporting the use of puberty blockers for the treatment of central precocious puberty are also prospective observational trials with relatively small numbers of participants.

09:29:42 There are no randomized controlled trials to support the use of puberty blockers for central precocious puberty.

Q Compared to treatments in other contexts, is there anything about treatments for adolescents with gender dysphoria that would require prohibition by the State from an ethical

09:29:58 perspective?

A No.

Q And last question, Doctor. What are the ethical implications for medical providers treating minors diagnosed with gender dysphoria if Senate Bill 184 is implemented?

09:30:11 A They would be unfortunately placed in the untenable position of either violating their ethical obligations to their patients to conform with the law, or fulfilling their professional duties to their patients and being criminally charged.

09:30:28 MR. POWERS: Thank you. No further questions.

THE COURT: Cross?

CROSS-EXAMINATION

BY MR. BOWDRE:

Q Good morning, Dr. Antommaria. My name is Barrett Bowdre.

09:30:53 I represent the State defendants.

A Good morning.
Q You agree, don't you, that most individuals who experience gender dysphoria in childhood desist?
A The evidence would support that individuals who experience
09:31:18 gender dysphoria at young ages such as three or four, that the majority of them do desist.
Q You noted that the goal of clinical practice is the individualized assessment in providing care for the individual patient that you're treating. But no clinician can accurately
09:31:45 predict whether the patient sitting in front of him will persist in their gender dysphoria or will, as the majority do, desist; isn't that correct?
A So at the point of evaluating an adolescent, the desistance rate is substantially smaller than it is for the
09:32:11 desistance rate of young children, and that there would be the ability to be fairly certain that they are unlikely to desist. But expecting perfection in the practice of medicine and being able to predict with 100 percent certainty is unrealistic because there's nothing in health care that can occur with 100
09:32:36 percent certainty.
Q Can you predict with 80 percent certainty whether the individual patient sitting in front of you will persist or desist in his or her gender dysphoria?
A The evidence of which I am aware would suggest that the
09:32:53 desistance rate is -- for adolescents is substantially less

than 80 percent. If the desistance rate for adolescents -- I apologize -- is substantially less than 20 percent.

Q Is that for adolescents who are treated with puberty blockers, or adolescents who are not treated with medical interventions?

A The most robust data that is available are adolescents who are treated with gender-affirming health care.

Q So can you tell with 80 percent certainty whether an individual patient, an adolescent who is not treated with puberty blockers, would desist or persist in the gender dysphoria?

A So the evidence base in that area is less robust, but the evidence of which I'm aware would still suggest that the desistance rate for individuals who are adolescents is less than 20 percent.

Q And what studies do you rely on to say that it's -- I mean, for adolescents -- we're talking about a 12 or 13 year old who has entered what, Tanner Stage 2 of puberty; is that correct?

A Correct.

Q Okay. So what evidence do you rely on to say that without treating with puberty blockers the group who are not treated there's a more than 80 percent likelihood that the individual patient is going to desist to that point?

A So I would say that that is based on -- so I am not aware

of a specific prospective observational trial that answers your question, but that experience in the field would suggest that that -- the desistance rate is low.

Q And what is that experience?

09:34:47 A Of the clinicians who provide care to this patient population.

Q I guess my question is -- I'm trying to figure out -- I understand that the majority of children who are started on puberty blockers go on to cross-sex hormones. Is that true?

09:35:02 A Can you restate your question?

Q The majority of children who are -- who start on puberty blockers will then go on to take cross-sex hormones; isn't that right?

A Correct.

09:35:16 Q Okay. And so my question is: If a child does not start on puberty blockers, what degree of certainty can we say that the gender dysphoria would go away? And we are talking about a Tanner Stage 2 adolescent.

A So I would differentiate the likelihood of them desisting

09:35:42 from the quality of evidence that supports that claim. The likelihood of them desisting based on the available evidence would be that it would still be infrequent, the evidence is -- would currently be based on expert opinion of individuals who provide that care.

09:36:01 Q Okay. So there are no studies to support that claim; is

that right?
A I'm not aware of a study on that specific question.
Q Okay. Would you agree that the combination of puberty blockers and cross-sex hormones -- let me start over.
09:36:24 Because you testified that most children who begin on puberty blockers go on to cross-sex hormones, wouldn't it be reasonable when we're talking about the risks to view those together?
A No.
09:36:42 Q Why is that?
A Because they occur at separate periods of time. So that informed consent is obtained for the use of puberty blockers, there are ongoing conversations about the efficacy of that treatment and the individual symptomology, and a separate
09:37:01 detailed informed consent process is obtained prior to the start of gender-affirming health care.
Q But wouldn't it be relevant to a parent or a child determining whether to start puberty blockers to know that almost everyone who starts on this treatment goes on to
09:37:18 cross-sex hormones?
A It would be relevant for parents to know that the clinical practice guidelines for the treatment of gender dysphoria generally recommend treatment with puberty blockers followed by treatment with gender-affirming hormone therapy.
09:37:42 Q Okay. My question was: Wouldn't it be relevant for them

to know that almost everyone who starts on puberty blockers then goes on to cross-sex hormones?

A I don't believe that that would -- that category of information would be relevant. I don't know that that specific framing would be useful and informative to patients.

Q Okay. So you do not think that the --

THE COURT: Hold on a minute, Mr. Bowdre.

Ladies and gentlemen, let me say this: If you are sitting in the audience and you're head nodding or you're mouthing words and looking at the witness, please stop that, because that could give the appearance that you are trying to influence the witness.

So let me just put that out there. Please follow my guidelines on that.

I am not suggesting that you are being influenced by anyone out here, but it's possible that someone might want to influence you.

So go ahead, Mr. Bowdre.

MR. BOWDRE: Thank you, Your Honor.

Could you read the last question? I'm sorry.

(Whereupon, the Court Reporter read back the pending question.)

BY MR. BOWDRE:

Q Would you agree that there are substantial risks involved in someone starting puberty blockers and going on to cross-sex

hormones?
A There are risks involved in the treatment course for the treatment of gender dysphoria.
Q What are some of those risks?
09:39:39 A Can you be more specific? Of the entire course of treatment, or particular parts of the treatment?
Q The entire course of treatment.
A So I would disaggregate the risks of puberty blockers from the risks of gender-affirming hormone therapy and the risks of
09:40:06 testosterone therapy are different from the -- or are somewhat different than the risks of estrogen therapy.
Would you like me to review all of that.
Q Let me just ask you a couple of those.
Would you agree that some of the risks of puberty blockers
09:40:18 and cross-sex hormones would be loss of fertility?
A There is a risk of impaired fertility.
Q Okay. Would you agree that a risk would be loss of sexual function?
A Particularly the use of testosterone therapy has a risk of
09:40:42 changes in sexual function. I apologize. The use of estrogen therapy in -- has a risk of alterations in sexual function.
Q So if someone cannot predict with very much accuracy whether gender dysphoria will desist, then you cannot predict whether the interventions will help or harm that person; is
09:41:20 that true?

A No, that is not true.
Q Why is that not true?
A Because there is sufficient certainty that gender dysphoria will persist to have a discussion about the potential
09:41:37 benefits and risks of treatment.
Q Okay. So if it were the case that one could not tell with much accuracy whether the, you know, 11 or 12 year old at Tanner Stage 2 sitting in front of you, whether that person's gender dysphoria would desist, assuming that, then is it true
09:41:56 that you would not be able to know whether the intervention treatments of puberty blockers and the cross-sex hormones would be helpful or harmful to that person?
A So it would depend on how much uncertainty there was, and that would likely be information that was relevant to the
09:42:24 informed assent discussion and the parents' decision about whether to proceed with treatment.
Q What if you were 40 percent sure that the -- that the child would persist, then could you tell whether the interventions would be helpful or harmful?
09:42:52 A It -- so part of -- so do you mean 40 percent sure that your prediction of their likelihood of persisting was accurate, or do you mean that their likelihood of persisting was 40 percent?
Q I'm sorry. Let's assume that you are -- that you -- that
09:43:18 it is 40 percent accurate that the person sitting in front of

you is going to persist. The person has a 40 percent chance of persisting.

A Then in that hypothetical case, there would be less justification for proceeding with that course of treatment. But that is a hypothetical case and not the decision that patients and their families are currently facing.

Q Okay. Dr. Antommaria, what is a detransitioner?

A So I don't know that there's a technical -- currently a widely accepted technical definition of that term, because people -- individuals use that term in a variety of different ways to mean different things.

Q Okay. Would one definition, sort of a common definition be someone who identifies or has been diagnosed with gender dysphoria, has begun puberty blockers, cross-sex hormones, and then the dysphoria desists, or for whatever other reason they realign with their biological sex and they stop the medical interventions; is that a fair overall description?

A So that is a potential definition. The one qualification I would make is if it's defined in terms of an individual who discontinues medical therapy, there may be a wide variety of reasons for individuals to discontinue their medical therapy beyond change in their gender identity.

Q And have you reviewed the literature -- let me be more specific.

Have you reviewed recent surveys of people who identify as

detransitioners, specifically Lisa Littman's and Elie Vandenbussche's? Have you reviewed those two?

A No, I have not reviewed those two.

Q Are you -- do -- let me -- I will strike that.

09:45:34 Are you aware that at least, according to one of those studies, only 25 percent of people who detransition ever tell their gender-affirming care doctors that they have detransitioned?

A I heard you state that yesterday in court. But, no, as I

09:45:54 said, I'm not aware of those particular studies.

I would say that, for example, our clinic's informed consent documents emphasize if individuals discontinue their treatment, it's very important for them to provide that information to their health-care providers.

09:46:11 Q Okay. Does the fact that some people who are diagnosed with gender dysphoria, given puberty blockers and cross-sex hormones, dramatically change their bodies, sometimes permanently, and then divert to identifying with their biological sex give you any pause that we might not be so good

09:46:32 at identifying who are good candidates for these medical interventions and who might not be good candidates?

A Can I ask what you mean by give me pause?

Q Does it give you concern?

A So I think that in this field, all the available data and

09:46:46 information should be considered in making treatment decisions.

That would be potentially relevant information that should be incorporated in an ongoing basis in treatment decisions and revisions of clinical guidelines when they're revised.

Q But you have not reviewed at least these studies on detransitioners to consider whether those would impact your clinical standards; is that true?

A So those -- so I am aware of the discussion about detransition, including the stories of individual patients who have detransitioned. The body of literature is large.

And at this point in time, no, I have not reviewed those two specific studies. If it became relevant, I would make effort to review those studies.

Q Thank you.

You do not touch on this in your testimony, but in your declaration, you spent a couple of pages talking about access to top surgery for gender dysphoric minors; is that right?

A Yes. There's reference to top surgery in my declaration.

Q Okay. In such surgeries -- we're talking about mastectomies usually; is that right?

A That's one way to characterize the procedure.

Q Okay. And they are performed on minors in at least some states in the United States; isn't that true?

A That is true.

Q Okay. At what age do you think that a -- someone can consent to a double mastectomy as part of the gender-affirming

care?
A So I would be unable to answer that in terms of an age. The relevant factor is their decision-making capacity, which only has a correlation with age, but is not specific to age.
09:48:56 Q Okay. You said in your declaration that adolescents generally possess comparable medical decision-making capacity to adults; is that right?
A So part of the question is how you define adolescents. But, yes, older adolescents generally have comparable medical
09:49:22 decision-making capacity to adults.
Q So what age are we talking about?
A So the specific study that I cited in my declaration compared 14 year olds to older adults.
Q Okay.
09:49:35 A Or to adults.
Q And you would agree that Tanner Stage 2 puberty normally occurs before age 14?
A Correct.
Q Okay. So given that adults can consent to both top and
09:49:51 bottom sex-change surgeries, why can't a 14 year old not?
A Can you restate the question?
Q Yeah. Given that adults can consent to both top and bottom sex-change surgeries, why should a 14 year old not be able to consent to those procedures?
09:50:15 A Because in general, adolescents are not permitted to

consent to medical treatment, and we rely on their parents or legal guardians to consent.

Q But why is that? If they -- you just testified that 14 year olds have comparable medical decision-making abilities to

09:50:31 adults, is it simply a matter of law that they cannot consent, or is there some basis in the literature that would require the parental consent for 14 year olds?

A So at a minimum, the legal requirement -- so informed consent is in part a legal requirement. And although there are

09:50:53 exceptions to permit minor -- some minors to provide consent for certain forms of medical treatment, parental consent is required for a variety of different reasons, not a single reason.

Q I want to read to you a paragraph -- I will go -- I want

09:51:30 to read to you a paragraph on an amicus brief to the American Psychological Association, the American Psychiatric Association, and the National Association of Social Workers did in a case called Miller vs. Alabama.

All right. And so this is the amicus brief. And I am

09:51:50 going to flip to page 12.

In highlighted portion, paragraph 3, it says, Finally, juveniles differ from adults in their ability to foresee and take into account the consequences of their behavior. By definition, adolescents have less life experience on which to

09:52:15 draw, making it less likely that they will fully apprehend the

potential negative consequences of their actions. Moreover, adolescents are less able than adults to envision and plan for the future, a capacity still developing during adolescence. The study of maturity of judgment discussed above found that adolescents' future orientation is weaker than adults'.

I will skip the sentence about the specific subjects.

Then it says, Similarly, studies have shown that among 15 to 17 year olds, realism in thinking about the future increases with age, and that the skills required for future planning continue to develop until the early 20s. The ability to resist and control emotional impulses, to gauge risks and benefits in an adult manner, and to envision the future consequences of one's actions -- even in the case of environmental or peer pressures are critical components of social and emotional maturity necessary in order to make mature, fully considered decisions. Empirical research confirms that even older adolescents have not fully developed these abilities and hence lack an adult's capacity for mature judgment.

Do you disagree with that?

A So you would appreciate having seen this for the first time and not being able to review the evidence on which it's based, it's difficult for me to form a full opinion, but I am happy to provide my initial reaction.

And that would be that informed consent is generally considered to be a threshold at which people need to meet. The

language that I see here refers to optimal capacities which might far exceed that threshold. If you read the language that it continues to mature into the 20s, I don't take it that that's justifying that the age of consent should be moved to 20 or 22 instead of 18.

09:54:30

So I think it's consistent to say that individuals' medical decision-making capacity may continue to mature over time without saying that adolescents lack the sufficient capacity to assent to treatment.

09:54:49 Q Thank you.

THE COURT: How much longer do we have with our cross?

MR. BOWDRE: 20 minutes, maybe 30.

BY MR. BOWDRE:

Q Do you agree that more research is needed to study the efficacy and the cost and benefits of providing gender-affirming care to minors?

09:55:23

A I would say that more research is needed in all areas of health care, and that the State's legislation would prohibit such research.

09:55:44 Q And what are the questions that would need to be answered that the research needs to answer in this area that are left open?

A There are a range of questions that might benefit from further refinement, including issues about the timing of the initiation of therapy, dosing. There are a variety of

09:56:10

considerations that could be further refined and developed. But further refining those treatment protocols would be a refinement.

Q In your declaration, you noted that once the FDA has approved a medication for one indication, thereby agreeing that it is safe and effective for this intended use, prescribers are generally free to prescribe that for other indications; is that correct?

A That is correct.

Q Okay. But that does not mean that an off-label use would always be safe to prescribe to an individual simply because it is an FDA-approved medication for some purpose?

A Correct.

Q So, for instance, a nine-year-old boy with diabetes, the FDA has approved the use of insulin for that purpose, but providing insulin to a nine-year-old boy without diabetes would be very dangerous, wouldn't it?

A Yes.

Q So whether an off-label use is appropriate depends on the proven risks and benefits of that particular use that we're looking at?

A Yes. But the fact that a medication is used off label does not intrinsically mean that that evidence does not exist.

Q Okay. In your direct testimony, you said -- I think you said -- correct me if I'm wrong -- that randomized controlled

trials in this area would be unethical because no equipoise exists between treating someone simply with psychotherapy versus treating someone with psychotherapy and puberty blockers and cross-sex hormones; is that fair?

09:58:21 A Correct.

Q When did that equipoise come into existence?

A I don't know that I can provide you a particular date as to when that lack of equipoise came into existence.

Q For that equipoise or lack of equipoise to come into

09:58:48 existence, wouldn't we need studies that, you know -- doesn't there need to be at least one study that shows -- that looks at a group treated only with psychotherapy and one group treated with the medical interventions?

A Can you restate your question?

09:59:09 Q For the lack of equipoise to come into existence, for us to know that, you know, psychotherapy plus puberty blockers and cross-sex hormones are the way to go and that any other treatment would be unethical, don't we first need to have a study that treats someone with psychotherapy and has a

09:59:30 controlled group that way versus someone who is treated with all of those interventions?

A No. There are prospective observational trials that demonstrate the efficacy of puberty blockers and gender-affirming hormone therapy, and withhold those treatments

09:59:48 from an individual may be considered unethical.

Q Okay. So you were asked whether there were any high quality randomized controlled studies looking only at psychotherapy, which I will note is not the level of evidence that you are relying on.

10:00:29 But doesn't that concern you that we have no idea whether psychotherapy alone versus psychotherapy plus puberty blockers plus cross-sex hormones is doing the work in creating any benefits that we see?

A So there is substantial clinical experience that -- so I

10:00:53 will differentiate psychotherapy from psychological and psychiatric treatment given that psychotherapy is a distinct entity. But that there is substantial experience that providing mental health care to adolescents with gender dysphoria in and of itself is not sufficient to resolve

10:01:21 individuals' dysphoria and hence the reason for proceeding with medical interventions.

If a patient had gender dysphoria and was -- their gender dysphoria was adequately treated with mental health care, they would not proceed to medical therapy.

10:01:40 Q Do you contend that the Endocrine Society's practice guidelines that were released in 2017 provides a more robust overview of the literature than the UK's recent literature review of looking at puberty blockers and cross-sex hormones?

A Can you be specific as to which British report you're

10:02:16 referring to?

Q Yes. And if you want to look at them, they are Defendants' Exhibits 9 and 10. I think you do have the right binder.

A So I can't answer your question because it's asking me what in effect are apples and oranges. One is a systematic review of the literature, and one is a clinical practice guideline, which are different types of material.

Q Okay. I believe you testified that the -- I mean, the clinical practice guidelines you said does a comprehensive review of the literature and then suggests -- suggests, you know, practices. Is that fair?

A So a clinical practice guideline will be based on a systematic review of the literature and grades the quality of the evidence and the strengths and recommendations.

Q Okay. So for that part of the practice guideline analysis, the literature review part, would you say that the Endocrine Society's review was more extensive and is more accurate than the UK's more recent literature reviews that you're looking at in Defendants' Exhibits 9 and 10?

A So I can't answer your question in detail without more thoroughly reviewing the documents.

Based on my understanding of the Endocrine Society's methodology, I would expect them to be comparable, but I can't form a formed opinion based on the information that I currently have.

Q Okay. You have not reviewed closely the UK's recent literature reviews?
A So I've reviewed their conclusions. I haven't reviewed them in the degree of methodological detail that your question would require.
There are a large number of systematic reviews available in the literature. Some of which I know in detail, and others of which I know at less -- a lesser level of detail.
Q What are the prospective observational studies that you claim demonstrate the efficacy of puberty blockers and gender-affirming care?
A So the specific references are included in my report. But in general, they're the studies that are conducted by the Dutch group.
Q And in that study, both the 2011 study that looks only at puberty blockers and then the 2014 report that reported on people who then went on to cross-sex hormones and total surgical interventions, those studies -- so everyone in those studies got psychotherapy and psychiatric help the entire time; is that true?
A Correct.
Q Is it also true that people who had psychological comorbidities, depression, things like that, were excluded from the treatments from the medical interventions?
A So I would have to review their specific inclusion and

exclusion criteria to be able to answer your question.
Q Okay. Do you know if everyone in that study, whether their psychological functioning and improvements went to a new clinical range or not?
10:06:29 A So there were a variety of different outcome variables that were examined in the study, some of which were unchanged, but some -- but others of which showed statistically significant improvement. And so can you clarify what you mean by a new range?
10:06:52 Q I think I will move on, given our time.
If parents of a 14 year old can consent to cross-sex hormones, why cannot parents of -- and the 14 year old consent to a double mastectomy?
A As a legal matter -- can you clarify your question?
10:07:28 Q As a medical ethical matter.
A So I don't believe that there would be an indication to perform a mastectomy on a 14 year old.
Q Why not? Isn't mastectomy a gender-affirming care for a transgender man?
10:07:52 A So in general, the purpose of utilizing puberty blockers would be to prevent the development of those secondary sexual characteristics, and the use of cross-sex hormones would be to promote the development of secondary sexual characteristics that are consistent with an individual's gender identity. And
10:08:19 there would be a period of time in which it would be required

for the gender-affirming hormone therapy to take an effect.

The effects develop over a period of years. So it's hard for me to understand the clinical scenario that you're presenting.

10:08:37 Q Well, what if someone did not start on puberty blockers and comes to the clinic as a 14 year old already having developed?

A So in -- so it would be my general understanding that that individual -- would they be -- presumably may be pursuing

10:08:59 gender-affirming hormone therapy and would not -- so I'm having trouble understanding.

Are you suggesting that they're not starting gender-affirming hormone therapy and are simply moving to top surgery?

10:09:12 Q Either that, or -- I mean, my understanding is that if, you know, if a biological woman has already developed breasts, then providing testosterone, you know, doesn't make the breasts go away, right? You still need the double mastectomy. So why could not that person, a 14 year old, not -- her and her

10:09:31 parents not consent to that?

A So I'm having trouble with your construction, particularly related to the age.

But I would say that I think that parents and their adolescent children who are less than 18 potentially are

10:09:54 capable of consenting to top surgery. And it would depend,

then, on the specific clinical circumstance.

It's hard for me to answer your abstract formulation.

Q You provided an example in your declaration on -- I guess as an example of how the medical community often relies on low-quality evidence. And your example was that a doctor might prescribe, you know, 20 minutes of exercise and a low-calorie diet as a way to treat obesity. And I guess your point was there were no randomized controlled studies showing that 20 minutes of exercise and a good diet, you know, is always going to treat obesity.

But in that example, the risks of following that protocol are pretty low, aren't they?

A Yes.

Q Yeah. And would you agree that it might make sense to follow minimal low-quality evidence for low risks for high reward endeavors, such as exercising for 20 minutes, but that we might want higher quality of evidence or more robust mound of it before relying on it for something where the risks were quite high?

A That assumes that we cannot make decisions until some speculative future in which that evidence is available. Unfortunately, clinicians have to make decisions based on the evidence that is currently available to them.

Q Okay.

MR. BOWDRE: May have just a moment to confer with

counsel?

THE COURT: Yes.

MR. BOWDRE: Thank you, Dr. Antommaria.

THE WITNESS: Thank you.

10:12:02 MR. POWERS: No further questions.

THE COURT: All right. May the witness be excused? Sir, you can step down. Thank you.

THE WITNESS: Thank you, sir.

THE COURT: All right. In the interim -- do you have

10:12:15 something you want to say?

MR. DAVIS: No, Judge. I wanted to see how you wanted to proceed.

THE COURT: All right. Well, I thought -- I know we have several parties seeking leave to file briefs, including

10:12:27 several states and several professional organizations. I just wanted to see if the parties wanted to address that very quickly, whether there are any objections or not.

MR. LACOUR: I will go first, if that's all right, Your Honor.

10:12:41 THE COURT: That's fine.

MR. LACOUR: Would you like me to approach the podium?

THE COURT: Yes, please.

MR. LACOUR: Your Honor, we think that the brief from states should come in. It was filed in a timely manner, indeed

10:12:57 before Alabama's brief was even on file, which gave plaintiffs

time to assess those arguments before their brief was filed.

We do not -- for similar reasons, we do not think that the brief from the AAP should come in. They did not file it until we were actually here about the beginning of opening statements. So there was not time to look it over.

I will be candid. I have not even had time to read it myself. I think some people on the team have, but there has been a lot to do in a very short amount of time.

And so I think for that reason the Court would -- we would oppose that brief coming in at this moment.

THE COURT: All right. What about original plaintiffs?

MR. DOSS: Your Honor, we think both sets of amicus briefs are another data point that Your Honor could consider in looking at all of the evidence and thinking through all the arguments.

We have no opposition to the several states, their amicus brief, provided that the amicus brief of the professional organizations is also allowed to be filed in.

This has been a long week. I think, if I remember correctly, the states' brief was filed on Tuesday, the professional organizations' brief was filed on Wednesday. I don't think the timing makes any difference one way or the other.

But to the extent Your Honor is wishing to consider any

amicus brief, I would submit that both should be considered, Your Honor.

THE COURT: Well, I certainly will consider them all, you know, on final merits. The issue is whether we consider them now. Obviously, if I do consider them now, we are looking at this deadline.

Does anyone have any thoughts on that, just the practicality of me trying to take that in and consider it with all this evidence under a time crunch? I think that's worth addressing by both sides.

MR. DOSS: As I read the states' brief, Your Honor, it expresses general criticism as to what it -- what they refer to as consensus-based medicine. I don't really see the states' amicus brief is presenting really any legal argument, as best I could tell. The only legal citations were two citations to dissenting opinions from the U.S. Supreme Court. It seemed to me more of a policy statement rather than really much of evidence or legal argument.

As to the professional organizations, their amicus brief, I think we have gotten a sense of what those positions are over the past day and a half from Dr. Ladinsky and Dr. Hawkins. If consideration of any brief is going to delay consideration of the merits for present purposes, I would say -- I would submit defer consideration of those amicus briefs until later. We're just trying to get the preliminary relief at this point.

THE COURT: A very practical position.

How about the United States?

MR. CHEEK: We would concur with the plaintiffs on that.

10:16:16 THE COURT: Do you want another bite at the apple, Mr. LaCour?

MR. LACOUR: Your Honor, I would just note -- sorry -- point out the ECF notice. The Arkansas brief was on file by 5:23 p.m. or 5:30 p.m. on Monday. So just for the record, that 10:16:43 is when it came in.

And, of course, the brief from the medical organizations did not come in until the hearings were essentially already begun, so...

THE COURT: All right. All right. Last question that 10:17:00 I have, and it won't offend me if nobody wants to address this, but it's possible I have missed this in the briefing or the filings, but I certainly know who sponsored this bill. Where did this bill come from? Who wrote this bill? Is that something any party wants to address?

10:17:27 MR. LACOUR: Your Honor, it was a bill introduced into the Legislature, considered by the Legislature, enacted, so this is the work product of the Legislature.

If there are more detailed questions, we can certainly try to answer them.

10:17:58 THE COURT: I'm just throwing the door open for any

party to say what they want to.

MR. LACOUR: That's what we have to say, Your Honor.

THE COURT: All right.

MR. CHEEK: Your Honor, the United States does not know, but we are happy to get some people to work on it. And if we can find it out during the course of, you know, the next couple of hours, would it be permissible for us to revisit that question or submit a one-page notice to the Court if we can pin that down?

10:18:31 THE COURT: We have got more time. We can take it up again if somebody wants to.

Mr. Doss, is this something that you want to address? Again, nobody has to. I am just asking the question.

MR. DOSS: I don't know, Your Honor.

10:18:45 THE COURT: All right. Who is our next witness?

MR. DAVIS: Your Honor, we are going to call Dr. James Cantor. I don't know if you want us to begin now. We're prepared.

THE COURT: I think this is a great time to have a 10:18:58 short break.

So why don't we come back in 12 minutes?

(Recess.)

THE COURT: Thank you. Please be seated.

All right. Any further witnesses from either of the 10:39:14 plaintiffs?

MS. EAGAN: No, Your Honor.

THE COURT: All right. State's case.

MR. DAVIS: Your Honor, the State calls Dr. James Cantor when you are ready.

10:39:28 THE COURT: I'm ready.

JAMES CANTOR, MD,

having been first duly sworn by the courtroom deputy clerk, was examined and testified as follows:

DIRECT EXAMINATION

10:39:46 BY MR. DAVIS:

Q Good morning, Dr. Cantor.

A Good morning.

Q Would you state your full name?

A James Michael Cantor.

10:40:02 Q What is your profession, Dr. Cantor?

A I am a clinical psychologist and neuroscientist.

Q What degrees do you have? Academic degrees.

A Bachelor's degree in computer science and mathematics, a master's degree in applied psychology, and a Ph.D in clinical

10:40:17 psychology.

Q Where do you work?

A I am currently in private practice in Toronto, Canada.

Q And what is the nature -- are there any particular focuses of the counseling you provide or the research that you have

10:40:32 performed?

A Human sexuality and atypical sexualities.
Q Would that include studies of gender identity?
A Yes, it is. Yes, it does.
Q Are you knowledgeable about the research surrounding gender dysphoria?
A Yes, I am.
Q Have you analyzed research concerning the benefits and harms of different ways of treating gender dysphoria?
A Yes, I have.
Q Do you have skills and expertise assessing the strengths and weaknesses of scientific studies?
A Yes, I do.
Q And do these skills and expertise include judging what those studies do and do not prove as a matter of science?
A Yes.
Q Have you treated people who presented with gender dysphoria?
A Yes.

MR. DAVIS: Your Honor, we proffer Dr. Cantor as an expert on psychology, human sexuality, research methodology, and the state of the research literature on gender dysphoria and its treatment.

THE COURT: Any objection?

MS. EAGAN: No, Your Honor.

THE COURT: All right. He will be accepted for that

purpose.
BY MR. DAVIS:
Q Dr. Cantor, there is a notebook in front of you with a blue cover. Would you please turn to the second tab?
10:41:51 A I'm sorry. It just occurs to me I didn't bring my reading glasses. They're in my brief case.
MR. DAVIS: Your Honor, can the witness get his glasses?
THE COURT: Absolutely.
10:42:43 THE WITNESS: Part 2, you said?
BY MR. DAVIS:
Q Yes. Tab 2, which is Defendants' Exhibit 2.
Can you identify that document, Dr. Cantor?
A Yes. That is my report, which I submitted for these
10:42:54 proceedings.
Q Thank you.
I think actually, since we just heard Dr. Antommaria, I would like to begin with addressing some things that we heard this morning.
10:43:02 Did you have the opportunity hear this morning's testimony by Dr. Antommaria?
A Yes, I did.
Q Did you understand Dr. Antommaria to testify that randomly controlled studies are not available in this area of medicine?
10:43:16 A Yes.

Q Did he then say, if you understand -- as you understand, that because the randomly controlled trials are not available, we can rely on observational trials?

A That is roughly what I understood him to say, yes.

10:43:33 Q Do you have any response to that?

A Yes. That's not -- it is true that none of the existing studies are randomized, but it is entirely untrue that we therefore can rely -- can make decisions based on the least reliable kinds of studies.

10:43:48 There is a wide, wide range of studies in between, and there's a wide, wide, range of different scientific methodologies that we can employ in order to minimize the laws that we get from completely randomized studies.

It's also actually possible if we wanted to conduct such 10:44:09 studies such as by allowing people to undergo different parts of a treatment at different times, so we can compare the differences between them when one group has started on that type of treatment and the other hadn't yet.

Q Okay. So the randomized trials would be considered like 10:44:29 the gold standard, the top-tier level of scientific research?

A Randomization is one factor in determining how high quality a study is. It is not a -- it's neither an all or nothing.

Q I understand. But did I understand you to say that if you 10:44:47 assume that's not available, that's no reason to drop down to

the lowest quality of evidence?
A That is correct.
Q I understood Dr. Antommaria to testify that the level of evidence supporting the WPATH and Endocrine Society guidelines
10:45:05 is comparable to the level of evidence supporting other treatments in pediatrics. Can you respond to that?
A I am not aware, of course, of all the other treatments in pediatrics. However, there are no studies yielding positive effects of either the Endocrine Society standards or the WPATH
10:45:24 standards.

The studies which have shown effects have used the Dutch model, which uses a higher set of standards than either the Endocrine Society or the WPATH group.
Q Speaking of the Dutch study, I also understood
10:45:42 Dr. Antommaria to say there is no high quality evidence supporting the use of psychotherapy alone for gender dysphoria. Do you agree with that?
A No, I do not.
Q What would you say in response? What's the countervailing
10:45:56 evidence?
A There exists roughly 15'ish studies following up these kids at all. All of the studies, which without exception that used medical interventions also used psychological -- psychotherapy at the same time. So all of the studies which
10:46:17 could seem to show a benefit for medical interventions are

unable to distinguish that it was the medical intervention causing the benefit, versus the psychotherapy causing the benefit.

Of those studies, two were designed in a way that it was possible to peel apart the effects of psychotherapy versus medicine -- the Costa study and the Achille study. The full references are in my report.

In the Costa study, there was a -- there were two phases. There was a phase that people went through when they received psychotherapy alone. And then in the subsequent phase, they received both psychotherapy and medical interventions.

There were no significant differences between the group. Both groups improved, and there were no significant differences between the group that received psychotherapy alone and the group that received psychotherapy plus medical interventions.

The other study, the Achille study, used a statistical method to control for the effects of psychotherapy. That group also improved after medical intervention, but when the effects of psychotherapy were statistically controlled, there was no additional benefit of the medical interventions after that.

Q I want to break some of that down. You mentioned studies where all the participants were receiving both psychotherapy and medical-affirming care at the same time, right?

A Correct.

Q Is that the Dutch -- oh, is the Dutch protocol, the Dutch

study an example of such a study?
A Both Dutch studies, the 2011 and the 2014, yes.
Q If, at the end of that trial, you look and see the people that were receiving both psychotherapy and medical-affirming
10:48:06 care at the same time, improved in mental health at the end of the trial, can you as a scientist tell whether the improvement is the result of the pharmaceuticals or the psychotherapy?
A Not in the design of those studies, no. That's what in science is called a confound.
10:48:27 Q Confound?
A Correct.
Q What does that mean, confound?
A It describes exactly that situation. When two things are done at once, when you see the result, you can't peel apart
10:48:37 which -- which of those two interventions was responsible or the interaction between those two interventions was responsible.
Q Okay. But the Costa and Achille study, on the other hand, they do provide scientific evidence that psychotherapy alone is
10:48:53 helpful, did --
A That's correct.
Q Okay.
A That psychotherapy is helpful and not the medical interventions.
10:49:01 Q I also understood Dr. Antommaria to say that he had not

read studies about detransitioning. But if it ever became relevant, he would make an effort to review such studies.

You are familiar with the body of the literature concerning gender dysphoria, correct?

10:49:21 A Yes.

Q In your opinion, are the studies of detransitioning relevant to someone trying to assess the benefits and harms of these treatments?

A Yes, of course. It's very difficult -- detransition would

10:49:35 be the situation that one is trying to avoid. The best way to avoid a situation is to understand that situation.

Q Dr. Antommaria said that there are prospective observational trials that demonstrate the efficacy of puberty blockers in gender-affirming care, and then later said the

10:49:59 trials he is referring to were primarily the Dutch group studies.

Are those the studies you just mentioned, the 2011, 2014 studies?

A Those are the Dutch studies that usually we use. I can't

10:50:12 know if he is referring to some other study that I didn't make a specific reference to.

Q That's fair.

In this area of medicine, when someone's talking about the Dutch studies, the Dutch group studies, is it your

10:50:25 understanding they're generally referring to these 2011 and

2014 studies from the Dutch project?
A Almost always, yes.
Q Okay. And those are the studies you just mentioned that have the confound problem, right?
10:50:36 A Correct.
Q You can't unpack whether it's the psychotherapy or -- not from that study, you can't unpack whether it is the psychotherapy or the pharmaceuticals that are making the difference?
10:50:47 A That's correct.
Q Okay. More generally, I'd like to read for you a statement from the plaintiffs' brief in support of their preliminary injunction motion.
For the record, it's Doc 8 at page 18.
10:51:07 Dr. Cantor, the plaintiffs wrote in that brief, For more than four decades, medical organizations have studied and created an evidence-based standard for the medical treatment of transgender patients. This standard confirms that transition, including puberty blockers and hormone therapy where 10:51:26 appropriate, is the only safe and effective treatment for gender dysphoria?
Dr. Cantor, does the research literature support that statement?
A No, it does not.
10:51:37 Q Do you understand the plaintiffs primarily to be pointing

to the guidelines of medical organizations such at WPATH and the Endocrine Society and the American Academy of Pediatrics to support their positions that wish to continue giving these treatments to children?

10:51:52 A Yes. They cited those repeatedly.

Q Okay. What observations have you had about the WPATH guidelines and whether they have support in evidence?

A The WPATH guidelines and the Endocrine Society guidelines have been tested among the set of -- as I say, roughly 15

10:52:13 outcome studies, some of them have used the WPATH guidelines or Endocrine Society guidelines instead of the Dutch protocol. And those studies demonstrated that there was no improvement at all.

I shouldn't say none at all. One of them used several

10:52:36 kinds of measures of improvement, and I think it was all but one demonstrated no differences at all. And one small one gave an indication that suggested the possibility.

Q Have these organizations acknowledged anything about desistance rates -- these organizations, I'm referring

10:52:57 specifically to WPATH and the Endocrine Society?

A I can't say that they've never addressed it, but to the extent if it was ever addressed, they are grossly, grossly minimized.

Q Can I refer you to paragraph 12 of your report on page 4?

10:53:33 A I got it.

Q You say in that paragraph that the plaintiffs' documentation -- and I assume by documentation, you mean their -- the pleadings in this case and the briefs that you had seen?

10:53:50 A That's correct.

Q You said the plaintiffs' documentation misrepresents the contents of the associations' policies themselves.

Which associations were you speaking of there?

A They mentioned several other societies which made short

10:54:04 statements in general support of sexual diversity, but without actually issuing specific standards about how to treat people in that community with what or at what ages.

Q And what inconsistencies did you see between what those organizations have said and the arguments you saw in

10:54:23 plaintiffs' briefing?

A The plaintiffs referred to the societies as if they were providing very specific support for very specific policies rather than general recommendations to provide, for example, respect and values for diversity, but no specific guidelines.

10:54:48 Q Okay. Well, looking at paragraph 12, is one of your points here looking at the bullet points that even WPATH and Endocrine Society acknowledge as you write, that desistance of gender dysphoria occurs in the majority of prepubescent children?

10:55:04 A That is correct.

Q And then turning the page, were there other issues you saw that the statements -- that these organizations believed and plaintiffs' briefing was inconsistent with what the organizations had stated?

10:55:16 A That the issue of mental health and that mental illnesses and similar concerns need to be resolved before considering transition rather than depending on transition to be the resolution of, for example, depression and anxiety.

Q And have any of these organizations acknowledged that

10:55:42 puberty-blocking medication is an experimental not a routine treatment?

A Yes, they have used that phrase.

Q Which organization?

A Again, I would have to look up to see exactly who used

10:55:52 which word. I believe it was WPATH, but I again have to go back and check to make sure that it was they.

Q And let's turn to the American Academy of Pediatrics. And I will refer you to your appendix.

And, Dr. Cantor, if you look at the top of the page, you

10:56:12 will see a line of blue figures. And it's page X out of 106. The appendix I am referring to is page 100 out of 106.

A Got it.

Q What does the American Academy of Pediatrics or AAP, what do they recommend in this area of care?

10:56:42 A They recommend what I can best describe as affirmation on

demand.
Q Okay. Did you review their recommendation when it came out?
A Specifically I reviewed the sources on which they based their recommendations.
Q Okay. Did you write about that?
A Yes, I did.
Q And does that appear as an appendix to your report beginning at page 100 of that pdf?
A That is correct. I summarized all of my comments. I submitted them to a journal where they underwent peer review. And it's an official published peer-reviewed paper.
Q This is not a letter to the editor?
A That is correct. This is part of a scientific -- now part of the scientific literature.
Q What did you comment upon?
A I really just checked what the authors of the AAP policy, Dr. Rafferty, what their claims were, what they said was in their references versus what was actually in their references.
And not only did their sources not contain what they were alleged to have obtained, they often contained the very opposite of what the AAP policy said they contained.
Q Did you have an agenda to disprove -- to prove or disprove anybody when you undertook that review of the evidence?
A I wouldn't say an agenda other than to set the record --

pardon the pun -- straight.

This was a situation where these sources I had known for many years. I had read them when they had first came out.

And when AAP came out with its policy, I was stunned by its content. And as I read what they were basing it on, my recollection was immediately this is not what those sources said.

So immediately I just started double checking myself. Did I misread something? Am I misremembering something?

10:58:36 And as I just checked in my own files with copies of these papers -- most of these papers already in it, my memory was correct. They said as -- the kinds of things I recalled them to be saying.

Because we were now talking a major medical association 10:58:51 rather than an individual other scientist. This was different from just one scientist like me disagreeing with another scientist. This was now -- now had the potential to cause a great deal of damage to a great number of people.

So because I had the ability to do it, I simply summarized 10:59:11 the contents of the original paper and contrasted point by point the claims being made by AAP and simply quoting verbatim what was in the original studies.

That entire thing was published, and the AAP has never responded. They were approached by the media, and they just 10:59:33 would refuse to talk even to the media. They have yet to have

any response.
Q So to date, the AAP has not responded to the criticisms that you raised?
A That is correct.
10:59:42 Q I will refer you now to page 6 of your report. Going by the numbers at the bottom of the pages.
A Yep.
Q As you noted in your review of the plaintiffs' expert report -- well, first off, did you review the expert reports
11:00:08 submitted by the plaintiffs by Dr. Hawkins and Dr. Ladinsky?
A Yes, I did.
Q And did you note that they studied a 2016 Olsen study claiming that it proves that transition reduces the risk of mental illness? That that was their claim?
11:00:23 A Correct.
Q Does the Olsen study show that?
A Just referring to my own report. Ultimately, no, it did not. There was several statistical errors in the Olsen study. The data were obtained then by the -- they -- upon request, and
11:00:45 Olsen provided their data to another author who reanalyzed -- I should say, correctly analyzed the Olsen data, who demonstrated that Olsen's data did not contain evidence of improvement. In fact, it contained evidence of deterioration.
Q So in your opinion, does the 2016 Olsen study support
11:01:04 plaintiffs' position that children need these affirming --

these medicalized affirming treatments in order to improve their mental health?

A No, it does not. Making such a claim is a half truth. It would ignore the subsequent entries in the scientific literature.

Q And what about the de Vries study that plaintiffs cited in which you address on page 9 of your report? And does it show that medical transition of minors improves mental health?

A No. It contains part of the confound. The de Vries study as part of a Dutch group also included psychotherapy during transition. So it is not possible to differentiate which type of therapy, medical or psychotherapy, is responsible for the benefits reported in that study.

Q I see. So participants in that study did have improved mental health, correct?

A Yes.

Q But it's just not possible scientifically to tell what caused the improvement?

A Correct.

Q And what about the Greene and Turbin studies plaintiffs' experts cited which you discuss in paragraph 24 of your report?

A Yep.

Q Do those studies show that medical transition improves mental health?

A No, they do not. These are retrospective correlational

studies. They are not able of describing any causal effect coming to any causal conclusion.

Q Okay. Now, you mentioned there that -- you say this very pattern is what one would predict from clinical gatekeeping. What do you mean by clinical gatekeeping?

A One of -- across the various clinical standards are to prevent somebody with mental illness from undergoing transition. So such people are being held back. They're being filtered out of groups who do undergo transition.

So when a clinic then compares the people who underwent transition to the people in their files who did not undergo transition, they are necessarily comparing a group of people from whom the mental illness was removed and comparing them to a group of people from whom the mental illnesses were not removed.

So when you see better mental health amongst the people who had transitioned, the improvement is not because of the transition, the improvement is because you have removed the people with the worst mental health from the group in the first place.

Q Okay. So is it correct, then, that one thing you might see in these studies is by picking out the people with the best mental health, and giving them the treatment, then comparing them to the people with lower mental health, then, of course, the people who went through the study would do better?

A That is correct.
Q Did you review any of the other studies that plaintiffs have submitted into evidence such as the Allen study, the Turban articles, the Biggs (phonetic) study, the Lopez de Lara
11:04:24 study, Tordoff?
A Yes, I have.
Q Do you have any comments on those studies and whether they support plaintiffs' position?
A They suffered from the same methodological problems as the
11:04:35 other studies.
Q Did any of those studies support the position that medical transition improves mental health?
A No, they did not.
Q In minors with gender dysphoria?
11:04:47 A Correct. No, they do not.
Q Oh. What has been called the Yale study by Brouware, B-R-O-U-W-A-R-E, was the first named author. Did you review that one?
A Yes, I did, but it wasn't a study.
11:05:07 Q What was --
A Apparently, that was a report submitted by those authors for another -- or for a combined set of court cases.
Q Okay. But you would not refer to that document as a scientific study?
11:05:21 A From the Yale group with -- again, the name I don't -- I

hesitate to try to pronounce, but, no, it was not a study at all. It was those authors' report reviewing the literature and providing their opinions.

Q Okay. As a matter of fact, Dr. Ladinsky was asked about that study yesterday. And for the record, that testimony appears on page 116 of the rough transcript.

The question was: In this document, do the authors also cite a number of peer-reviewed studies that contradict some of the supports or the principles that the State articulated as the reasons for SB 184? And Dr. Ladinsky responded, They do, a considerable compendium of them.

Is she right? Did those authors show that there are studies that contradict the State's position in this case?

A There was such a statement. There was no meaningful way to try to put together what claim went together with what source. Rather than -- what's done more typically either in science or in pause, best as I understand, is here the claim and here is the source justifying it. Here is next claim, here the source justifying it.

Instead, that document made a long series of unsourced claims and then provided a long series -- a series of very large footnotes with 20 and 30 references. And there was just no way to see what fact was alleged to have come from what source.

Q So we've talked about whether the literature the

plaintiffs' -- the studies that plaintiffs cite to support their position. Let's talk about whether the literature supports the State's position. But a little background first.

Could you describe from your review of the literature just what's the difference between adult onset gender dysphoria, child onset, and adolescent onset? And I know this is a broad question, but I just mean like age groups.

A Usually we would be referring to these as a prepubescent onset. Then the literature is very, very long, but reported on adult onset. And by adult, on average, these were people in their 20s and in their 30s and 40s. It was very, very distinct. It was not, you know, a bell-shaped curve with some midpoint around 18 or 19 years old.

It's only within the past --

THE COURT: Hold on one second.

Go ahead. Sorry.

THE WITNESS: It's only within the past ten years or so that a different profile has begun to emerge and was noticed by clinicians. And that now is being called either adolescent onset or rapid onset.

Now, all three of these groups have in common that they're complaining about the same thing. Doc, I feel like I am in the wrong body. Doc, I am the brain of one, but in the body of the other.

So the way that they describe it is similar. But every

objective way we have of measuring these people shows that these are independent phenomena. They are not related except in the way that people describe the situation, describe what they're experiencing.

11:08:50 The best analogy I have would be if somebody came to a doctor saying I have a headache. Okay. I got it. Got that's a symptom. I have some more questions. But we cannot from that say that a migraine headache is the same thing as a tension headache is the same thing as having just suffered a 11:09:08 head injury.

The causes are different. How we respond to them is different. And the other characteristics about each of these are different. They only resemble each other in the most superficial ways.

11:09:19 Childhood onset or prepubescent onset gender dysphoria appears to be entirely unrelated to adult onset gender dysphoria. And the two of those appear to be entirely unrelated to the rapid onset or adolescent onset gender dysphoria.

11:09:40 BY MR. DAVIS:

Q Well, let's break that down. Adult onset, typically people who present with what you're referring to adult onset gender dysphoria, what age are they when they come into the doctors' office and say, something's wrong?

11:09:50 A On average, in their 30s and 40s.

Q Okay. Has there been research considering whether those -- that universe, the adult onset universe does well after transitioning?

A Those who are mentally healthy by and large do, do well after transition.

Q Can you apply those studies to consider whether someone with child onset gender dysphoria is going to do well after transitioning?

A No. Because these are independent phenomena. The information from one does not -- from one group does not generalize to the other.

Q Comparing the adult and the child onset, what is the difference that makes the studies of one, you know, it's not apples to apples?

A Correct.

Q Okay. What is the difference between those patients?

A The -- they -- as I say, differed in just about every objective measure we've been able to apply to them.

There are, of course, the ages themselves. Something -- the sex ratios in them are different. The adults are almost 100 percent biological male. There's more of a mix amongst the childhood onset.

The adults are almost always attracted to females. That is to say, relative to being biological male, they are almost always heterosexual.

The childhood onset almost always are attracted to the same biological sex. They are almost always homosexual.

Q Talking about the child onset, is that a new phenomenon, child onset gender dysphoria?

11:11:31 A I wouldn't say new. It's been systematically studied for 20 to 30 years'ish.

Q From the literature that you reviewed, do most of these kids, if not socially transitioned and given hormones, will they want to transition after reaching puberty?

11:11:52 A Generally not.

Q And page 36 -- excuse me -- paragraph 36 of your report, Dr. Cantor, what statistics do you provide about the rates of desistance among those presenting with childhood onset gender dysphoria?

11:12:15 A The exact numbers are between 61 to 88 percent of them desist. In the appendix in my report, I list all of the studies that have ever been conducted with that group, all the outcome studies that have been conducted with that group.

Q We probably both need to slow down just a little bit

11:12:37 for...

A I'm from New York. It just happens.

Q We'll do our best.

Dr. Hawkins was asked about your paragraph 36 yesterday. And I will represent that on page 30 of the rough transcript,

11:12:54 she said that when the study such as the ones you're citing

offers this elevated rate of desisters, quote, what we tend to find is that the initial cohort that was given the diagnosis of gender dysphoria is actually false.

My question, Dr. Cantor, is: Does the research literature support Dr. Hawkins's statement?

A No. As I say, I listed every single such study.

Q Do we have any tools today that reliably tell us which kids will desist and which kids will persist?

A No, we do not. There have been some attempts to develop such a test, but they have never been able to find a good characteristic, a feature, a pattern, a test result in which the majority continued to want to persist.

The best that they have ever been able to do was find a tool which distinguished unlikely to want to persist versus even less likely to want to persist.

Q There's been testimony about something called the DSM-5. Do you know what that is?

A Yes, I do.

Q What is it?

A The full name is the Diagnostic and Statistical Manual of Mental Illnesses, published by the American Psychiatric Association.

Q If someone were to claim that now that we have the DSM-5 we may be able to do a lot better with identifying who's the desister and who is the persister, is there any research on

that?
A No. Nobody's ever tried to differentiating any of the DSMs from DSM-I through its various versions to the current one.
11:14:38 Q So there have been at least five?
A There was a I, a II, a III, III-R, IV, IV then had a text revision. They switched some of the commentary around the diagnoses, but they didn't change any of the diagnostic criteria themselves. There was then the 5. And there is as of
11:15:01 last month a 5 again with a text revision, but no changes to any of the actual diagnostic criteria.
THE COURT: Mr. Davis, how much longer do you think we will be?
MR. DAVIS: Your Honor, direct will take us up to
11:15:14 about noon, I would predict. There's just a lot to cover with Dr. Cantor.
THE COURT: I am not rushing you. I am just trying to get a road map of that.
So how long do we think cross might be?
11:15:25 MS. EAGAN: It's difficult to predict because I am not sure what else he may say, but maybe an hour, hour or less, I would think.
THE COURT: All right. I am leaning toward an earlier lunch than we did yesterday. So maybe -- if it's okay with
11:15:45 you, let's just go ahead and find a stopping point at your

leisure, and we will just pick back up after lunch.

MR. DAVIS: Thank you, Your Honor. This is as good as any.

THE COURT: Is it?

11:16:00 MR. DAVIS: Yes. We have just talked about DSM-5. Going to watchful waiting next. This is as good a place as any.

THE COURT: Okay. Good. Good. With that said, then are we still on target with your last witness?

11:16:17 MR. DAVIS: Yes, Your Honor. Ms. Wright is here. I don't know if she is in the courtroom yet or not, but she is in Montgomery, and she will be ready to go when we finish with Dr. Cantor.

THE COURT: We think the length of that witness would

11:16:30 be what?

MR. DAVIS: Oh, I would say direct would be well under 30 minutes, but I don't know about cross.

THE COURT: Okay. All right. Okay. Well, I think we're on target.

11:16:38 Let's take a good long lunch today. Let's see here. Let's come back at 12:45.

MR. DAVIS: Thank you, Judge.

THE COURT: Thank you.

MR. DOSS: Judge?

11:16:54 THE COURT: Yes?

MR. DOSS: Closing, how long would you like?

THE COURT: You know, I mean, this is important. I'm not going to, you know, jack everybody up on this, but to the extent you can hold it to around 25, I think would probably be a good thing.

11:17:07

And in your openings, I think you really road mapped it very well, both sides did.

So, you know, again, I know the arguments. I'm really interested in, you know, some analysis with case law. And I am going to be directly asking about a few cases. I'm very interested to know parallels between the Arkansas decision and that law. And then I may give you some hypotheticals that you won't like.

11:17:22

See you after lunch.

(Recess.)

11:17:40

THE COURT: All yours, Mr. Davis.

MR. DAVIS: Thank you, Judge.

BY MR. DAVIS:

Q Welcome back, Dr. Cantor.

We spoke earlier about the Dutch protocol. Did the participants in those Dutch studies have psychotherapy before beginning treatment? Before that study?

12:51:00

A They were receiving treatment as part of their participation in the study. I don't think they reported whether anybody happened to have attempted psychotherapy before

12:51:21

approaching the clinic at all.
Q Okay. Forgive me if I'm mistaking which study is which. I was reading about a study that described the psychotherapy that was available to the participants as extensive. And that
12:51:40 that extensive psychotherapy was at least two years. Which study am I thinking of?
A That wouldn't have been a particular study so much as what they use in their process in general.
And then the Dutch group was reporting the results, you
12:51:56 know, of -- periodically over the course of the study.
Q I see.
A But by the time the first set of results, their earlier study, the 2011 study, the participants in it will have already been through a substantial amount of therapy.
12:52:13 Q Okay.
A They also emphasize that in assessing the children that it's a very extensive assessment, and the assessment itself was also ongoing over the course of the study.
So even before deciding who might be eligible for
12:52:30 hormones, they have now many, many months to years' experience with the particular case even with a particular child even before making a decision. That's very, very different from just having an appointment, taking a test, and then having a diagnostic decision an hour later.
12:52:46 Q That is exactly what I was meaning to ask you about. I

was using sloppy language.

So this extensive assessment that happened before some of these children began treatments, they were assessed, you said, over a course of a couple of years?

12:52:59 A Correct.

Q Okay. So does literature support having such an extensive assessment period before subjecting someone to these treatments?

A I don't know if I would say support it, but all of the

12:53:16 conclusions that come from the literature depend on it.

Q Thank you.

Is there a way of treating gender dysphoria that some practitioners refer to as a watchful waiting approach?

A Yes. Watchful waiting usually refers specifically to

12:53:40 withholding any decision about medical interventions until they have a better idea or feel more confident for a particular case about whether that kid is going to be a persister or desister. It is given the knowledge that that's available that the majority of these kids do desist. Nobody wants to make a

12:54:00 decision upon first appointment.

And so -- so they tend to provide psychotherapy, whatever kind of care, whatever is appropriate to the individual kid until enough time has gone by to give -- to suggest is this a kid whose feelings like they're feelings are slowing down and

12:54:19 they just need more time, are they building up, or are they

staying steady?

So the watchful waiting period would be postponing any decision about medical interventions until the clinicians had some confidence.

12:54:31 Q While you are watching and while you are waiting, are you just leaving him alone, or her?

A No. That would be the time during which one would be supplying a therapy for whatever else is going on in the kid's life.

12:54:42 Q Okay.

A Usually they're associated with -- there's a great deal of what we call comorbidity. They're also suffering from other problems at the same time, either depressions, anxieties, early evidence of personality disorders, for example. And it's never

12:55:00 clear whether their gender dysphoria is a result of those other psychological problems.

So by helping them develop the tools to deal with those other problems, if they remain dysphoric afterwards, we know that the dysphoria wasn't the result of those other problems.

12:55:17 So rather than just leaving them alone, they're still receiving support, and the family is still receiving support over that period.

Q So I believe you pointed out in your report that clinical guidelines suggest that mental health issues such as the

12:55:33 comorbidities you mentioned should be resolved before

transition; is that correct?
A Yes.
Q Okay. Why?
A Because it's never clear what's causing what. We cannot from a correlation conclude anything about a causation. It's very possible, and it's been frequently observed that a lot of these kids are using gender issues as an explanation for the unhappiness that they're experiencing elsewhere in their life.
So rather than developing the skills to -- for example -- better social skills. If a person feels awkward and they're withdrawing from kids their own age, we are not sure if they want to transition because they're blaming gender dysphoria for why they feel unpopular or uncomfortable, and we're not -- versus we can't tell if anxiety or depression is a result of how they're being treated by the rest of society.
So it's only by helping them deal with and by giving them the skills to overcome those other disorders that we can see if the gender dysphoria itself resolves just as a result of that.
Q So if a person is suffering from depression, or is struggling with their own sexual identity, or some type of abuse, or any of these other comorbidities, explain how this psychotherapy process would work, how a psychotherapist such as yourself would try to dig down into the issue and see if that is something that's generating these feelings that are being mistaken as gender dysphoria, or whether the gender dysphoria

is its own thing.

A Just to be specific, I'm specifically an adult clinical psychologist. I see clients ages 16 and up. So it wouldn't be me personally.

12:57:23 What the literature shows about these kids is that they can be very, very diverse. It certainly is feasible that they are experiencing, for example, depression or anxiety as a result of social transphobia, but that doesn't explain the other things that we're observing.

12:57:41 For example, a transphobia doesn't cause autism, which is another very, very common disorder in that group. Transphobia wouldn't cause the development of borderline personality disorder, which we're seeing in very, very, large proportions among the teenagers.

12:57:58 So although certain symptoms like anxiety and depression can feasibly be the result of social reactions to being trans, but that does not explain the overall phenomenon. What does better explain the overall phenomenon is that there is some thing troubling this kid, and it is resulting in both the

12:58:20 psychological symptoms, depression, anxiety in someone, and also producing the gender dysphoria, that discomfort with being their natural sex.

Q I would expect this could vary wildly from patient to patient, but if you -- and I recognize and thank you for

12:58:37 clarifying that you deal with a more adult-age group.

But if you're helping someone, an adolescent, work through some of these issues, how often do you think a psychotherapist would want to see the patient and over what period of time?

A It does vary widely. And the kind of disorders that they're reporting do tend to be the kinds that require very long-term interventions.

As I say, autism, and related Asperger's syndrome, and also very, very high rates of borderline personality disorders, which, again, is a very, very long-term disorder to help somebody deal with.

Q Fair to say this would not be two or three sessions?

A Correct. This would be over the course of months or years.

Q Does the research literature show that there are risks associated with medical transitioning?

A Yes, quite substantial, including both loss of -- primarily loss of function, and depending on the person's point of view, whatever the cosmetic effects are.

Q What are the risks of the watchful waiting approach in providing psychotherapy in helping the child deal with any underlying emotional issues?

A There don't appear to be any, at least any concrete.

Q I will refer you to paragraph 68 of your report, Dr. Cantor.

Tell me what the advantages there are to a patient, what

opportunities it opens up to him or her if any emotional issues are dealt with before the decision to transition.

A If a person fails to deal with whatever emotional issues before it transition, and then transitions and discovers that they continue with whatever psychological issues are pervading them, they have gone through the entire transition process entirely unnecessarily. They haven't been helped. They have now lost whatever -- they have now been sterilized, lost whatever sexual -- or other functions, but it hasn't actually resulted in any improvement in their psychological function.

If you go the other way around and you help the person deal with psychologically whatever it is that's going on, they still retain the option for transition after that. And it's that situation that the professional societies have repeatedly -- that the standards of care have repeatedly pointed out.

Q So watchful waiting approach does not eliminate a person's ability to transition to the opposite sex later in life if they so choose?

A Correct.

Q Does the research literature show there's any relationship between children who present with gender dysphoria and those who later in life turn out to identify as gay?

A Yes. The large majority of the ones who believe that they were born the wrong sex turn out to be gay or lesbian.

To a prepubescent child who doesn't yet have a sex drive, they have no way to interpret why they feel different from other boys or other girls their age. It's only with the onset of sex drive that they start -- and start developing crushes and physical attractions that they now have the information they need to realize why they're different. But to an eight year old or to prepubescent children, the only explanation they have for why they're not like other boys or not like other girls is they must be the wrong sex. They're misinterpreting their feelings.

THE COURT: Let's take a quick time out.

So, you know, I guess I'm wondering how both sides are wanting me to use all this expert testimony. I mean, the Eleventh Circuit has said more than one time that, you know, medical psychiatric professionals are in a far better position to make decisions about medical and psychiatric issues than judges are.

So I guess I want to know from each side real quickly, how do y'all envision that I use these experts? I mean, are you asking me to say, well, this guy's science is junk and this guy's science is perfect; or something in between? What am I -- tell me how you envision me using this.

MR. LACOUR: May I?

THE COURT: Perfect. Absolutely.

MR. LACOUR: Your Honor, as we began the opening

statements, when there's an area of medical uncertainty, the State has wide discretion to regulate. So if it's not so clear to you as to which side's experts have it right, if you see that uncertainty, then under Supreme Court precedent, the State 13:03:29 is allowed to regulate.

The State has to think about all 5 million Alabamians. We have to take all that into account when regulating in these areas where it is not certain.

The judge has an important but a limited role in our 13:03:45 federal system to see whether those judgments the State has reached in those areas of uncertainty somehow conflict with the Constitution.

And we submit we have come forward with evidence to at least put into question whether there is this consensus that 13:04:03 has been proclaimed by the plaintiffs here.

Again, I think the bar on the plaintiffs is quite high, to show an absence of uncertainty, or to show some great certainty.

And when you look at the international studies and the 13:04:19 literature reviews, when you hear from very qualified experts like Dr. Cantor, who have applied great rigor to these studies that are being relied upon by the plaintiffs, by their experts, by the AAP, for example, then I think that is enough to create that doubt to create that space for uncertainty. And when that 13:04:45 is there, the State can step in.

So that's how we see it. We don't think that you sit here as an independent medical board to assess whether a particular treatment is going to be the best for any particular individual. The role of the federal courts in our federal system, the laboratories of democracy is to see if we have done something that is somewhat inexplicable.

I think there is ample evidence to explain why the State has done what it's done in addition to the lengthy legislative findings in SB 184.

We have come forward with multiple experts from fields of endocrinology, psychology, and pediatrics, and have brought forward substantial amount of other peer-reviewed research and literature reviews to show that this very novel area of the law -- keep in mind the UAB clinic didn't open until seven years ago. This is a novel area of medicine, rather -- is just, in the State's judgment, too risky. And if that's a reasonable judgment for the State to make, then that's the end of the case.

THE COURT: All right. Mr. Doss.

MR. DOSS: Your Honor, I'm unaware of a case that establishes that principle that's so long as there's uncertainty and a reasonable judgment, then that alone is sufficient for the State to violate constitutional protections.

The standard of review is what I think helps frame some of this testimony. So, for example, if strict scrutiny applies,

it is the State's burden to establish a compelling state interest. And that its infringement on the constitutional protection has been narrowly tailored.

And I guess to preview Your Honor for closing, that is a 13:06:40 key focus that I plan to spend some time with in closing on why this testimony we've heard yesterday and today, number one, does not establish a compelling State interest. But number two, even if you assume that it does establish some interest by the State, the interest that the State has identified and the 13:06:58 regulation that it has imposed are mismatched. It's not narrowly tailored for the very reasons offered by the State through its witnesses.

And based on the standard of review, it is not a reasoned judgment. That's not the test for when a constitutional 13:07:13 violation has occurred. The test is whether there is satisfaction of this demanding standard for the law's viability.

And so as I mentioned in opening, I don't think that Your Honor's job for the purpose of this hearing is deciding 13:07:31 ultimately maybe even who is right. It's to show that there is scientific -- there are standards of care that exist, there are approved approaches to dealing with these issues. These are real medical diagnoses. These are real medical treatments.

And though the State may disagree them, that's not enough 13:07:50 to establish the violation of the constitutional rights, Your

Honor.

THE COURT: And on that note, at least from what I can tell from both sides, State and government, and original plaintiffs, am I correct to say that everybody agrees that these are real diagnoses? Or no?

13:08:07

MR. LACOUR: Your Honor, could you --

THE COURT: And I am going to say this one more time. I don't need head nods. It is out of hand. This is not entertainment. This is the real world and the law. So we're not in a movie theater. I don't need head nods. I don't need approval or disapproval. If you want to do that, take it outside.

13:08:25

Go ahead.

MR. LACOUR: Your Honor, I think -- Your Honor, we agree that gender dysphoria is a psychological diagnosis, but as we have shown in both our written evidence and through witness testimony from both defense witnesses and plaintiffs' witnesses, we don't know whose gender dysphoria is likely to persist. And that's very important.

13:08:46

Even Dr. Antommaria this morning said that if you -- the level of certainty you have --

13:09:07

THE COURT: You are giving me more detail than I want. I just need you to answer my question.

MR. LACOUR: Okay. Can I respond to something Mr. Doss said before?

13:09:21

THE COURT: Very quickly.

MR. LACOUR: He is unaware of the standard. We cited it multiple times in our P.I. response. It's Gonzales vs. Carhart, a 2007 decision from the Supreme Court where the federal government had regulated partial birth abortion. That was an area of medical uncertainty.

13:09:32

There were -- I will go back and I will look at the filings in that case, but I would be shocked if the AMA did not chime in, in favor of the plaintiffs who were challenging the ban on partial birth abortion there saying that it was a safe or necessary -- medically necessary treatment for some people.

13:09:46

It was enough that Congress found medical uncertainty there. And there were values, as well, in unborn life that Congress was able to promote even though there were medical organizations.

13:10:04

I will confirm this before closing, but I am fairly certain there were medical organizations who were not fans of Congress's action there.

Even so, and even in an area like abortion where there is more law at least for the last 49 years in that space, addressing some right to abortion, even then, that ban was upheld by the Supreme Court.

13:10:16

THE COURT: And I'm sure you can get into that on closing.

Let's go back to my original question. Just answer it

13:10:31

succinctly for me.

MR. LACOUR: And that would be are these real diagnoses?

THE COURT: Yes. Just answer my question in two sentences.

MR. LACOUR: Gender dysphoria is a diagnosis. I think the debate is how should it be treated. And SB 184 is expressed in Section 6.

There's no ban on psychotherapy whatsoever. The ban only applies to these novel risky potentially long-term harm-inducing or causing medications.

THE COURT: So no argument from the State on status, diagnosis, any of that? You are only -- your only issue is treatment; is that correct?

MR. LACOUR: Correct, Your Honor.

THE COURT: Got it. Thank you.

Anything else, Mr. Doss? And I will give the government a shot --

MR. DOSS: No, Your Honor.

THE COURT: -- if they want to be heard.

MR. CHEEK: Nothing else to add that hasn't already been said, Your Honor. Thank you.

THE COURT: Okay. All right.

Mr. Davis, I have gotten right in the middle of your witness again. Sorry. Pick it back up.

MR. DAVIS: I certainly understand, Judge.

BY MR. DAVIS:

Q Okay. Dr. Cantor, we to try to pick up where we were.

Let's take two young boys, eight years old, say. So puberty hasn't started yet. They both have gender dysphoria, even though they may not really understand it yet.

And I know I'm asking you to assume some things that an outside observer may not be able to confirm just by looking at that child.

And let's assume that both those young boys would, if not intervened with transitioning care, would both grow up to identify as gay.

So the boy who is left alone to go through natural puberty, what does he come to understand once puberty kicks in?

A Once he -- as puberty kicks in, of course, sex drive comes in as a part of that, and he starts experiencing sexual attractions and sexual arousal.

That, then, because he is experiencing it towards other men, teachers, peers, whoever it is, he can now -- he now has the opportunity to understand the nature of his experiences and why he doesn't feel quite like other boys, why he doesn't feel as masculine, and why he doesn't feel as masculine.

Now, in otherwise healthy circumstances, he will grow up to be a healthy gay man.

Q Now, the other boy is given puberty blockers. What

happens in his case?
A Such a person who does not develop sexual -- the capacity for sexual arousal and sexual attractions because the very biological features which produce that have been held from him,
13:13:14 he never experiences an orgasm. He never experiences sexual arousal, and doesn't have the opportunity to understand the other potential explanations for why he feels the way he does, and go from a child's understanding of why he doesn't feel like other boys, to an adult's understanding of why he doesn't feel
13:13:36 like other boys.

By blocking puberty, you are blocking the very information that he needs to understand his own situation.
Q And you are not claiming to describe every person who is experiencing gender dysphoria, I take it?
13:13:49 A Correct.
Q Does the evidence show that sexual orientation changes after a person identifies as gay or lesbian?
A No. There is no evidence to suggest that sexual orientation is unstable or changes.
13:14:05 Q What does the evidence show about whether a person's gender identity can change?
A That shows the very opposite. Among the children, it changes in the majority of them.

They're even people who identify and describe themselves,
13:14:19 for example, as being fluid, the very definition of which is

that their gender identity changes on a constant basis.
Q Are you familiar with the argument that if we do not allow minors to transition medically, the result will be increased suicides within these group of young people?
13:14:38 A I've heard that said, yes.
Q Does the research literature support the argument that denying these treatments will lead to an increase in suicidality?
A No, it does not.
13:14:50 Q Are you familiar with what other countries are doing, with respect to treatment of gender dysphoria?
A Yes, I am.
Q Are there any changes going on in recent years?
A Very much. In fact, things -- it's almost as if the
13:15:10 pendulum has reached its far point, and it's now coming back to a much more moderate evidence-based tone.
There was really -- sparking off of the social media age more than anything else, we're able to identify a greatly, greatly accelerated, great and greatly expanded number and type
13:15:31 of person who was potentially going to go through transition entirely, unlike the groups which we had previously studied.
Several countries, especially in Europe, permitted them with lower and lower standards. And then once the reports started coming out that that was failing greatly, they're now
13:15:53 restricting very, very quickly and very, very greatly.

The two most substantial bans have been in Sweden and in Finland. And there are also now very, very strong statements urging the medical field to pull things back in the UK and in France.

13:16:08 Q Dr. Ladinsky testified yesterday that -- I don't have her exact words in front of me -- but she said that what's going on in the UK and Sweden and Finland isn't as relevant here because those countries have a centralized health-care system, whereas we have a less centralized health-care system, and all these

13:16:35 experts unrelated can see the same child.

That's a poor paraphrase. The record will speak for itself. But assume she made that type of testimony. Would you agree with her?

A No. I can't see the logic of it. It's certainly

13:16:53 feasible, in fact, more than likely that decisions are made differently when there are centralized boards and a centralized authority charged specifically with reviewing the evidence that will be the basis of the medical procedures of that country, and the U.S. lacks that.

13:17:11 But there's no reason to think that that situation would change the actual outcomes of the actual children getting the actual interventions.

Q So is it possible, then, that a more centralized health-care system may provide the ability -- an even greater

13:17:24 ability to study and evaluate the risks and benefits of

gender-affirming care?
A That's demonstrably true. That is exactly the process they have gone through. They have published the results of exactly their reviews, and that is how their health-care
13:17:40 systems -- that is what their health-care systems are responding to.
The American professional associations have not gone through such a comprehensive process. They're merely coming up with policies and citing only individual pieces of studies that
13:17:54 appear to support it, rather than a comprehensive review.
Q I want to close a loop on adolescent onset gender dysphoria. We talked about ways different groups are different.
What's unique about this group of adolescent onset, or you
13:18:11 referred to it also as rapid onset gender dysphoria?
A Yeah. It's been called both.
Where both the childhood onset and the adult onset are primarily male, the adolescent -- the adult onset and childhood onset are primarily male. The adolescent onset is primarily is
13:18:28 female. They present with a different set -- it's a different epidemiological set of characteristics, and the evidence that we have about both adults and children don't seem to apply to that middle group.
Q Does this group of people presenting with gender dysphoria
13:18:45 in their adolescence -- you said primarily female?

A Yes.
Q Do they tend to have any issues or comorbidities in common with each other?
A The most common one of those would be borderline personality disorders and other difficulties with integrating socially into their environments. As I say, such as autism and Asperger's syndrome.
Q You are not saying that's true for everyone presenting with gender dysphoria for the first time in their adolescence?
13:19:13 A Correct.
Q But many?
A Correct.
Q What does the research literature show about the desistance or detransition rates of people who transition after
13:19:25 first presenting with gender dysphoria in their adolescence?
A There has never been any such study.
Q Did you review the plaintiffs' reply brief, Dr. Cantor?
A Yes, I did.
Q Did you see any response to your report in plaintiffs' reply?
13:19:41 A Not a single comment. My name was never mentioned. None of the studies that I cited were referred to. None of the arguments were addressed. I don't believe I was quoted anywhere in it, unlike the other experts.
13:19:56 Q I did note a line that the plaintiffs criticized the

defendants' experts in general for relying on older studies.
A Yes. I saw that claim. I was a bit confused by it.
In my report, I provided a comprehensive list of every single study. There were 11 in total. So the old studies were
13:20:18 listed, the new studies were listed. It was comprehensive.
It was also a tangential argument. As I said, the 11 studies which have been conducted were unanimous in their findings. They all found the same thing. The majority desists.
13:20:33 So it doesn't matter even if one did rely only on the older studies, the newer studies showed exactly the same thing as the older studies.
Q We spoke a little bit about some of the things we heard from Dr. Antommaria this morning. I want to turn to some of
13:20:55 the things in his report.
You reviewed his written expert report, did you not?
A Yes, I did.
Q He -- Dr. Antommaria wrote on -- in paragraph 17 of his report -- and I will find a copy if you need it, but this is
13:21:07 one sentence.
Quote, gender-affirming medical care is supported by clinical studies. Is he right?
A That's true for adults, but that's not true for the other groups.
13:21:21 Q And Dr. Antommaria spoke about how if a drug is FDA

approved in one area, it's okay to use it off label in another area?

A That's what he said, yes.

Q What does the research literature say, or what opinion do you have about using the same drug, a puberty-blocker in the case of a person who's six, seven, eight, the purpose is to -- precocious puberty, what about the cases of precocious puberty and using puberty-blockers to help someone medically transition at the beginning of normal puberty?

A Well, the ability to use a medication off label is not a blanket permission to give any drug you want for any reasons you want or for any conditions you want.

Ultimately, it's going to depend on what the scientific literature itself says, which in turn is what the various regulatory bodies use to make their decisions to decide what's off label or on label to begin with.

So because a medication would be useful for some people in some situations and some circumstances, does not mean it's automatically going to be useful for other people in other circumstances. Indeed it could be deleterious.

If you use a puberty-blocker in somebody with precocious puberty, you are pushing somebody who is far below the average age of puberty, and you are bringing them closer to the species-typical range of puberty.

If you give that same drug to somebody who is already

having a typical age of puberty, you are now pushing them outside of the species-typical age.

Q Thank you, Dr. Cantor.

I am going to sum up. Does the research literature support plaintiffs' claims that we need to treat children and adolescents with gender dysphoria with social transition puberty-blockers and cross-sex hormones?

A I'm sorry. Could you say that -- I missed the first half of that sentence.

Q My apologies.

Does the research literature support plaintiffs' claims that we need to treat children and adolescents with gender dysphoria with social transition, puberty-blockers, and cross-sex hormones?

A No. That's terrible overstatement.

Q Does the research literature support Alabama's description of these treatments as experimental?

A Yes. They're fairly called experimental.

Q When does a drug or a course of treatment stop being experimental?

A That's an excellent question. There is no real test for it. There is no objective way to decide something is one versus the other.

Science is never finished. It's always possible for there always to be some future piece of information that changes what

we know.

There are, of course, you know, different situations -- drugs, issues under active investigation, where it's very clear that it's still experimental, and others where, you know, there is only very little question left.

For this particular situation, we have a very small number of studies that in certain situations might look like they might be helping, but a much larger body of better performed studies showing that the improvement is not actually coming from the transition itself.

Indeed, there were other areas of the report that were referred to already ongoing studies testing exactly these interventions. Well, that there exists ongoing tests of these interventions is pretty much the definition of calling something experimental.

Q If scientists are eventually able to replicate the same results under the same conditions over and over again, can you then pretty much say something is established?

A Yes.

Q Has anybody been able to replicate the results of, say, the Dutch study that showed at least some positive results with a combination of treatments?

A No. Most of the studies have demonstrated no improvement in these children from medical transition.

Q Do you understand plaintiffs to argue that Alabama is out

of step with groups like the American Academy of Pediatrics?
A Yes, I've heard them say that.
Q What's your response?
A Well, it's actually the American Academy of Pediatrics which is out of step with the international standards.
Q Is there a consensus, a medical consensus internationally in support of these treatments?
A There is now a very quickly developing one. It is still ongoing debate, so I would hesitate to describe it -- describe that there is a solid consensus.
As I say, really what we have seen is a pendulum swing which is overswung and now is substantially and very quickly correcting itself.
Q Is the pendulum swinging in favor of medical transition use of puberty-blockers and cross-sex hormones for children and adolescents?
A No. It's swinging now against that.
Q Is there a medical consensus in the United States for the best way to treat gender dysphoria?
A No, there is not.
MR. DAVIS: Thank you, Dr. Cantor.
THE COURT: So I do have a question myself.
Dr. Cantor, you said that an adult should be affirmed in their transgender status.
THE WITNESS: An otherwise mentally healthy adult,

yes.

THE COURT: All right. So make it clear to me, then, when should an adolescent or a child be affirmed in that status?

13:27:10 THE WITNESS: That, to me, is an empirical question. We are not sure actually when the best time do that is. Every time we check, we keep finding that, no, that's not exactly the right way. No, that's not exactly quite working. And when we do think we have run into a clue that gives us 13:27:26 an idea of when, we are not able to recreate that situation.

THE COURT: Is that case by case, then?

THE WITNESS: I would hesitate to say case by case exactly because --

THE COURT: Let me rephrase it. Under what 13:27:44 circumstances would you affirm a child or an adolescent?

THE WITNESS: I can't say that there's a situation -- all of the situations will be gray. I can't think of any evidence that would give us the kind of certainty in any case that would outweigh the potential risks.

13:28:19 THE COURT: So you would never affirm a child or an adolescent?

THE WITNESS: Not with the current evidence available, no.

THE COURT: Okay. All right. Cross?

13:28:28 CROSS-EXAMINATION

BY MS. EAGAN:

Q Good afternoon, Dr. Cantor.

A Good afternoon.

Q Dr. Cantor, you are an adult clinical psychologist, correct?

A Yes.

Q You are not a medical doctor?

A Correct.

Q Your private practice -- in your private practice in Toronto, the average age of your patients is 30 to 35 years old?

A Average, that would be about right, yes.

Q You've not ever provided clinical care to transgender prepubertal children?

A Correct.

Q You have not provided care to a transgender adolescent under the age of 16?

A Correct.

Q The extent of your experience, Dr. Cantor, working with transgender adolescents consists of counseling six to eight transgender patients between the ages of 16 and 18; isn't that correct?

A Yes.

Q So your clinical experience with gender dysphoria really lies in the counseling of adult patients?

A Correct.
Q And you acknowledge that gender dysphoria in children does not represent the same phenomenon as adult gender dysphoria, correct?
13:30:24 A Correct.
Q And, in fact, to use your words, they differ in every known regard, from sexual interest patterns to responses to treatments?
A Correct.
13:30:36 Q Dr. Cantor, you have never diagnosed a child or an adolescent with gender dysphoria?
A Correct.
Q Never treated a child or an adolescent for gender dysphoria?
13:30:48 A Correct.
Q You have no experience personally with monitoring patients who are undergoing puberty-blocking treatment?
A Correct.
Q You don't know what type of monitoring is typically done
13:31:04 or not done on those types of patients; isn't that fair?
A No.
Q No, that's not fair?
A Well, you -- I personally didn't do it, but I am aware of the procedures that are done.
13:31:15 Q Okay. But you have no experience with that?

A That's correct.
Q Similarly, you have never monitored -- or you have not monitored an adolescent or teenage patient on hormone therapy?
A Correct. Until -- well, I wouldn't be monitoring the
13:31:34 status in any case, so, yes, that's correct.
Q I am going to switch to UAB Children's, the gender clinic here in Alabama.
Have you ever spoken to a child or adolescent who was treated at the gender clinic here in Alabama?
13:32:00 A No.
Q Have you ever spoken to any former patients of the clinic?
A No.
Q You weren't here yesterday to hear Dr. Ladinsky talk about the treatment protocols they have at children's UAB, were you?
13:32:12 A Correct.
Q You weren't here to listen to the results of treatments provided to adolescent patients at UAB's Children's in the gender clinic; fair?
A Yes. They have never published them.
13:32:27 Q And you weren't here to hear them?
A Correct.
Q Dr. Cantor, you have no personal knowledge of the assessment or the treatment methodologies that are used here in Alabama at UAB Children's Hospital, correct?
13:32:42 A Correct. Correct.

Q You do not know the disciplines of the medical providers who are part of the treatment team involved in that assessment at UAB Hospital?
A Correct.
13:32:56 Q Now, I heard your opinion that it's important to assess the mental health issues of an adolescent patient to see whether that is a potentially contributing factor to gender dysphoria and whether there's a need to address. That's a fair statement of your opinion?
13:33:17 A I'm sorry. Would you repeat that, please?
Q Sure. It's your belief that mental health issues need to be assessed and addressed before a transition occurs?
A Correct.
Q Do you know what assessment protocols at UAB Children's
13:33:31 are to address mental health issues before a child is put on any transitioning medication?
A No, I do not.
Q Do you have any idea or do you know what the doctors at UAB Children's discuss with their adolescent patients about the
13:33:48 risks and the benefits of medical treatments at UAB?
A No.
Q Wouldn't you agree -- well, never mind. I am going to move on.
Dr. Cantor, I want to talk with you a minute about -- or a
13:34:18 little bit about your criticisms of the various studies

regarding the efficacy of puberty blockers and hormone treatments, okay?

A Yep.

Q As I understand your report and your testimony today, one of the criticisms you have of some of those studies is that it relies on participant's self-assessment I believe is the language that you used.

Essentially, it is based upon what socially transitioned youth and their family is reporting about their mental health in these studies?

A I would say that's incomplete. My criticisms would be relying on such subjective accounts entirely for all the decision making rather than using it as one part of the decision making.

Q In other words, basing your study based upon what the participants in the study tell you how they're feeling at different points in the study?

A Being limited to that is a problem, yes.

Q And I believe the way that you phrased it, you said, subjective self-reports about how one is doing may not be reflecting reality objectively.

A Correct.

Q But, Dr. Cantor, self-reports about how one is doing may reflect reality, fair?

A That's correct.

Q So when somebody says, I am doing well, my mental state is better, that very well may be the case?
A May be the case, yes.
Q Another complaint that you have, I believe, is what you call confounded data. And I believe you referred to the de Vries study for that?
A The two de Vries's studies, yes. As a matter of fact, it's all but two of all papers in that set of literature.
Q And by confounded data, the way that I am understanding it, what you're saying is that you are not able to tell because the data is, quote, confounded, whether one's improved mental health for a minor who has socially transitioned, whether that came from the actual medical services, whether it came from the psychotherapy, or whether it came from the combination of both?
A Correct.
Q But one thing, Doctor, that you do have to admit is when adolescents with gender dysphoria have transitioned through a combination of medical services and psychotherapy, you have to admit that based upon the studies, their mental health improved, correct?
A No. There were several studies that showed no improvement even though -- even though they were receiving both. I've listed them in my report.
Q Can you direct me to where in your report those are, please, sir?

A Sure.

THE COURT: While he is looking, did you say your target is an hour; is that right?

MS. EAGAN: Yes, sir. I believe I should be able to be done in an hour.

13:37:33

THE WITNESS: Page 20, footnote 40.

BY MS. EAGAN:

Q I'm sorry, sir?

A Page 20, footnote 40. The Carmichael study, the Hisle-Gorman, et al, study, and Kaltiala.

13:37:48

My full sentence was, New studies continue to appear at an accelerating rate, repeatedly reporting deteriorations or lacks of improvement in mental health, footnote 40 -- or again, those were the specific studies -- and then or lack of improvement beyond psychotherapy alone, footnote 41.

13:38:23

Q Certainly, Dr. Cantor, though, there are many study -- or there are studies that indicate when adolescents with the combination of medical service and psychotherapy transition, their mental health has improved. You agree with that statement?

13:38:40

A I would have to check to see if the number is zero or a handful. There have been reports of there having been such improvement, such as the Branstom study, which once it was reanalyzed, discovered to have problems, and the finding was withdrawn.

13:39:00

So there -- again, I would have to go through and check to be sure that it's not zero. It would be fair to say that there might have been a study which found such a thing. But the majority of studies are finding either no improvements or deteriorations, or it's a situation that we call a failure to replicate.

Q Sir, I am a little bit confused, because I want to go to two of your studies that you have actually talked about today, the Costa study and the Achille study.

Now, as I understand your testimony today, in those studies, there was -- the studies reported that there was an improvement in mental state for adolescents who were treated with medication and psychological treatment in transition that there was an improvement, but in those, you said you can't tell whether it's from the medication or from the psychological treatment?

A No. The Costa study and the Achille study associated the improvement specifically with the psychotherapy and ruled out that the effects were due to the medical interventions.

Q Okay. Well, let's pull those studies, Doctor, and let's look at those.

If you could, there should be a notebook up there that has plaintiffs' exhibits in it. Is that one plaintiff, sir?

If you could please, sir, turn to Plaintiffs' Exhibit 34.

A Yes.

Q All right. Plaintiffs' Exhibit 34, is this the -- do you say Costa or Costa?
A I'm sorry?
Q Do you say Costa?
13:41:05 A My guess is Costa. I have never met the person.
Q All right. Exhibit 34 that you have in front of you, is that the Costa study?
A Yes, it is.
Q All right. So, Doctor, I first want to focus in on --
13:41:18 well, let me ask this: This study was aimed at assessing gender dysphoric adolescents' global functioning after psychological support and after puberty suppression, correct?
A Yes.
Q Bear with me. I am going to take this out so I can put it
13:41:42 up on the Elmo, sir.
All right, sir. I am going to direct your attention to results that I have highlighted on my copy. Okay? According to the abstract here, the results?
A Yes.
13:42:18 Q At baseline, gender dysphoric adolescents showed poor functioning with -- it defines the mean scores. So baseline means at the start of the study, correct?
A Usually it does. I would have to check that that's exactly how they used the term.
13:42:35 Q All right. We will get to the details of that in a

minute.

Okay. Gender dysphoric adolescents' global functioning improved significantly after six months after psychological support. And then it goes on to say, Moreover, gender dysphoric adolescents receiving also puberty suppression had significantly better psychosocial functioning after 12 months of puberty suppression compared to when they had received only psychological support.

Did I read that right, sir?

13:43:07 A Yes.

Q Do you remember the methodology that was used for this study, sir?

A Roughly.

Q Pardon?

13:43:14 A Yes. Roughly.

Q Sorry. I meant to -- all right. And do you recall that the methodology was everybody started at baseline. For the first six months all of the adolescents received psychological counseling. And then for the next 12 months beyond that, one

13:43:36 group received puberty blockers, and one group just continued to receive psychological counseling. Do you recall that?

A Yes.

Q All right. And then I am going to direct you, sir, to page 2211 of the -- if you look at the blue writing on the top,

13:44:12 it's page 6 of 9.

A Yes.
Q All right. And I am going to direct you, sir, to on the CGAS on follow-up?
A Yes.
13:44:32 Q All right. And I am going to start at the second paragraph where it says delayed eligible. Do you see where I am talking about?
A Yes.
Q This is talking about there were three follow-ups, right,
13:44:43 at 6 months, at 12 months, and at 18 months for this study; is that correct?
A That sounds familiar to me, yes.
Q And let's read through that together.
Delayed eligible gender dysphoric adolescents, who
13:44:55 received only -- and gender delayed, GD adolescents, is your recollection that those were adolescents who were eligible to receive puberty blockers, but they delayed them for six months so that they had everybody at a -- doing psychological study? Do you remember this is the group that gets the puberty
13:45:17 blockers?
A Yes, that sounds correct.
Q Okay. The delayed eligible gender dysphoric adolescents who received only psychological support for the entire duration of the study -- excuse me -- I take that back.
13:45:29 This was actually the group that just got the

psychological -- had significantly better psychosocial functioning after six months of psychological support, okay?

However, despite scoring better at the following evaluations, they did not show any further significant improvement in their psychosocial functioning.

Did I read that right?

A Yes.

Q Also, the delayed eligible group continued to score lower than a sample of children adolescents without observed psychological psychiatric symptoms even after 18 months of being in psychological support.

So what that's saying is after 18 months, they were still below a group that did not have psychological therapy or issues, correct?

A Yes.

Q On the contrary, the immediately eligible group, who at baseline had a higher, but not significantly different psychosocial functioning than the delayed eligible group, did not show any significant improvement after six months of psychological support. However -- and this is the key -- immediately eligible adolescents had a significantly higher psychosocial functioning after 12 months of puberty suppression compared to when they had received only psychological support.

Did I read that correctly?

A Yes.

Q Then you see at the top of this, there is a chart. And when you look at this chart, the bottom is actually the three different check-ins. Time zero is baseline, when the study started, right?

13:47:18 A Yes.

Q Time one is the six-month check-in, correct?

A Yes.

Q And during that six months, both groups are getting just psychotherapy, correct?

13:47:31 A Yes, I believe so.

Q The rest -- and just to orient us.

The red group, the red line is the group of adolescents who only got psychotherapy or psychotherapy through the entire 18-month study, right?

13:47:46 A Yes.

Q The green line that you see that goes up -- goes up and keeps going up, that is the line of adolescents who receive puberty blockers; fair?

A Yes.

13:47:59 Q And so, Doctor, to get to the ultimate conclusion of this study that you say shows that puberty blockers don't work or don't give any improvement in mental condition over psychotherapy, the conclusion, this study confirms the effectiveness of puberty suppression for gender dysphoric

13:48:37 adolescents. Recently, a long-term follow-up evaluation of

puberty suppression among gender dysphoric adolescents after that CSHT, which is hormone therapy and GRS, which is puberty blockers, has demonstrated that gender dysphoric adolescents are able to maintain a good functioning into their adult years. This present study, together with this previous research, indicate that both psychological support and puberty suppression enable young gender dysphoric individuals to reach a psychosocial functioning comparable with their peers.

Did I read that conclusion correctly?

13:49:17 A Yes.

THE COURT: Ms. Eagan, when you reach a comfortable spot, let's take a post-lunch break.

MS. EAGAN: Perfect. We're good, Judge. We can go ahead and break now.

13:49:35 THE COURT: Okay. I will see you in 15 minutes.

(Recess.)

THE COURT: Go ahead, Ms. Eagan.

MS. EAGAN: Thank you, Your Honor.

BY MS. EAGAN:

14:09:00 Q Dr. Cantor, my understanding from paragraph 63 of your declaration is that the other study that you point to in support of your assertion that testing revealed that puberty blockers did not improve mental health any more than mental health does on its own is the Achille study you mentioned

14:09:29 earlier today; is that right?

A Yes.
Q If you, please, sir, could turn to Plaintiffs' Exhibit 42 in that binder in front of you, and this would be the plaintiffs' exhibits that we were looking at earlier.
14:09:42 A Yep. Got it.
Q All right. Is Plaintiffs' Exhibit 42 the Achille study that we just mentioned?
A Yes.
Q All right.
14:09:59 MS. EAGAN: Your Honor, do you mind if I take this off of this?
THE COURT: That's fine.
BY MS. EAGAN:
Q All right. I am going to -- so this is Plaintiffs' 14:10:15 Exhibit 42.
And the Achille study, again, was -- in this case if we look at the abstract, the background of the study or the purpose of the study was to examine the associations of endocrine intervention puberty suppression and/or cross-sex 14:10:35 hormones therapy with depression and quality of life scores over time in transgender youths.
That was the purpose of the study, correct?
A Yes.
Q And looking down to the results section, between 2013 and 14:10:56 2018 -- so this went over a five-year period, right?

A Yes.
Q And there were 50 participants in the study, correct?
A That sounds right, yes.
Q All right. And that they received endocrine intervention both -- some were in the form of puberty blockers, and some were in the form of cross-sex hormones, but endocrine -- and over that time period and completed three waves of questionnaires.
Is that your recollection of this study?
A Yes, roughly.
Q Okay. And when that was -- with those treatments, mean depression scores and suicidal ideation decreased over time, which means their depression was -- went down, or they got better. Suicidal ideation went down, which is improvement, correct?
A Yes.
Q While mean quality of life scores improved over time.
And then it goes on to say, When controlling for psychiatric medications and engagement in counseling, regression analysis suggested improvement with endocrine intervention. And then it goes on to say that this reached significance in male to female participants. And the male to female participants, those are ones that were receiving hormone therapy, correct?
A I believe they were both receiving hormone therapy. It

was not significant in one group, and so they're just reporting the successful in the other and not reporting the nonsuccessful group.

Q Well, let's talk about that. Let me pull up paragraph 63 of your declaration.

When you're discussing this study, here is what you said. You said that upon follow-up, some incremental improvements were noted; however, after -- so, in other words, upon follow-up, they saw improvements.

But after statistically adjusting for psychiatric medication and engagement and counseling, quote, most predictors did not reach statistical significance.

And that's your basis -- that statement is your basis to say there was not a statistical significance of difference between just counseling versus with meds; is that right?

A I'm sorry. Could you say that part again?

Q The language that you seize onto, to say that puberty blockers did not improve mental health more than mental healthcare did on its own --

A Right.

Q -- was the statement in the study that most predictors did not reach statistical significance.

A Well, I wouldn't say that I derived that just from that sentence. It's just easier to convey that idea to readers by using the sentence. My evaluation of the study is by those

statistics directly.
Q All right. Let's go to the language in the study that they talk about, the regression analysis that you were just referencing there.
14:14:11 Okay. And this is here in the regression analysis.
Let me first say this: The mean changes over time. And it does say, Mean depression scores decreased. Quality of life improved, but did not reach statistical significance.
But then when you go on to the regression analysis, here
14:14:39 is what it says. It says, Given our modest sample size -- which in this case was 50 people, right?
A Yes.
Q Given our modest sample size, particularly when stratified by gender, most predictors did not reach statistical
14:14:57 significance.
So one of the contributing factors to that, of course, was the size of the number of participants, correct?
A Yes. In statistics, that's a truism. The precision of the statistics is the direct -- direct result of the sample
14:15:20 size.
Q Okay. And then it goes on to say, That being said, effect sizes values were notably large in many models. In the male to female participants, only puberty suppression reached a significance level. And it gives the number in one of the
14:15:43 sample -- one of the tests, and associations with the two other

scores approached significance.

And then it goes on to say, For female to male participants, only cross-sex hormone therapy approached statistical significance.

14:15:57 All right. Statistical significance are not -- on all planes, the numbers improved, correct?

A No. That's -- the very meaning of determining -- factoring in whether something is statistically significant or not.

14:16:15 Q Ultimately, the writers of this study stated, if you look at the next paragraph -- or look on the discussion part if you want -- can you see the screen up here?

A Oh, I have the same thing on this screen.

Q Oh. You have got one. Okay, good.

14:16:31 Our results suggest that endocrine intervention is associated with improved mental health among transgender youth.

Did I read that right?

A Yes. Those are their words.

Q Doctor, to be clear, you agree that the U.S.-based medical 14:17:15 association guidelines and position statements are in support for the use of medical treatment combined with mental health treatment for adolescents with gender dysphoria, correct?

A I don't think I would phrase it quite that strongly. Most of the associations are using relatively vague terms. And it's 14:17:35 not clear when they're talking about adults or children, when

they're talking about transition, medical services versus psychotherapy, or a relatively blanket statement of demonstrating respect. I can only accept that they're endorsing a particular treatment when they're endorsing a particular treatment.

So is there a specific association or specific statement you have in mind?

Q The major medical associations that were involved in this space endorse the use of medications to treat gender dysphoria in children -- excuse me -- gender dysphoric adolescents once they reach puberty when appropriate?

A I can think of two medical associations, one interdisciplinary association, and the other -- and all of the others are, as I say relatively, vague words of support, and it's not clear exactly what it is that they're recommending.

Q Well, my understanding is what you like to look at is the international standards. That's what you're talking about today in support of your opinions?

A Oh, I looked at each of them, and I think I described each of them. I did my best not to leave any out.

Q So, and according to you, the Dutch approach is internationally the most widely-respected and utilized method for the treatment of children who present with gender dysphoria?

A Yes.

Q And the Dutch approach is also, I believe, what you call that watchful waiting approach?
A No.
Q Okay. The Dutch approach is what is accepted -- I have already said what you said.
14:19:24
The Dutch approach says social transition can happen at age 12, puberty blockers may be prescribed at age 12, hormones at age 16, and then resolve other mental health issues before transition. That's the Dutch method?
14:19:43
A Yes.
Q Do you know how that approach aligns with protocols that are utilized at UAB Children's in Alabama?
A I don't know.
Q In any event, what you say is internationally the most
14:20:03
widely-respected and utilized method for treatment of children who present with gender dysphoria, you would agree that that approach would be a felony in Alabama with this new law, correct?
A Yes. It's true that the Alabama law didn't leave an
14:20:26
exception for research purposes.
Q Okay. So let's talk about the European countries that you mentioned very briefly, the UK, Finland, Sweden and France.
When you look at those four European countries, Doctor, not one of them has enacted a ban to puberty blockers and
14:20:46
hormone treatments as Alabama has done here, correct?

A No.
Q That's not correct?
A Correct. That is not correct.
Q UK has not fully banned puberty blockers and hormone treatments in youth 18 and younger?
A That's correct.
Q Finland has not banned -- let me ask it this way: Has Finland banned blockers and hormone treatments in youth ages 18 and under for gender dysphoria?
A Yes, I believe it has.
Q It has?
A I believe so.
Q A blanket ban? Should I refer you to paragraph 131 of your declaration, sir?
A Hang on. That's just where I am now.
Q Okay.
A Oh, yes, they did leave an exception for hormones. The total ban was on surgery.
Q Thank you, sir.
Sweden, has Sweden put an absolute ban on puberty blockers?
A Yes.
Q And bear with me. Have they put a ban on puberty blockers and hormone treatments in youth ages 18 and under for gender dysphoria in Sweden?

A 18 and under?
Q Yes, sir.
A No. They allowed exceptions for 16 year olds -- 16 year olds within research circumstances.
14:22:32 Q Has France banned the use of puberty blockers and hormone treatments for adolescents ages 18 and under?
A No.
Q Can you point me to a single country, Doctor, in Europe that has put a blanket ban on the use of puberty blockers or
14:22:50 hormone treatments for youth ages 18 and under for gender dysphoria?
A Blanket ban in the way you're describing it, no.
THE COURT: How about any country?
THE WITNESS: No, not that I know of.
14:23:04 BY MS. EAGAN:
Q I want to turn very briefly to the subject of -- I will use your word desistance.
If you turn to paragraph 36 of your declaration.
A Yes.
14:23:36 Q In that -- you state, Among prepubescent children who feel gender dysphoric, the majority cease to want to be the other gender over the course of puberty ranging from 61 to 80 percent desistance across the large prospective studies.
I know that's a point that you also raised earlier today.
14:23:59 So I want to ask this question: Of those that number, do

you know, Doctor, what percentage of those kids cease to want to be the other gender -- that's using your words -- before or as they enter puberty, in other words, before they actually get into puberty? Do you know how many of those desisters are in that window?

A I must not be understanding your question, because it makes me want to say the same number that's in the report, 61 to 88 percent. What's different from what I said and what you're asking?

Q The 61 to 88 percent, is that children that realign with their birth sex before -- or as they're entering into puberty, that's that number?

A Yes.

Q Okay. All right. So I want to focus on a different category of youth. Let me ask you this: The medications in the United States, puberty blockers and hormone treatments cannot be given to kids for gender dysphoria until after they've actually entered into puberty, correct?

A Very many clinics are doing it as close to the beginning as soon as puberty starts as they are able.

Q But it's once they have entered puberty?

A Yes.

Q So let me ask you about that category of youth.

And that is adolescents who have entered into puberty, okay, and who have been -- have suffered from gender dysphoria

persistently, consistently, and insistently in childhood leading up to puberty, okay?
A Okay.
Q Do you have any data regarding what percentage of those individuals desist after they enter into puberty?
A No. I don't think that level of follow-up has yet been conducted.
Q And, Doctor, in fact, it's your belief that the majority -- that while the majority of prepubescent kids cease to feel trans, you know, to puberty or during puberty, in other words, as they enter into puberty, the majority of kids who continue to feel trans after puberty rarely cease?
A That does seem to be the case, yes.
Q Okay. Doctor, are you being paid to be here to testify today?
A Yes.
Q What's your rate?
A 400 an hour.
Q Who is paying your fees?
A The Alabama state -- State of Alabama.
Q Okay. Dr. Cantor, have you attempted to recruit parents in Alabama whose children have gender dysphoria and were prescribed or referred to gender-affirmative treatments, have you tried to recruit them to give a witness statement in this case that they believe the treatments are harmful?

A No.
Q Do you tweet?
A Yes.
MS. EAGAN: Your Honor, may I approach?
14:27:49 THE COURT: Yes.
BY MS. EAGAN:
Q Doctor, I've marked as Plaintiffs' Exhibit 45 a tweet Dr. James Cantor retweeted. And it's -- let me say this: Is this a tweet that you actually did?
14:28:40 A No. I --
Q You retweeted?
A Retweeted, exactly.
Q From a group called Genspect, or what's -- I don't tweet. Would you call that a group? I guess it's a group called
14:28:56 Genspect?
A It's there is a group called Genspect, and this is their Twitter account.
Q All right. And then you retweeted it?
A Yes.
14:29:03 Q And it says, Urgent. Attention. Alabama parents, if your child experienced gender dysphoria and was prescribed or referred to gender-affirmative treatments and you believe these treatments are harmful, please direct message, e-mail us at once. We are looking for witness statements. Can be anon.
14:29:26 By anon, I guess that means anonymous, correct?

A That would be my reading, yes.
Q All right. Doctor, have you seen a sworn statement under penalty of perjury for any Alabama parent whose kid received puberty blockers or hormones and the parent said the
14:29:50 medications hurt their kid more than they helped them?
A I'm sorry. Did you ask have I seen such a statement?
Q Yes, sir.
A Not that I recall.
MS. EAGAN: Nothing further.
14:30:05 THE COURT: Any redirect?
MR. DAVIS: Short.
THE COURT: Ms. Eagan, did you intend to offer that into evidence or no?
MS. EAGAN: Oh, yes. Thank you, Judge. I offer
14:30:37 Plaintiffs' Exhibit 45.
THE COURT: It will be admitted.
REDIRECT EXAMINATION
BY MR. DAVIS:
Q Dr. Cantor?
14:30:51 A Hi.
Q Is it true as a clinician you are not treating anyone who has presented with gender dysphoria as an adult or as a child?
A I treat adults with gender dysphoria, not children.
Q You are not treating them while they are adolescents or
14:31:09 children, you are not currently treating someone who is like

under age 16?
A Correct.
Q Okay. But you are familiar with the research literature on these issues, correct?
14:31:19 A Yes, quite.
Q And even those that are studying -- or children in adolescents?
A Of course.
Q You're knowledgeable about the treatment they're
14:31:29 receiving?
A Yes, very.
Q And are you knowledgeable about what the research shows about the efficacy of these treatments?
A Yes.
14:31:35 Q You had an exchange with Ms. Eagan where you admitted that a fact that is self-reported by a participant may be true?
A Correct.
Q What's the rest of that sentence?
A It is certainly not necessarily true. We need something
14:31:53 objective before we can make any decisions upon it.
Q Let's turn to the Costa study. That's at Tab 38 of the book of plaintiffs' exhibits.
MR. DAVIS: Your Honor, I'm sorry. I left a notebook. May I step over?
14:32:40 THE COURT: Certainly.

THE WITNESS: I'm sorry. You said Tab 38?
BY MR. DAVIS:
Q I was mistaken, Dr. Cantor. It was 34.
A 34 of the defendants'?
14:33:02 Q No. Of the plaintiffs' book.
A Yes. Now I'm back there.
Q Okay. Now, you have a line in your report in paragraph 57 of your report that I will just read to you.
It says, Both groups improved in psychological functioning
14:33:25 over the course of the study, but no statistically significant differences between the groups was detected at any point?
A Correct.
Q Okay. Are the three groups represented by the three colored lines -- the three groups you're talking about, the
14:33:41 three groups on the three colored lines on this chart I'm showing you?
A Part of the information is contained in that graph, yes.
Q Okay. Does this table tell us more about the statistical significance or lack thereof shown in the Costa study?
14:34:02 A Yes, it does. The results of this table, although much harder to read, indicate that there was no statistical significance between the groups.
Q Okay.
A What was changing in the groups was change over time
14:34:13 within the group relative to the same group previously. But

there were no changes -- no significant differences between the groups themselves.

Q Okay. What does it mean in a study if a finding lacks statistical significance?

14:34:29 A That there was a substantial probability of getting a pattern like that just by random chance.

Q And are there any reasons other than puberty suppression that the delayed group did not have the same change over time as the immediately eligible group?

14:34:45 A It's not exactly clear if they didn't change just as much. That's one of the ambiguities that, again, comes from statistics. When you look at it in different ways, you can see different aspects, different aspects of it.

Q And the authors actually noted statistical significance or

14:35:11 lack thereof, did they not, in the language that are bracketed there? It says, this difference failed to reach significance possibly because of sample size?

A That is correct.

Q Have you said anything about the Costa study in your

14:35:24 report that you need to withdraw after your exchange with Ms. Eagan?

A No. Everything I said is accurate.

Q Okay. Is the same true for everything that you have said about the Achille study?

14:35:39 A Yes. Everything I said was accurate. Nothing in the

prior discussion changed it.
Q The UK is still reviewing these treatments, are they not?
A They are in the middle of deciding what to do with what they have now discovered from their comprehensive review of the literature, which showed what they were doing was wrong.
Q What did they discover?
A They discovered that they said exactly what I said, that there is no evidence to support the medical transition of these children.
Q And they have not yet decided how to respond to that revelation, correct?
A Correct. They have now taken that report, and they're now reorganizing and deciding exactly what it is that they're going to do.
Q And in France, is it not correct that they've said about hormones that the greatest reserve is required for their use?
A That is correct.
Q And is it true that, quote, they have said that speaking of hormones, they're irreversible nature must be emphasized?
A That is correct.
Q And in Sweden, is anyone under 16 getting puberty blockers or hormone treatments?
A No. That is banned.
Q And what about over 16? Youth -- like --
A Between 16 and 18, they're permitted to do it, but only

within recognized research programs. A regular physician can't.

Q And how many such research programs are going on at present?

14:37:04 A Oh, in Sweden?

Q Are you aware of any?

A I am aware of one lab that has two locations. I don't know what its current status is with its current research program.

14:37:20 Q Okay. Can you say whether a single child under 18 is currently receiving hormones for the purpose of transitioning in Sweden?

A I don't know.

MR. DAVIS: Thank you, Dr. Cantor.

14:37:39 THE COURT: Any recross?

MS. EAGAN: No, Your Honor.

THE COURT: May this witness be excused?

MR. DAVIS: Yes, of course, Your Honor.

THE COURT: All right. You can step down, sir.

14:37:48 THE WITNESS: Thank you.

THE COURT: All right. Call your next witness.

MR. DAVIS: Your Honor, the State calls Ms. Sydney Wright.

THE COURT: All right.

14:37:54 SYDNEY WRIGHT,

having been first duly sworn by the courtroom deputy clerk, was examined and testified as follows:

THE COURT: And we think this will be how long, again?

MR. DAVIS: Less than 30 minutes on direct.

14:38:19 THE COURT: Good afternoon, ma'am.

DIRECT EXAMINATION

BY MR. DAVIS:

Q Good afternoon, Ms. Wright.

A Good afternoon.

14:38:26 Q Would you state your name for the record, please?

A Yes. It is Sydney Wright.

Q Can you pull that mic up a little closer to you?

A Yes. Will that work a little bit better?

Q Yes. Where do you live?

14:38:36 A I live in Cedar Bluff, Alabama.

Q And how old are you?

A I am 23.

Q What do you do for a living?

A Me and my wife own a business together.

14:38:47 Q What kind of business?

A We own a cleaning company.

Q Do you have any children?

A Yes. We have two.

Q What is your biological sex, Ms. Wright?

14:38:57 A It is female.

Q Did you at any time in your life seek medical treatment to try to appear more like a male?
A Yes, sir, for many years.
Q How old were you when you first decided to seek some type of transitioning care?
A I was 17 when I first started.
Q I've put a picture on the screen, Ms. Wright. This, for the record, is page 2 of Defendants' Exhibit 41. Is this you?
A Yes, sir, it is.
Q How old were you in this picture?
A This is my graduation pictures.
Q Were you about 17 when these were taken?
A Yes, I was. The summer before.
Q At the time -- at the time of this picture -- well, is this before you started receiving any cross-sex hormones?
A Yes. Yes. Yes.
Q To be clear for the record, at some point, you did receive testosterone, a cross-sex hormone in order to transition to male?
A Yes, I did.
Q What was going on in your life at the time that you decided that you were -- that you wanted to transition or to at least explore that?
A In my mind, there was this confusion inside of me that I was not matching with what was in my head, and what I saw in

the mirror with how I looked in the mirror. Like I felt like I was not the person I was supposed to be.

Q Had you been dating by the time you were 17?

A Yes.

14:40:37 Q Had you dated boys?

A Yes. I had -- I dated one man, yes.

Q Had you also dated girls?

A Yes.

Q Did you decide you would rather date girls?

14:40:48 A I sure did.

Q Did you at first struggle with coming to peace with the desire you had to date girls?

A I did. Both of my parents are very religious, as am I, and I struggled with being seen as being a lesbian and holding

14:41:06 my partner's hand and being seen that way, yes, sir.

Q When you started feeling that way, did having a feminine body cause you distress?

A Yes, sir.

Q What clicked for you? What first made you think that you

14:41:26 were living in the wrong body? What gave you the belief that you wanted your body to be more masculine?

A I first saw -- I never knew much about it until I got on Instagram, and I saw that others were transitioning.

And everything that I read up on it seemed to be so

14:41:40 positive, in that -- like that would fix the problems that I

was feeling inside, and it would fix my current problem of feeling like I shouldn't have been a woman.

Q Was it -- was most of what you learned about transitioning and gender-affirming care at first at least from social media?

14:42:03 A Yes. Yes, sir, most of it. Uh-huh.

Q Where did you turn for treatment when you decided, I really want to look into this?

A I turned to a psychologist at first. And then I turned to a gender clinic, as well.

14:42:16 Q Let's talk about the psychologist. How many times did you visit this psychologist?

A The psychologist, I visited them about six to eight times. I did keep going after I got my testosterone letter.

Q All right. How many times had you seen the psychologist

14:42:32 before you got the testosterone letter?

A I saw her one hour five times.

Q Okay. And I guess we need to make clear for the record what a testosterone letter is. What are you talking about?

A You have to have a letter to present to your gender clinic

14:42:49 doctor in order to be approved for hormones.

Q Now, understand I'm asking you to talk only about the experience that you had, not what anybody else going through this has had or what happened in any other clinics.

But for you, how deeply did you think this psychologist

14:43:13 delved into what was going on in your life before he or she

said, let's get you some testosterone?
A Looking back, she did not dive in deep. I was -- I went -- I had let known that I had been through trauma and that my parents went through a really bad divorce, and there was some very rough things in my childhood that was not dived into.
Q Did she also refer you to a mastectomy?
A Yes, she did.
Q Now, after you got your letters, did you go to a medical doctor to try to get these treatments?
A Yes, I did.
Q And where did you go? Is that the gender clinic you're referring to?
A Yes. I did go to the gender clinic.
Q All right. Tell me about your experience at the gender clinic.
A The gender clinic, they want to move you in and move you out as fast as they can with as little as talking to you as they can. The gender clinic I went to -- I went to two different ones, and they both acted the same.

The doctor that I gave my hormone letter to never even opened the letter. He kind of scoffed at me. And it was very belittling.

And I could tell right off the bat these people didn't care about me. And it -- and then you keep going. And I had read on my blood work on a couple lines, and he told me

everything was fine. And I started looking things up, and they were not so fine.

Q What do you mean you started looking things up?

A My blood work was showing signs that had never been shown in any of my blood work all through my life. And all of a sudden, they're off the charts. Like everything's going everywhere. And I'm starting to panic. I've committed my life to something, you know, and here I am now I -- you don't know what's happening. You're scared. So I was -- I was really scared at the time.

Q Did you seek medical treatment for these things that were going on?

A Yes. I ended up in the ER like four times.

Q Let's -- before we get further into that, let's talk more about these gender clinics. Where were they?

A In Atlanta, Georgia.

Q Okay. So you have never visited a gender clinic in Alabama?

A No. But they do, do them here at Planned Parenthood, and there is a couple of different places.

Q You don't have personal knowledge about those clinics?

A No, sir. Huh-uh.

Q So you saw the two clinics in Alabama (sic).

That first time you went, you said the doctor didn't even open your testosterone letter?

A No, sir, he did not.
Q Did you get the prescription for testosterone?
A He gave it to me without opening the letter. He -- I handed it to him, and he goes, great, here. You can go pick
14:45:58 your prescription up.
Q Okay. What do you do then? What do you do with your prescription?
A Well, I asked him, I said, am I -- what do I do? Like how do I -- are you going to give me my first shot today? And he
14:46:08 was like -- he kind of laughed at me. And he goes, no, not unless you are going to go pick it up from Rome and drive back to Atlanta, which was two hours, and bring it back to me. And I said, no, I can't do that. And he said, well, you can go home and figure it out. Watch YouTube videos. He said, you
14:46:24 can't kill yourself. So...
Q But you don't get the testosterone shot at the gender clinic. You get a prescription that you go get filled, and then you self-administer the shots?
A You can do it either way.
14:46:36 Q Okay. What were you told about the effects of testosterone?
A At the time, I was told everything you want to hear is going to happen. And I was told that there was going to be muscle mass increased, and that you are going to get facial
14:46:57 hair, and that your voice is going to deepen. You know,

everything that you are thinking is going to fix you.
Q Did your voice deepen?
A Yes, very much so.
Q Is it still deeper than it was when you were 17?
14:47:12 A Yes.
Q Is that likely a permanent effect?
A It is a permanent effect.
Q What were the other effects on your body from taking testosterone?
14:47:23 A Permanently?
Q Any.
A Any?
Q Let's start with when you were actually taking it. How did your body change?
14:47:34 A When I started taking it, the first couple things was my voice did drop. I did start to gain slight weight. And then after more months of being on it, the weight gain got very, very excessive. And I became prediabetic from my blood work and from the hormones. And then also my digestive system
14:47:55 started to not fail, but they were not working properly.
Q This picture, this picture is printed over two different pages, so I am trying to put it together now. Is that you?
A Yes, sir, it is.
Q And this is for the record pages 7 and 8 of Exhibit 42.
14:48:15 Where in the course of your treatment were you about this

time this picture was taken?
A A little under a year.
Q So you said weight gain. And then did you say prediabetic?
14:48:29 A Yes. I have become prediabetic.
Q And were you told that that was the result of the testosterone?
A Yes, sir, it was.
Q And this picture is from pages 9 and 10 of Exhibit 41, and
14:48:50 I will represent to you that the caption on this picture says that it was after a year on hormones?
A Okay. Yes. That one, yeah. That one.
Q That's you?
A Yes, it is.
14:49:02 Q And is that about a year after you were on hormones?
A Yes, sir.
Q How were you feeling physically?
A Physically, exhausted. I felt drained of life. Every bit of it.
14:49:19 Q Were you at least at first pleased with your body becoming more masculine?
A Absolutely. It was -- it was what I was wanting. That's why I can see both sides of everything.
And I was on the complete other side at the beginning. I
14:49:34 was all for this. This is everything I ever wanted. That's

why I did not want to -- I would have rather died than quit at the time.

Q Were you telling people you were a male?

A Yes.

14:49:46 Q Were you presenting yourself as a male?

A Yes. At the time, I worked for a very large corporation, and everybody referred to me as male.

Q Did you make any other changes in your life to reflect your change and identity from female to male?

14:50:01 A Yes. My driver's license and a lot of documents did reflect.

Q At the time, you were sure, weren't you --

A Oh --

Q -- that you wanted to be a male?

14:50:12 A -- 100 percent.

Q Were there any changes with your blood counts, like your red blood counts?

A Yes. My red blood cell count went sky high. That's when they started warning me of a heart attack or a stroke. That's

14:50:35 when things started getting way more intense.

Q Other than you mentioned being tired, feeling tired, did any of this -- any of the rest of this just make you feel bad in any way?

A Yes. So the red blood cell count -- I had no idea, but I

14:50:48 started itching very badly around my legs and my arms. It was

from the red blood cell count going up. My blood was starting to thicken. So it was putting me at a risk of heart attack or stroke.

They thought at one point I was developing a blood clot in my lung. And I was in the ER. And we had to do a couple of different painful tests. And they came to find out that it wasn't the blood clot, but that it was tachycardia, which was also caused by the hormones.

Q After you went to the emergency room, did you decide then, oh, I have made a mistake, I am going to get off these hormones?

A No. I was still determined.

Q Are you living as a male today?

A No, sir.

Q Are you a male?

A No, sir.

Q You are a woman, right?

A Yes, sir.

Q What changed? What made you at some point decide, I'm going back, and I am going to present myself as a woman and be the woman that I am?

A Well, one day my grandfather, who is the most important man in my life, like we had a down-to-earth talk. And we -- he made me realize a couple of things. And he said, if you will just quit, just for three years, just, you know, take a step

back, look at this at a couple of things. And so I did. I said, all right. You know what? You are not asking me to quit permanently. You are not asking anything outrageous. So, yes, of course. And so I quit. And that's where we went from there.

Q Let me show you the picture that's page 11 of Exhibit 41. Who is in this picture?

A My granddad.

Q And you?

A (Nodded head.) Yes. He -- he is the one that helped me and saved my life. And, gah, he's been a blessing.

Q That's you with your grandfather, though, right?

A Yes. He's never cared how I looked or anything, as long as I came to see him.

Q So he was suggesting that you get off the hormones long enough to look at things clearly?

A Yes. He was worried about my health.

Q Looking back, when you were going to the gender clinic, what did you need? Did you need medicine to try to make you look like a man? Or did you need counseling?

A I needed counseling.

Q You gave a written declaration in this case, did you not?

A Yes, sir, I did.

Q You had a line in there that I am going to read to you. For the record, this is Exhibit 27 and paragraph 23 of that

exhibit.

A Uh-huh.

Q You said, Unfortunately, there are more and more young people like me being deceived every day, being told that the solution to their insecurity and identity problems is to get a sex change.

Do you think the people telling those young people that are right, that that's what they need? They need a sex change?

A No.

Q Why not?

A Well, I believe that unfortunately that the doctors are out for the money, because there's a huge market on it. Because once you get somebody hooked on some medicine like this, you can never get off. It is a lifelong commitment. You have a lifelong patient.

But I also believe that at the end of every single day, I remember how I felt. At the end of every single day, I was a woman. You can't change it. There's no way -- like I could not change it. I could not escape what I was trying to escape. And eventually, you have to come to terms with that.

There's no -- I couldn't -- there was no way. And I lived it. I wanted it to be true. I wanted it so bad. But, no. At the end of every day, it's not.

Q What was your biological sex after you had been taking testosterone for a year?

A It was a female.
Q What was your biological sex when it said male on your driver's license?
A It was a female. I mean, every time.
14:54:52 Q So how long have you been off the testosterone and decided you're not going to go that course anymore, I am going to live my life as a female?
A I think I've been off for about three-and-a-half years, I would say.
14:55:09 Q Is there any way that you're different today physically -- still today as a result of having taken hormones three-and-a-half years ago?
A Yes. Yes. I still have to go to the doctor. I'm still having -- my digestive system is still messed up. I have
14:55:28 tachycardia still. I still have to get my blood work done because they're worried about my red blood cell count.
And some doctors -- my gynecologist isn't even sure if I am ever going to be ever be able to have children. It took my right away to have children.
14:55:45 Q Did you ever consider making a claim against the doctors who gave you these treatments?
A I tried to do a malpractice suit. And I couldn't find a single attorney to take the case.
Q Why not?
14:56:00 A They were afraid.

Q Afraid of what?
A They were afraid against the standard of code.
Q Was there any concern that you heard from any of the lawyers you spoke with about how long it had been since you had
14:56:15 received treatments?
A They were worried about the statute of limitations.
Q How long did it take you to realize that -- bad question. Let me start over.
How long did it take, from the day you set off on the
14:56:37 course of this treatment, to come to believe that the doctors had mistreated you?
A From starting it?
Q Yes.
A Okay. Half -- I would say around six to seven months I
14:56:51 started getting a little shaky feeling because I could -- I could -- I have common sense. I can see when people care and don't care about me. And when you're just being, you know. So I started seeing how they treated people. And I started watching the others at the gender clinics. And I -- it raised
14:57:13 more and more concerns as I went on.
Q Maybe some inkling. But I mean when you were -- when your eyes were opened --
A Oh.
Q -- and you realized oh, this was wrong? And you needed to
14:57:24 do something about it and possibly even seek recourse against

these doctors?
A That was -- when I was very much so in the hospital all the time was when I knew that I had to probably do a malpractice suit, or do something, or fight it. Because I didn't want anybody else to go through this at all.
Q It wasn't overnight. It took a while for you to come to that realization, right?
A Yes. It took months, years, like very, very time consuming. It took time.
Q Did you support Alabama's bill that affects these treatments?
A Yes, I did.
Q In what way did you support it?
A I spoke in support of the bill at the committee hearing.
Q The committee hearing. You mean the committee at the Legislature?
A Yes.
Q So you were a witness there?
A I was, yes.
Q Did you tell them that you hoped they would vote in favor of this bill?
A I did, yes.
Q What would you tell a young person who is struggling with gender dysphoria, feels like they were born in the wrong body, and they're wondering if the answer to their problems is to see

a doctor and get some hormones that will help them transition to the other sex? What would you advise that person?

A I would advise them to take a lot of time. Take a lot of time.

14:58:57 And you're going to realize in life that there is so many more important things than this. You are going to see that, you know, the people that care and love you. And just time will show you and open your eyes that it's not necessarily -- you will slowly see how you'll learn to love yourself. It 14:59:22 takes a lot of time.

And we can't fix who we are. But we are stuck who we are. And you should just love yourself.

And it doesn't matter if you are a girl. You can do guy things. And I can dress like a tomboy if I want. And it 14:59:37 doesn't have to be a certain way.

I've learned to love myself and love -- hold my wife's hand in front of other people. And it doesn't have to -- I don't have to transition for it.

Q Now, you have been through these treatments yourself, 14:59:55 Ms. Wright?

A Yes, sir.

Q Do you think doctors should be allowed to give minor children hormone treatments to try to make that person appear to be the other sex?

15:00:03 A Absolutely not.

MR. DAVIS: Thank you. I pass the witness, Your Honor.

CROSS-EXAMINATION

BY MR. DOSS:

15:00:17 Q Good afternoon, Ms. Wright.

A Good afternoon.

Q My name is Jeff Doss. I'm one of the attorneys representing the plaintiffs. We haven't met before.

Just to be clear, you don't know which of my clients, 15:00:34 Michael Boe, Zachary Zoe, Allison Poe, and Christopher Noe, all of whom are children, you don't know which of those children are, in fact, transgender, do you?

A No, sir. I would have no way of knowing.

Q Exactly. You don't know any of these kids, do you?

15:00:49 A No, sir.

Q And so you don't know whether any of my clients have been correctly diagnosed with gender dysphoria, do you?

A I don't believe in that diagnosis, sir.

Q I appreciate that clarification.

15:01:01 So, in your opinion, you don't think any medical treatments should be provided for anyone with gender dysphoria, do you?

A I believe that that's your own decision after the age of 21 or 18.

15:01:14 Q Another good point.

When you were testifying on direct examination, you kept using the expression young people, right?

A Okay. Uh-huh.

Q Now, you wrote an article in October of 2019 for the Daily Signal, correct?

15:01:29

A Yes, sir.

Q And that's marked as Defendants' Exhibit 41. And I will show you page 3 of that article.

You wrote, At age 18, I started seeing a bunch of transgender men's success stories on Instagram, right?

15:01:46

A Okay. Yes.

Q And you went on to write, I resented that and began to envy the transgenders. I looked into it for myself. Correct?

A Right.

Q So you were a legal adult at the time that you began considering that perhaps you were transgender, right?

15:01:58

A No, sir. I was 17. And then I turned 18 when I got the hormones.

Q Well, let's talk about that. On page 4 of the article, you wrote, I soon found a therapist who said she would help me, and I took her -- I told her I wanted to start the hormones on my 19th birthday, which was only five weeks off. She required only a one-hour appointment each week. Right?

15:02:19

A Right. Yes.

Q So did you start the hormones on your 19th birthday or

15:02:33

before?
A Started questioning at 17. 18, I started taking action to get a psychologist. And then I wanted to have the hormones by my birthday.
15:02:47 Q Okay. Did you, in fact, get your hormones by your 19th birthday?
A I was a couple of weeks off, but right at it.
Q Okay. So is it fair to say that when you received the diagnosis and you received the hormones, you were an adult?
15:03:00 A At the time, yes, uh-huh.
Q Ms. Wright, you are not and never have been transgender, right?
A I was transgender at some point, yes.
Q You considered yourself to be transgender?
15:03:22 A Yes.
Q Do you believe that you are, in fact, transgender?
A I am not now, no.
Q But at the time, did you believe you were transgender?
A Yes. When I believed it was something that could happen.
15:03:34 Q Okay. I believe you received a diagnosis of gender dysphoria; is that right?
A Yes, I did.
Q But sitting here today, you don't think that you really had gender dysphoria, right?
15:03:44 A No. I think it was a mental delusion.

Q So you did not think -- sitting here today, you don't think you had a diagnosis of gender dysphoria?
A No. I think I had mental problems.
Q Okay. And what was the name of the doctor who prescribed the testosterone for you?
A Katrina Jensen.
Q What practice was the doctor with?
A Balanced Living.
Q Okay. And that was in Georgia, right?
A Correct.
Q And, in your opinion, your counselor misdiagnosed with you gender dysphoria, right?
A Not that she misdiagnosed me. Because at the time, I did believe in gender dysphoria. That is why I was there.
Q Sitting here today, you believe that your counselor misdiagnosed you with gender dysphoria?
A Looking back, I don't think it was a misdiagnosis. I think it is a problem with gender dysphoria.
Q Okay. So do you think at the time you, in fact, did have gender dysphoria?
A You can think that the symptoms are similar and not necessarily the same as -- gender dysphoria, it's a mental problem. Like you don't see yourself as who you want to be, but it's probably caused from other issues coming in your life.
So necessarily, gender dysphoria is probably caused from

some other things coming from your life.

So I mean, I guess that she could have summed it up as that, yes, and whatever she put at the time was what she had thought. I -- I don't want to say I believe in it or don't believe in what she put at the time. She has since resigned counseling.

Q Okay. And to be clear, you have had no academic training, in terms of psychological diagnoses, right?

A No.

Q Okay. You testified that you tried to file a medical malpractice lawsuit against this doctor, but no attorney would take the case.

Did you report the doctor who prescribed the testosterone to you to any sort of state regulatory board in Georgia?

A I did not -- I reported -- I reported the counselor. The counselor has -- had her license removed, I believe. So that's the only one.

And then I tried to handle the doctor, but I could not make progress with the actual gender doctor.

Q When you say you tried to handle the doctor, what do you mean by that?

A I tried to -- I tried to do a malpractice suit and tried to report him anywhere I could.

Q So did you report the doctor to the state regulatory board concerning doctors?

A No. At the time, I didn't know how to do that.
Q All right. Ms. Wright, because you don't know any of my clients, you can't say whether or not they have benefitted or will benefit from puberty blockers or hormone treatments, right?
15:06:36
A Can I give a response? I can --
Q That's what I am looking for.
A Right. The only thing is I can say that it could harm them in the future if they change their mind. It's permanent.
15:06:48
Q But sitting here today, you don't know what benefits that they have experienced as a result of these medical interventions, correct?
A I don't know the benefits, but I do know the cons.
Q Absolutely. So you don't know what benefits they have
15:06:59
experienced, right?
A Sure.
Q All right. In your article that we looked at a second ago on page 14, you closed with, Until we do something, until the medical community puts up serious guardrails and begins to do
15:07:34
its due diligence, and until politicians grow a spine and step in, expect to see more young people scarred for life.
Did I read that correctly?
A Yes, sir.
Q Do you know what guardrails exist at the UAB Children's
15:07:48
health clinic?

A Please do tell me.
Q I am asking if you know.
A I don't. I want to know.
Q And then getting ready for today, I noticed -- I am not marking this as an exhibit, but I noticed, is this your LinkedIn page, Ms. Wright?
A I don't have it any longer, but at one point, yes.
Q Okay. And that's a photo of you when you appeared at the Alabama State House while testifying against this particular law, right?
A Yes, sir.
Q And if we go down a little bit, the about section, you wrote, I also speak as a child advocate in very large court cases all around the U.S.
Did I read that correctly?
A Yes.
Q Other than this case, what other court cases have you testified in?
A I have spoken for the VCCAP bills, the Vulnerable Child Protection Act. And I have spoke for South Dakota. I have spoke for Alabama a couple of times. And I think that's all at the moment.
Q And let me clarify. You wrote court cases.
A Oh, well --
Q Have you ever testified in court before?

A No. I'm -- I might not be the brightest on lawyer terms.
Q Likewise, under volunteer experience, you wrote that you are a public speaker for Compassion Coalition, and you said, I travel and speak at very -- all caps -- large court cases that change laws and standards of care and health, as well as make new laws. Right?
A That was what I helped with at one point.
I was trying to build my resume to try to look good for a position that I had put some experience that I did on there. So this is what I have experienced, not what I have done or any positions that I hold.
Q Okay.
A What does my past have to do with -- my past work have to do with the court case -- or not court case, but today?
MR. DOSS: One moment, Your Honor.
THE COURT: Uh-huh.
MR. DOSS: Thank you, Ms. Wright. That's all the questions I have for you.
THE WITNESS: Perfect. Thank you.

REDIRECT EXAMINATION

BY MR. DAVIS:
Q Ms. Wright, were you just mistaken when you referred to other events as court cases?
A Yes. 1,000 percent. I was -- and that was probably three years ago when I spoke at my first one and was extremely

excited.
Q Now, you said you do not support medical treatment for folks with seeking to transition. Let's be clear about that.
You mean -- did you mean by that like puberty blockers and cross-sex hormones, that's what you're against?
A Right. Yes.
Q Are you in favor of those folks getting counseling?
A Yes, 1,000 percent. I want all the children to be helped.
Q Do you consider yourself to have been mature enough to make the decision to transition to male and to take the hormones?
A No.
Q And you were how old at that time?
A At the time, I was 19. I still probably wouldn't have been good by 21.
Q Do you think under any circumstances a 13, 14, 15 year old would be mature enough to take these drugs?
A Absolutely not. If you would have told me that I could have become an animal or something at 12, you know, you would have taken that leap or something? No.
Q Thank you, Ms. Wright.
A You're welcome.
THE COURT: May this witness be excused?
You can step down, ma'am. Thank you.
THE WITNESS: Thank you.

MR. DAVIS: Your Honor, the State defendants have no other witnesses.

THE COURT: Okay. All right. Well, then, why don't I give everybody 20 minutes to get ready for their closing.

15:11:38 You know, again, I will give everybody 25 minutes. I think that's probably too long. I'm really interested in you giving me your analysis and tying in your evidence here at the end.

You know, to the United States, you know, I would say 15:11:51 since you are only arguing one issue and not five, to the extent you can limit yourself to ten, that would be appreciated, as well.

Does that sound reasonable to everybody?

All right. And by the way, if anybody just, you know, 15:12:04 needs five minutes, that's okay, too. So don't be compelled to use all your time.

Okay. Well, let's take 20 minutes so you have time to kind of recap, and we will come back and knock those out. Thank you.

15:12:17 (Recess.)

THE COURT: Please be seated. Thank you.

All right. Let's go ahead and get started.

Tell me how you think your time usage is going to run, Mr. Doss.

15:33:26 MR. DOSS: Hoping well below 25 minutes, Your Honor.

THE COURT: Excellent. Excellent.

So instead of asking any hypotheticals and putting anybody on the spot too hard, let me just say, you know, and I think you probably will do this anyway, but I would like everybody to directly address how to read Bostock and Brumby together.

I get it that Fourth Circuit precedent is not binding here, but I also want to see what you think the interplay is with Grimm. And then anything else you want to tell me.

But that would kind of be at the front of my mind. Everybody read those together for me.

So all right. Go ahead.

MR. DOSS: May it please the Court.

First, Your Honor, thank you for your time the past two days.

The State has spent the last two days, Your Honor, answering a question that is not dispositive of anything.

The State has focused and questioned our witnesses and introduced its own evidence to prove that there exists medical risks associated with the treatments that this particular Act aims at banning. We don't dispute that premise, Your Honor. We haven't disputed it since the beginning.

There is no such thing as a risk-free medical treatment. No one has come forward into this courthouse and identified what that risk-free treatment would be.

Mr. Bowdre, I thought it was telling when he was

questioning the United States' expert this morning, Dr. Antommaria about what if a person has a 40 percent chance of persisting, would it be appropriate to prescribe gender-affirming treatments? But that is simply not how clinical practice works, Your Honor.

15:35:22

No doctor in the state of Alabama that Your Honor has heard about is making these sorts of sterile clinical judgments based on statistics alone. It is a three-dimensional assessment that takes into account the parents, the child, the network, the child's background, the history of gender dysphoria that the child may have presented with. All of these issues are taken into account. It's never as easy as opening a book and looking at statistics and basing a medical judgment upon it. It requires individualized attention and individualized treatment.

15:35:41

15:36:04

Even Dr. Cantor suggests that multiyear diagnoses preceding medication ought to be the widely-accepted approach in this area. But this Act, Your Honor, strips doctors of that ability, and it strips the parents of the ability to weigh those risks. It is a fundamental freedom in this country, Your Honor, that parents have control over the care and custody and medical matters affecting that parent's child.

15:36:27

But the State replaces that right to weigh the risks. With its categorical prohibition, it supplants parental judgment and replaces it with the State's sole unchallengeable

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without exception judgment that no child should receive these.

There was a question this morning by the State to one of the witnesses that if a nine year old with diabetes receives insulin, that would be effective, but if a nine year old without diabetes receives insulin, it would be, quote, very dangerous. That hypothetical illustrates exactly what the problem the State is concerned about. Whether the diagnosis is accurate, and if it's not accurate, the treatment.

It makes sense that if you don't have diabetes, you shouldn't be prescribed insulin. In the same way, if you don't have gender dysphoria, it may cause issues if you're prescribed these gender-affirming treatments.

That becomes relevant, Your Honor, because of the standard of review applicable to our due process claim on behalf of the parents. Because the State is interfering in a fundamental right, the State must show a compelling State interest, and the State must show that these laws are narrowly tailored to meet that interest. This Act fails on both levels.

First, even if the Court were to credit all of the evidence in the State's favor and find that the evidence demonstrates a compelling interest, that alone does not save this law. If we take a step back and look at the evidence offered by the State, the principal concern, as I understand it, is that there's a strong possibility of desistance, as the State says. So this idea of watchful waiting is better than

medical intervention.

But that's a problem with the diagnosis, Your Honor. By definition, the obliteration of choice, the obliteration of treatment cannot be narrowly tailored.

15:39:05 Perhaps if the State had implemented regulations that set forth concrete guidelines that a clinician must follow before prescribing these medications, maybe that would present a closer question. Maybe we wouldn't be here today.

But the State didn't do that. The State took all

15:39:28 treatments off the table and made it a felony to follow these widely-regarded medical approaches.

A concern for misdiagnosis does not call for the obliteration of choice and treatment. I expect the State will cite to the Carhart vs. Gonzales opinion for the proposition

15:39:56 that medical uncertainty gives the government wider discretion in terms of regulating medical treatment.

Carhart, Your Honor, was an abortion case. It concerned the federal so-called partial birth abortion ban. And as Your Honor might expect, there's a very different analysis

15:40:17 associated when you're considering an abortion regulation, as opposed to when you're considering the deprivation of a fundamental freedom like parental choice.

Setting aside that difference, even assuming we can draw some meaning from the Carhart decision, the language that the

15:40:36 State is seizing upon, this issue of medical uncertainty, was

only part of the analysis. That may have given the State some interest in regulation, but that alone was not the end of the inquiry.

The Supreme Court went on to consider whether the 15:40:58 regulation imposed an undue burden, including whether the regulation would cause harm. We have shown, Your Honor, that this Act will undisputedly cause harm.

Our four plaintiff parents have very similar stories. You heard from one of them live, Ms. Poe. I don't think anyone can 15:41:27 hear her testimony and think that she is not sincere, that she doesn't have the best interest of her child in mind, and that she's -- she is seeing positive transformative, amazing benefits from these treatments that the State has dubbed risky.

Our other parents share similar stories. And those are 15:41:53 reflected in the declarations which we've submitted for Your Honor's consideration.

In this case, even if Your Honor were to apply that Carhart standard, which the State seems to be proposing, this law still fails. It undisputedly causes harm to those it is 15:42:14 seeking to supposedly protect. It is stripping them of positive medical treatments that exist.

Over the past day and a half, Your Honor, we have heard a refrain that these treatments are experimental. We've heard one -- two witnesses now define what that means.

15:42:40 Dr. Ladinsky gave an explanation. It doesn't fit these

treatments.

Dr. Cantor gave a definition I thought was interesting. As Dr. Cantor noted, it's very difficult to say when it no longer is experimental and it's established.

15:42:56 Under the State's logic, simply by dubbing a treatment experimental until we've reached some unknowable and undefinable level of certainty, that alone should be sufficient to override parental choice.

The problem, though, Your Honor, is that there are risks 15:43:15 with every medical treatment, and there are always unknowable risks. That's what makes them unknowable.

I can think of many commercials I have seen over the years where medications that have been on the market for years, some studies begin to associate them with adverse risks. And 15:43:32 plaintiffs' attorneys are soliciting clients because of these newfound risks.

In that regard, Your Honor, if we were to be as risk averse as the State is proposing, I submit with the introduction of antibiotics, the State likely wouldn't have 15:43:48 been on board because it had unknowable risks, despite our now knowledge that they are life saving.

At some point, medical treatment is going to be new. But newness on its own doesn't make it bad. And it certainly doesn't justify the State's interest in obliterating it and 15:44:06 criminalizing it.

And that is exactly what the Arkansas -- Eastern District of Arkansas found in the Brandt case. In that case, Your Honor, it didn't criminalize the parents. It only criminalized the physicians.

15:44:26 The Arkansas Court there still recognized that the physicians -- because this so intimately implicates parental choice, the physicians even had standing to assert those fundamental protections on behalf of their patients' parents.

The Eastern District of Arkansas found that the law in 15:44:47 Arkansas, which again didn't criminalize anything, it applied civil penalties. It was less egregious than the law here. Even the Arkansas law violated these fundamental protections and failed at strict scrutiny.

But we also challenge the compelling interest piece of the 15:45:13 strict scrutiny analysis, Your Honor. The State's compelling interest is, at best, that there's a concern for this desistance. But we have presented evidence suggesting that that concern is overblown.

Dr. Ladinsky testified that the standard of care endorsed 15:45:32 by every major medical association in the United States recognizes that the use of puberty blockers and hormone treatments can be appropriate in some adolescents with gender dysphoria.

Dr. Hawkins testified that the standard of care requires a 15:45:48 360 assessment that takes several months, and in some cases,

years before prescribing medical intervention such as puberty blockers. The standard of care allows time for adolescents to explore their gender identity, and not all adolescents receive medical intervention.

15:46:09 Recall, Your Honor, Ms. Poe's testimony. It took two years from the time that she and her daughter first visited the UAB Children's clinic until any medication was prescribed.

It is telling, Your Honor, that the State has been unable to identify a single doctor in the state of Alabama who has

15:46:38 ever run afoul of these kind of guardrails. It is equally telling, Your Honor, that the State has identified not one child who has received these treatments ever in the state of Alabama who later regretted them.

What we heard this afternoon was from Ms. Sydney Wright, a

15:47:03 Georgia resident who was an adult. Even if Georgia had had this exact same law in place, it would not have prevented her from obtaining the treatments she obtained. Ms. Wright's story is an unfortunate one. And if only Ms. Wright had had a doctor like Dr. Hawkins or a doctor like Dr. Ladinsky who was

15:47:31 committed to a deep meaningful evaluation of the child.

In Alabama, children receiving these treatments from the University of Alabama -- from UAB's clinic, they walk hand in hand with these physicians. That informs their choice.

We have introduced into the record, Your Honor, the

15:48:04 informed consents that parents are provided with, in addition

to loads of information. The parents still sign off on these treatments.

As Ms. Poe testified, she is terrified of what would happen if these treatments are prohibited. She knows well the risks, and she's weighed those risks against the benefits of receiving the treatment, and the devastating effects of not. And in light of that constellation, she exercised her freedom as a parent to make that decision in consultation with her child's team of doctors.

15:48:26 15:48:59 Indeed, Your Honor, even the study that the defendants have cited as the leading study, it recognizes the benefit of multidisciplinary approaches, including medical treatments in appropriate cases. The Dutch model that we heard about, it is the well-regarded standard nationally. It, too, would be illegal under this law.

15:49:19 So to the extent the State expresses some concern in support of its compelling interests, we submit that concern is hollow.

Even in the Carhart decision, Your Honor, the Supreme 15:49:37 Court acknowledged that a federal court's review of the constitutionality of a state statute looks at that underlying evidence, not just the State's stated concern.

In addition, as to the desistance risk, we've put in the Yale statement, Plaintiffs' Exhibit 19. There are two 15:50:06 footnotes that are important: 43 and 45. In that statement,

which is a literature review, it's a summary of the available scientific literature concerning this matter. It debunks this notion that there's widespread concern about desistance for the children who are receiving or eligible for treatment in the UAB clinic.

15:50:30

As I mentioned in my opening, Your Honor, at base, this law criminalizes a parent's concern and love for a child. There can be no clearer example of a violation of fundamental parental freedom.

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So as to the other compelling interests that the State cites, the kids can't understand because they haven't had sex and don't know if they will want kids. These are difficult questions, Your Honor, admittedly.

And if I were a parent of a child going through this, I

15:51:13

don't know how I would weigh it. But that's the point. I don't. And it's not my job to weigh it for someone else. These are highly personal, intimate considerations.

There are risks of fertility with other medications. A child with cancer going through chemotherapy faces such a risk.

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Under the State's logic, we ought to ban that. Of course, we don't do that.

In the same way, these treatments have proven, as Dr. Ladinsky testified, to be life saving. And they haven't been handed out like candy, as Dr. Cantor has tried to suggest.

15:51:56

There's no transition on demand in Alabama. It is not a

documented concern. I haven't even heard of it being a documented concern in the last day and a half anywhere in the United States.

The studies cited by the defendants in support of this concern for transition on demand, they all originate in Europe. Whereas, Dr. Ladinsky explained, regulation of hospitals, clinics in Europe, very different than it is in the United States.

The United States, the standard is clinics will have these robust protocols and procedures in place. They have these professional organizations that are providing this sort of oversight and input. We don't see that in Europe. So perhaps they may have been getting a little lax in Europe. But that's not happening in Alabama.

The defendants have suggested another compelling State interest is that the majority of kids ultimately align with their gender identity. But we've disproven that.

As Dr. Hawkins testified, gender identity is hardwired. It's unlikely to change. And once an adolescent reaches puberty, it's unlikely that they'll grow out of their gender dysphoria.

They suggest that a European pause is better than America's rush to treatment, but they have identified no country in Europe, in fact, no country in the world that has enacted a law like this one.

So for being a compelling State interest, I find it interesting that no other country has enacted a solution like Alabama proposes.

What does the State propose instead? Do nothing. Counsel them. That's an untested proposal. The State proposes an experiment on a grand scale. All transgender youth in the state of Alabama suffering from gender dysphoria should be guinea pigs.

15:54:01

THE COURT: I notice you're rolling through your time pretty good. Are you leaving some time to talk about your legal arguments?

15:54:21

MR. DOSS: Yes, Your Honor.

THE COURT: All right.

MR. DOSS: What's my time so far?

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THE COURT: I think you are just about there, but I might spot you a little bit.

MR. DOSS: In terms of the equal protection, I am going to defer to the government -- the United States because they're arguing that one. But I do want to make a couple of points.

15:54:44

The Eleventh Circuit has recognized that a violation of the Equal Protection Clause occurs when you discriminate on the basis of transgender people on transgender status, gender identity.

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In the State's opening, the argument I heard was that

that's in the employment context, and for employment, it may make a difference as to whether someone -- it should make no difference as to whether someone is male or female; whereas in the medical context, it does make a difference, and, therefore, it doesn't ultimately matter.

15:55:12

But it's not the Equal Protection Clause for an employment agreement. It's the Equal Protection Clause which ensures that no law forces the discrimination on the basis of sex. That that case concerned an employment issue is not the ultimate disposition. The issue is does the Equal Protection Clause recognize the discrimination on the basis of being transgender is, in fact, a violation? The Eleventh Circuit has said yes.

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So in light of that ruling, this law does, in fact, do that. It defines the scope of the law, in terms of people who are transgender, of obtaining a medical treatment in order to align one's gender identity with one's sense of self.

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By definition, the State tries to say not everyone with gender dysphoria is transgender, and not everyone who is transgender has gender dysphoria. But as Justice Scalia once noted, if you put a tax on yamakas, it's a tax on Jews. In the same way, not everybody may who has a yamaka may be Jewish, not every Jewish person may have a yamaka. But these things are so closely related that it's impossible to differentiate them and separate them out.

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And in that regard, we think it does violate the Equal

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Protection Clause. The State doesn't meet the standard of review for the same reasons outlined, with respect to the fundamental right to parental choice.

In terms of the First Amendment claim, I have appreciated the State's concessions, that they don't think that these things like referrals and mentioning the opportunities violates the First Amendment because of science or requirement.

But the problem is if you're making a referral for treatment as a doctor, you know full well what treatments are available, and you could, in fact, be construed as causing the receipt of those treatments. So it does criminalize speech.

THE COURT: So, you know, Alabama's criminal statute has a "but-for" in the definition of cause. So you think that overcomes the "but-for"?

MR. DOSS: I think the problem, Your Honor, it is not a proximate cause requirement. It's not the closest in time cause of treatment, but it is a "but-for" cause. It is a cause.

So had the child not received the referral, Dr. Ladinsky testified that 80 percent of her patients come to her through referrals. Had the patient not received the referral from the pediatrician, it's questionable whether or not the child would have been ultimately seen at the UAB clinic.

So it does raise a problematic chain of events. I mean, if it is a "but-for" cause, then that's all the -- alone that

is required.

THE COURT: I really like your chances in court in front of a jury if it comes down to just that.

MR. DOSS: As someone who primarily does criminal defense work, it's a little odd for me to be in court suggesting that something my client may do is a crime.

However, for purposes of this, I will say the way the statute's written, it's so broad. As the State argued in opening, a referral is both speech and an act.

So it is speech. In the same way the pastor's conduct could be swept under, that's enough to trigger First Amendment scrutiny.

As to the preemption claim, Your Honor, I will be brief. It's going to be primarily the same reasons as the Equal Protection Claim. There's at least the Northern District of Georgia case which recognizes that under the ACA, discrimination on the basis of sex can include discrimination due to transgender status.

It forces doctors to have to decide between compliance with federal law and compliance with state law. And, therefore, it should be viewed as preempted.

As to the void for vagueness argument, Your Honor, I think the State's responses to your questions throughout the past day and a half have illustrated the vagueness of this law.

When asked who is the primary defendant that the State

would charge, who is defendant number one that the State would charge under this law, the State hesitated. And you asked if -- Your Honor asked if it would only be doctors. The State hesitated.

15:59:36 The problem with this law, Your Honor, is no one can read this statute and get fair notice of what is and is not covered by the statute.

If I am a parent like the Noes, and I drive my child across state lines to get these treatments in Georgia where it 15:59:52 is legal, I've arguably caused. But I don't know. Maybe the State says that isn't covered.

If I am a treating pediatrician, if I am a local pediatrician, I make a referral, have I caused it? I don't know.

16:00:07 If I am a pastor, and I suggest that these things are available, have I caused it? I don't know.

The vagueness undercuts its constitutionality for those additional reasons.

Your Honor, we respectfully request that the Court enjoin 16:00:28 the enforcement of this Act.

THE COURT: Are you going to talk to me about Brumby?

MR. DOSS: That was the Eleventh Circuit --

THE COURT: Grimm?

MR. DOSS: That was the --

16:00:36 THE COURT: Bostock?

MR. DOSS: Bostock.

THE COURT: Three of those.

MR. DOSS: Bostock recognized in the Title VII context that discrimination against transgender people would be sufficient to qualify as a violation of Title VII. It's discrimination on the basis of sex.

Under Bostock, we think the same logic would apply when you're looking at either the ACA anti-discrimination provision or you're looking at the Equal Protection Clause, which would be consistent with Brumby, which was the Eleventh Circuit case I was referencing. I apologize I didn't mention the name.

But Brumby was the Eleventh Circuit opinion where the Eleventh Circuit recognized that both Title VII, as well as the Equal Protection Clause, protected against discrimination on the basis of transgender status.

THE COURT: So obviously Grimm is not binding precedent here.

And Bostock, the majority said, you know, we shouldn't prejudge what we might say about several other things, including the conduct in Grimm. And yet, they denied cert.

Do you want to read any tea leaves on that?

MR. DOSS: I don't, Your Honor. Only because I don't know -- it could have been a waiver issue. It could have been -- as to the denial of cert.

THE COURT: All right. Anything else?

MR. DOSS: That's all, Your Honor.

We respectfully request that the Court issue the injunction. We think that we've proven a substantial likelihood of success on the merits, as well as the other factors as laid out in our brief.

16:02:09

Thank you, Your Honor.

THE COURT: All right. United States.

MS. MONTAG: Good afternoon, Your Honor. Can you hear me?

16:02:25

THE COURT: I can.

MS. MONTAG: I'm Coty Montag on behalf of the United States. I intend to be brief.

At the outset of this hearing, the United States posed a single question to the Court. Does criminalizing certain

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medical treatments for transgender youth and only transgender youth constitute a form of discrimination that's barred by the Equal Protection Clause?

The testimony the Court has heard clearly demonstrates that the answer is yes. And failing to enjoin Senate Bill 184

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before it goes into effect in two days will immediately and irreparably harm youth, families, and providers.

The balance of the equities strongly favors preliminary relief.

The testimony the Court has heard demonstrates that we

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have met the requirements for preliminary relief on the Equal

Protection claim. And I want to briefly touch on the elements there.

First, the testimony set forth by the plaintiffs and United States demonstrates a substantial likelihood of success on the merits. Section 4 of Senate Bill 184 is subject to heightened scrutiny because it discriminates on the basis of sex and transgender status.

The law discriminates on the basis of sex by criminalizing gender-affirming care only when that care is being provided to transgender minors. The law prohibits transgender minors from obtaining care that has been well established as medically appropriate and necessary while imposing no comparable limitation on other youth for obtaining these same forms of care.

And Your Honor asked us to address Bostock, Glenn, and Grimm. And I just want to be very clear that these cases make clear the discrimination against transgender people is sex discrimination. And as Mr. Doss pointed out, in the Eleventh Circuit in Glenn vs. Brumby, this was in the Equal Protection context.

So because this is sex discrimination, heightened scrutiny must apply. And the burden is on the State to show that the law serves important governmental objectives, and that the means employed are substantially related to the achievement of those objectives.

And I just want to note from Bostock, when Justice Gorsuch said, Treating an individual differently because that person is transgender unavoidably constitutes sex discrimination because it rests on a person having one sex identified at birth, but identifying with a different sex or gender today.

Your Honor, defendants' assertion that the law does not discriminate based on sex is incorrect. There is no ambiguity in the law about the class of minors that it targets. It prohibits certain treatments only when used by those whose gender identity is different from their sex assigned at birth.

Defendants cannot meet the standard under heightened scrutiny. They cannot show that Section 4 of Senate Bill 184 serves important and governmental objectives, and that the discriminatory means employed are substantially related to the achievement of those objectives.

And I really want to touch on the substantial relation piece here, Your Honor, and make sure I'm connecting it to the testimony you have heard over the last few days.

First, as the Court has heard, the weight of medical evidence confirms that the medical care that Senate Bill 184 forbids is widely accepted, safe, effective, and medically necessary treatment for the health and wellbeing of some minors suffering from gender dysphoria based on individualized case-by-case consideration in accordance with well-established guidelines.

And for that, Your Honor, I would refer you to the testimony of Dr. Ladinsky, as well as United States Exhibit 7, the declaration of Dr. Antommaria at paragraphs 23 to 38.

The Court also heard testimony that the medical research supporting gender-affirming care is substantial rather than new or experimental, and that parents and minors are able to consent or assent to the risks involved.

And, again, I would refer to Dr. Ladinsky's testimony, as well as United States' Exhibit 7 at paragraph 16 and 21, and Plaintiffs' Exhibit 6, Dr. Ladinsky's declaration at paragraphs 7 and 47.

The Court has also heard testimony that individualized treatment is the goal here and that there is no rush to treatment under established guidelines for the care and treatment of transgender youth.

Again, this is from the testimony of Dr. Ladinsky, Plaintiffs' Exhibit 6 at paragraphs 9 to 13. It's very important here to emphasize that serious review and reconsideration at every step over a long period of time, normally years, is involved here. And all of the standards of care require a tailored approach based on an individual's needs.

The Court heard testimony that the medical care provided improves mental health for many transgender youth and reduces the risk of anxiety, depression, and self-harm. As Dr. Hawkins

testified, these youth receiving gender-affirming care not just survive, but thrive.

Again, I would refer to the testimony of Dr. Hawkins and Dr. Ladinsky, as well as Plaintiffs' Exhibit 3 at paragraph 27, and Plaintiffs' Exhibit 6 at paragraph 15.

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The Court also heard testimony as to the many harms if these minors are not treated, including depression, anxiety, suicidal ideation, eating disorders, and substance abuse. And we heard that from Dr. Hawkins and Dr. Ladinsky.

As Dr. Antommaria testified this morning, the law puts clinicians in the untenable position of either having to follow state law and knowingly harm their patients, or face penalties, including imprisonment and loss of their medical licenses.

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Your Honor, the standards of care for treating transgender individuals and particularly youth have evolved and will continue to evolve. But at the end of the day, it is well recognized that gender-affirming care can be and is an appropriate treatment for gender dysphoria for some transgender youth based on an individualized medical assessment in line with accepted standards of care.

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The well-recognized standards of care make clear that these treatments should only be made after extensive consultation with trained and qualified medical professionals, informed consent of the parents and the patient, et cetera.

But defendants' response through Senate Bill 184 is to

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simply criminalize access for transgender youth and only offer counseling.

At a minimum, even if there are two sides to whether this care is appropriate and effective and medically necessary, which, of course, we don't concede, that doesn't support a total ban, and a felony one at that. Instead, it supports individualized assessments of patients, which is already the status quo.

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The State has repeatedly argued in its papers and during oral argument that its legislative judgments are entitled to deference, and that the State is not required to de facto accept or adopt the conclusions or recommendations of a medical association or anyone else.

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But that's not what is at issue here under the Equal Protection Clause. It is well established that if the State makes the extraordinary decision of making a distinction or classification based on sex, which this law does, the burden shifts to the State to justify why it needs to take such a drastic step and why such a classification is necessary and justified. The weight of the evidence makes clear that the State has failed to meet that standard.

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Your Honor, I will not go into the other elements. We believe we have shown irreparable injury, the balance of the equities, and the public interests, and that they all justify preliminary relief.

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The United States seeks to preserve the status quo here and ensure that transgender minors can continue to access medically necessary and appropriate care while the constitutionality of this law continues to be litigated.

16:10:54 And I will close by saying the issue before the Court today is not whether someone's gender identity is fixed at birth, or whether minors with gender dysphoria have a right to gender-affirming care in every instance, or whether there's evidence on both sides as to whether and when these treatments

16:11:11 are clinically indicated. Rather, the question is whether Alabama can outright ban these treatments in every single instance, and not only that, make it a felony to provide or cause such care. Under the Equal Protection Clause, it cannot.

The United States asks this Court to maintain the status

16:11:31 quo, and grant its motion for temporary restraining order and/or preliminary injunction.

THE COURT: All right. Thank you.

Before you begin, Mr. LaCour, let me ask you the one question based on the original plaintiffs' closing.

16:12:03 So if a parent drives their child to Georgia for this treatment, does that trip the statute?

MR. LACOUR: Your Honor, I think the key is to look at the words "engage in" or "cause, prescription, or administration," not just cause in a vacuum. You always read

16:12:22 statutes in context. And "engage in" also "prescribe or

administer" are shedding light on cause. I don't think just driving them there would be causing the administration. I think -- another way to think about it is what would be cause?

So engaging in the administration of the puberty blocker for the prohibited purposes would be, for example, if a doctor used a needle and engaged in the administration.

Now, if the doctor ordered a nurse practitioner to do that instead, the doctor might not be engaging in the administration, but the doctor would be causing the administration.

So I don't think buying somebody a bus pass or driving them to the doctor would be that closely related such that it would be causing the administration. This is not a butterfly flaps its wings in the Amazon, as the plaintiff suggested in the reply brief. This is, I think, much tighter to the other key verbs in the statute.

THE COURT: All right. Go ahead with your closing.

MR. LACOUR: Thank you, Your Honor.

Over the last couple of weeks, and the last two-and-a-half days, the Court has heard about children and families facing very difficult situations. But as a matter of law, this is not a difficult case.

As mentioned earlier, the State has wide discretion to regulate areas of medical uncertainty. This has long been the law. As the Supreme Court reaffirmed in Gonzalez, at 550 U.S.

163, when the State, quote, undertakes to act in areas fraught with medical and scientific uncertainties, legislative options must be especially broad.

So when there is competing evidence about benefits and risks, the State can evaluate that evidence and make judgments with all five million Alabamians in mind. That is a well-established role of the State.

What this means is that in our federal system, a federal court has an important, but limited role. It is not up to federal courts to make the determination of the best treatment options for any particular individual. Rather, the judge's job is to determine whether the Constitution bars states from regulating in a particular area of medical uncertainty.

So plaintiffs have not only failed to bear their heavy burden of showing a lack of medical uncertainty, they have confirmed that SB 184 does not discriminate on the basis of sex or transgender status for reasons I will address in a moment.

Now, earlier -- and I apologize, Your Honor. I had suggested that the AMA had supported the partial birth abortion ban in Gonzalez. It does not appear they submitted an amicus brief in this case, but numerous other medical groups did.

The California Medical Association, which represented 30,000 members, submitted a brief. The American College of Obstetricians and Gynecologists submitted a brief. The American Medical Women's Association, which was a national

organization of 10,000 women physicians, surgeons, and physicians in training submitted a brief, as did the American Public Health Association, the Medical Students for Choice, the New York Obstetrical Society, and the University of Chicago Hospital's Department of Obstetrics and Gynecology.

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Even so, the Gonzalez Court did not hold that Congress was somehow limited in its ability to regulate in an area of medical uncertainty. Quite the contrary.

The Court refused to adopt a, quote, policy that would strike down legitimate abortion regulations if some part of the medical community were disinclined to follow the prescription. Considerations of marginal safety, including the balance of risks, are within the legislative competence when the regulation is rational and in pursuit of legitimate ends.

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Rational and legitimate ends. That is the language of rational basis, Your Honor. That is not the language of strict scrutiny.

Mr. Doss suggested it's different because it was an abortion case. Well, abortion is an area of the law where for half a century the Court has recognized a fundamental privacy right. And there is no similar right to gender transition procedures. And these are quite new. They're quite new on the medical scene.

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So if anything, the fact that abortion was involved in that case cuts in the State's favor, not in favor of the

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plaintiffs.

Plaintiffs' strict scrutiny rule we need to think about. What are the limits of it? I mean, it would destroy the system for FDA drug approval, because anytime a plaintiff could -- who
16:17:17 is a parent and has a child who wants some sort of drug that the FDA has decided is still experimental at this point, and it is not -- if the FDA has not decided yet whether the risks outweigh the benefits, or vice versa, the child would have no right to the drug, the parent would have no right to the drug
16:17:37 for the parent's use, but the parent would have a right to get it for their child.

But, of course, during the last two years of the pandemic as the FDA was considering the safety and efficacy of the COVID vaccine, there was no substantive due process right for a
16:17:53 parent to cut in line and sue and say, I think this is going to be really helpful for my kid. My kid is immunocompromised. They really, really need it.

That was not -- it's not a Fourteenth Amendment issue. There was not a right. Because what they have done is the same
16:18:08 thing the Eleventh Circuit has rejected expressly in the Morrissey case, which we discussed at opening.

They have defined the right with broad generality, a broad right to provide medical -- to basically care for your child.

But as the Eleventh Circuit and the Supreme Court have
16:18:28 recognized, when we're dealing with substantive due process to

the extent that's even a thing, you need to really describe the right with great specificity, and then root it in the history and traditions of our nation.

And there is no deeply-rooted right in the history and traditions of America that guarantees a parent the right to puberty blockers or cross-sex hormones for their child, particularly when the state of science is so uncertain.

If the plaintiffs are right, that this is a strict scrutiny case, then federal judges are going to become medical boards that are going to be adjudicating issue after issue after issue. And it is going to be difficult to imagine what sort of medical judgment is going to be available, what sort of medical judgment a state could still exercise, at least when it comes to parents desiring the drugs for their children.

So, I mean, turning to some of the facts, I mean, for years, rates of gender dysphoria in youth had remained stable, as did the patient profile which was typically male. And for years, the standard treatment for gender dysphoria was watchful waiting.

And that is not nothing, as Mr. Doss suggested. That is careful therapy with other types of mental health support to help relieve children's distress as they explored their still forming identities. The sort of thing that would have been very helpful to Ms. Wright, who you heard from earlier today, but instead received the fast-track approach.

Now, all that has changed, and quite dramatically and quite quickly. If you look at Defendants' Exhibit 7 at page 26, there is a very telling chart showing the increase in young people seeking treatment in gender clinics in the UK and Australia from 2010 to 2020. I mean, that data is particularly useful because they have national health-care systems that track all of these patients; whereas, we have a more disaggregated system in the U.S., where a plaintiff -- not a plaintiff -- a patient might go to a clinic and then later never show up again, and you lose track of them.

So, if anything, the fact that some of these studies are coming up out of Europe suggest that they should be given more weight because they just have better data on the people.

If you look also at Defense Exhibit 7 at page 31, that is two maps. That's the chart, the explosion of gender clinics in the last 15 years. So as of 15 years ago, there were two clinics in the entire country.

Now we're into the 50s or 60s. UAB is only seven years old. And, of course, we have heard a lot about UAB, but they're not the only place in Alabama where you can receive these sorts of drugs.

Ms. Wright had a different situation in Georgia. But I mean, really any doctor with a script could potentially write for some of these -- for some of these drugs, and there could be other clinics in the future that open up.

And in light of this new evidence, many countries are waking up to the grave uncertainty and the risks that this new approach to treating gender dysphoria has for youth.

You heard from leaders from two of the prominent gender clinics, Dr. Hawkins and Dr. Ladinsky. Neither of them had substantial familiarity with the careful assessments and conclusions reached by these progressive nations.

Hawkins transcript page 39, 1 through 4 said, Are you generally aware of it? Response to one of these studies? And she said she was not.

Dr. Ladinsky stated at page 124 through 125, I confess that I am not intimately associated with the position statements of other nations.

But listen to what Sweden had to say. Quote, For adolescents with gender incongruence, the board deems that the risk of puberty-suppressing treatments with puberty blockers and gender-affirming hormonal treatment currently outweigh the possible benefits. And the statement further emphasized both, quote, the continued lack of reliable scientific evidence concerning the efficacy and the safety of both treatments and the, quote, new knowledge that detransition occurs among young adults. It's Defense Exhibit 11 at page 3.

Similarly, the UK's review went through all of these studies, unlike the AAP's review that the plaintiffs have relied on. Their conclusion was again, quote, Any potential

benefits of gender-affirming hormones must be weighed against the largely unknown long-term safety profile of these treatments in children and adolescents with gender dysphoria.

And that same review found only five uncontrolled observational studies suggesting any benefit, and it graded those studies as, quote, a very low certainty, closed quote. In other words, medical uncertainty. It's Defense Exhibit 10 at page 14.

And, again, I implore the Court to look again to the appendix to Dr. Cantor's declaration where he has devastating explanation of all the problems in that AAP report that Dr. Ladinsky, I believe, had referred to.

Finland similarly said that in light of the available evidence, gender reassignment of minors is an experimental practice. It's Defense Exhibit 12 at page 8.

In France, they said, quote, there is no test to distinguish a structural gender dysphoria from transient dysphoria in adolescents. And because, quote, the risk of overdiagnosis is real, closed quote, treatment should consist only of, quote, psychological support as long as possible for children and adolescents expressing a desire to transition, closed quote. That's Defense Exhibit 13 at 2.

France even went on to emphasize, quote, the addictive character of excessive consultation on social networks as harmful to the psychological development of young people and

responsible for a very important part of the growing sense of gender incongruence. It's not just the French.

We had Ms. Wright here talking about going on Instagram, seeing these images, learning these things, and it, in turn, causing her to feel this dysphoria that she mistook for transgender status with great consequences for her personally.

16:24:48

So the evidence -- what WPATH itself has said shows that desistance rates are between 50 and 90 percent. That's Defense Exhibit 18, page 11.

16:25:10

Now, Dr. Hawkins, of course, said that unlike any other gender clinic this history they are, quote, exceptional at identifying who is, in her words, truly transgender. That is whose gender dysphoria is going to persist. But they don't have studies to back up this newfound certainty.

16:25:26

When asked to respond to evidence that only 25 percent of detransitioners tell their doctors that they have detransitioned, they said that they had read the study, but hadn't noticed that finding. That's Hawkins transcript page 53 through 54.

16:25:41

And I will try to make sure I'm moving quickly, Your Honor. I do want to get into some of the legal issues.

But, I mean, I think it's important that even if plaintiffs could guarantee whose gender dysphoria is likely to persist, there is still great uncertainty about whether these treatments even provide long-term benefits.

16:25:59

On the other hand, the risks are potentially quite severe. Recall Plaintiffs' Exhibit 41. This is the informed consent form from UAB. It detailed numerous risks, including heart disease, liver disease, blood disorders, loss of sexual function, and sterility.

And there are still other risks that are unknown because the long-term consequences of using puberty blockers and then cross-sex hormones such that a child never goes through natural puberty has simply not been studied with any rigor.

16:26:34 So in light of this uncertainty, how could plaintiffs possibly -- or how could -- yeah. How could plaintiffs possibly obtain informed consent from either children or from their parents?

The plaintiffs couldn't even explain the difference between the refusal to take consent for a mastectomy or a female circumcision for that matter, and their willingness to take consent for cross-sex hormones that they agree can cause equally, quote, permanent irreversible damage to basic reproductive function. That was Dr. Ladinsky's testimony, pages 133 through 136.

And you also heard from Dr. Antommaria that he does think that some young people could consent to mastectomy. So even some uncertainty and some conflict between the different witnesses that the plaintiffs have presented.

And worse still, even if puberty blockers and cross-sex

hormones would help -- and it's not clear that they do help -- because we can't know if a child is likely to persist, we really are in a situation like the hypothetical RSV vaccine that was discussed with Dr. Koe that would sterilize 5 percent of its recipients. That treatment would never be approved by the FDA, and Dr. Koe testified quite rightly she would never recommend to that her patients. The risks are just too great. In other words, it would be banned.

And here we have sterilizing treatments with far less guarantee of any sort of benefit at the end of the day.

So turning to the Arkansas order. I think this will be a good framework for addressing some of the legal issues, and I will try to thread some of the key facts, as well.

I am going to get to Equal Protection. I will also address Glenn, Bostock, and Grimm.

So first, at the beginning, there are statutory differences between the Arkansas law and the Alabama law. We think the Arkansas law is perfectly constitutional. That case, of course, is up on appeal at the Eighth Circuit. We would recommend Arkansas's briefing to the Court because it can explain in greater detail some of the problems with the Brandt decision.

For one thing, the Arkansas law lacks extensive legislative findings that support SB 184.

Second, our law is narrower because there is no provision

that expressly bans referrals.

Third, Alabama's law also expressly leaves open psychotherapy as a treatment for gender dysphoria.

And fourth, our law more specifically defines the
16:29:07 treatments that are barred by the law.

But turning to the opinion, first heightened scrutiny. The Brandt decision said the transgender people constitute at least a quasi-suspect class.

What the Court did not do is cite any evidence to back
16:29:23 that up. They have said in Grimm, and that was it. Contrast that with the last time the Supreme Court had before it the occasion to determine whether there was a new quasi-suspect class, that's the Cleburne case, 1985.

I particularly recommend the Fifth Circuit's opinion that
16:29:42 was facially -- or at least the releasing of which was reversed by the Supreme Court. There the Fifth Circuit had a great amount of record evidence of the discrimination against intellectually disabled people from the '80s and going back.

Such robust evidence that Justice Thurgood Marshall, who
16:30:04 would have concluded that the intellectually disabled were a quasi-suspect class, stated that in his view, quote, the mentally retarded were, in 1985, a group that suffered eugenic marriage and sterilization laws and whose treatment paralleled the worst excesses of Jim Crow. That was the record.

16:30:23 And even then, the Supreme Court said, this is not a

quasi-suspect class. We are not going to take that very dramatic step in designating a new quasi-suspect class.

So plaintiffs have submitted substantially no evidence to try to back up their claim that there's a quasi-suspect class here. I think for that reason, they have not made that showing, and the Brandt Court -- I have not looked all the evidence that was in front of the Brandt Court, but I know the analysis is incredibly thin. That would be one grounds to distinguish.

Next, the Court applied heightened scrutiny, because assuming there was suspect class, the Court held that the -- Arkansas's law, quote, refers to gender transition which is only sought by transgender individuals, closed quote.

Now, that's wrong as both a legal matter and a factual matter. And I mean, I think the facts that we have established here also clearly distinguish that decision from this case.

But first on the law, we've discussed it. We've briefed it extensively. The Supreme Court's 1974 decision in Geduldig, that was a case where California covered many medical treatments, did not cover pregnancy, however, in their state insurance plan.

A group of women sued saying this is discrimination on the basis of sex because only women can get pregnant. And the Supreme Court said this is not discrimination on the basis of sex, because there are two categories here -- people who are

pregnant and people who are not pregnant. While it's only women in the people who are pregnant category, there are men and women in the people who are not pregnant category. Therefore, not discrimination on the basis of sex.

16:32:03 Now, we can do you one better in this case, Your Honor, because there are certainly -- it's undisputed, there are people who are transgender who do not seek these treatments. And so in that category of people who don't seek these treatments are both transgender and nontransgender persons.

16:32:20 But then unlike in Geduldig, in the other category, there are also transgender persons and nontransgender persons who are in that category.

Dr. Ladinsky testified that at 106, lines 3 through 8, that some of her patients did start puberty blockers, but later

16:32:36 stopped and had their gender identity agree with their biological sex.

So -- and Dr. Hawkins's -- in the phrasing of Dr. Hawkins, these patients would not be, quote, truly transgender. Thus, as plaintiffs agree, not every person who is diagnosed with

16:32:55 gender dysphoria is transgender, and at least some people who are not transgender receive puberty blockers and cross-sex hormones. Indeed you heard from one such person today, Ms. Wright.

Justifications for the law. The Brandt Court said that,

16:33:14 quote, defendants state that the Arkansas general assembly

passed Act 626 in response to a recent judicial ruling of the UK High Court of Justice of England and Wales and in Arizona District Court. And then the Brandt Court found that neither of these authorities were persuasive or precedential.

16:33:37 In contrast, as I mentioned earlier, we have extensive legislative findings backing up our law. This was not simply hereto interesting Court decisions. Let's go ahead and enact this new law.

Then the Court further found that the reliance on the UK 16:33:53 court's ruling was not credible because the State allows the, quote, same treatment for cisgender minors as long as the desired results conform with the stereotype of their biological sex.

Now, I don't know all the evidence that was before the 16:34:08 Brandt Court, but on our record here, we have shown that puberty blockers for precocious puberty is not the same treatment as puberty blockers for gender dysphoria. I mean, that's the whole premise of the FDA having on-label and off-label distinctions. They're different treatments, even if 16:34:25 similar medications might be used.

So here -- I mean, in the context of hormones, giving a certain dose of testosterone to a boy with a measurable hormone deficiency to bring him up to normal range is not the same treatment as giving the same dose of testosterone to a 16:34:42 biological female to bring her levels up to a range that would

be abnormally high for females.

As our endocrinologist Dr. Laidlaw explained at Defendants' Exhibit 3, pages 3 through 5, that first type of treatment involves an endocrine diagnosis rooted in objective testing of hormone levels.

In contrast, a gender dysphoria is a psychological diagnosis. The fact the treatment for one might bear some passing resemblance to treatment for the other does not make them the same treatment.

And further, as discussed in treating gender dysphoria with hormones carries unique and serious risks, including many of those risks listed on the informed consent form from UAB and that are outlined by Dr. Laidlaw on pages 17 through 19 of his report.

Dr. Ladinsky herself appeared to recognize this fact when she was asked about two hypothetical boys. As you might recall, one of them had low testosterone and was -- needed some testosterone to get up to normal levels. The other had normal testosterone and wanted more to get to abnormally high levels so he could build more muscle mass. She agreed on page 143 of the transcript that those would be altogether different treatments.

A fortiori, when one child is given puberty blockers or hormones for an endocrine disorder, to move them into a normal range for their age and sex, that is an altogether different

treatment than using similar doses of those drugs to treat a psychological disorder and move them into abnormal ranges. It's simply not the same.

Dr. Koe basically confirmed the same thing on pages 185 and 186 of the transcript from yesterday. She stated that she performed testicular exams only on males, but not on females. And when she's treating transgender males for gender dysphoria, she would give them testosterone, but she would not treat a transgender female for gender dysphoria with testosterone.

She was asked, Are you discriminating based on sex? And she said no. She was, quote, giving each patient the care for which their sex and gender requires. It's not discrimination to recognize biological realities that you must recognize to perform medicines.

For the same reasons, Alabama doesn't discriminate because of sex. This also helps illustrate why our case is much different from Glenn vs. Brumby, Bostock, or Grimm, for that matter.

To greatly simplify the Glenn, the Bostock cases, I think a similar analysis would apply to Grimm, although Grimm was a bathroom case and not an employment case. In both Glenn and Bostock, there was a biological male who was fired because he wanted to show up at work presenting as a woman. Even though men and women are both able to wear dresses, only the man would lose his job for wearing one to work.

But here there is no way to provide a testicular exam to females. It would be a different treatment altogether. And prescribing testosterone to a boy to get his levels up to a normal boy's levels cannot be done for a girl, because she is a girl and not a boy. It would be a different treatment altogether.

Second, Bostock and Brumby were premised on the notion that sex is irrelevant to employment decisions. But sex is obviously relevant to medical decisions. Dr. Koe confirmed as much. Dr. Ladinsky confirmed as much.

So either there is no discrimination here, or if there is some sort of discrimination, although the Court has said in the Nyugen decision that recognizing biological realities is not a stereotype, like a law could not be more tailored. Like you have to know the sex to know what the treatment even is. The fit could not be tighter.

So moving on. The Brandt Court found that Arkansas's law was not substantially related to the regulation of ethics of the medical profession because gender-affirming treatment is supported by medical evidence that has been subject to rigorous study.

Now, the record before Your Honor shows that these statements are simply not accurate, at least on the record here in Alabama. The one certainty in this field is that there is no certainty. There are not rigorous studies, and we have

presented ample evidence of medical uncertainty.

The Brandt Court did not address similar issues. They did not address the Gonzales decision. They did not address the European reviews. They didn't recognize the weakness of the evidence for these interventions.

16:39:33

The Court also said, quote, Every major expert medical association recognizes that gender-affirming care for transgender minors may be medically appropriate and necessary.

The Court, of course, never addressed the international literature reviews.

16:39:49

And another key distinction, Your Honor, not -- some of these weren't even available at the time the Court was ruling on August 2nd, 2021. There's been more evidence coming to light. As Dr. Cantor said, to the extent the pendulum is swinging, it is swinging in Alabama's direction.

16:40:03

Turning again to substantive due process, which I addressed at the beginning, the Brandt Court I think made some of the same errors that the plaintiffs are making here finding that the plaintiffs in that case had a fundamental right to seek medical care for their children and in conjunction with their adolescent child's consent and their doctor's recommendation make a judgment that medical care is necessary.

16:40:21

Of course, that, again, defines the right far too broadly and misstates the right. And the Court never identified a history or tradition of that particular right, and similarly

16:40:41

ignored the implications of the new right. For example, every FDA decision would be subject to strict scrutiny.

Turning to the First Amendment, Brandt -- there was a First Amendment claim in Brandt that the claim there centered on the physician referral provision, which we do not have one of those in Alabama's law.

Now, finally, one thing -- another big thing I think that distinguishes our case from Brandt -- an issue we have with the Court's decision, it never once mentioned the risks of these procedures for kids. You will not see them mentioned at all. Not a word about bone health, not a word about heart disease, blood disorders, sexual disorders, or infertility. Not a word about a young women like Sydney Wright and the 13 other declarants who are either detransitioners or the parents of troubled youth, like not a word about any of them. And these people are suffering from having been experimented on.

But in this case, Your Honor, you should consider those risks. In this case, the only endocrinologist who has addressed whether treating someone at Tanner Stage 2 will affect fertility is Dr. Laidlaw. This is at page 9 of Defense Exhibit 3, the Laidlaw report. He lays this out.

Awareness of the Tanner stage of the developing adolescent is also useful to assess for maturation of sex organ development leading to fertility.

For girls, menstruation and ovulation occurs about

two years after Tanner Stage 2, and will typically be at Tanner Stage 4 or possibly 3. For boys, the first appearance of sperm is typically Tanner Stage 4. If puberty is blocked before reaching these critical stages, the sex glands will be locked in a premature state and incapable of fertility. His similar statements addressing the problems of sexual dysfunction that come from these treatments.

16:42:35

In contrast, you heard from Dr. Antommaria today. It is his view that clinics don't need to tell patients and families that puberty blockers will almost certainly lead to cross-sex hormones before kids are started on that pathway. That is their standard of care. And these are half truths to create a false consensus with the health and the lives of children on the line.

16:42:55

16:43:09

And to Mr. Doss's assertion, there is no evidence of lax methods in the U.S. They are completely ignoring the 14 declarations from -- and the testimony of Ms. Wright, for that matter.

There is plenty of evidence of this both in studies and in sworn declarations. There will be more and more of this unless states step forward and protect their children, because the medical community is not doing their job.

16:43:27

Now, addressing vagueness. We touched on it briefly. Again, the key language is, quote, no person shall engage in or cause, prescribing, or administering puberty-blocking

16:43:46

medication to stop or delay normal puberty. Of course, the cross-sex hormones provision that follows after that.

Here's how it works. If a doctor writes a prescription for puberty blockers, that would be engaging in prescribing the puberty blockers. If the doctor orders the nurse practitioner at the clinic to write the prescription, the doctor would be causing the prescription of the puberty-blocking medication.

Similarly, if the doctor gave a shot of testosterone for purposes of gender transition, she would be administering. If she ordered the nurse to do it, she would be causing.

But if a patient merely posted on Facebook that she had a great experience at the clinic, she would not be engaging in or causing the prescription of puberty blockers, even if a friend read the testimony or reached out to the clinic and later got it.

If Reverend Eknes-Tucker tells a congregant that she might receive help for her gender dysphoria at the clinic, he hasn't engaged in or caused the prescribing or administration of anything.

And if a parent merely drives his child to the clinic, he hasn't engaged in or caused the prescription of any drugs.

Now, if the parent injects the medications, I think he probably has engaged in the administering the puberty blockers. But merely driving him to the clinic, having conversations with their child, being there for them, that is not administering,

engaging in, or causing the administration of these drugs.

And, Your Honor, I think that's why Reverend Eknes-Tucker wasn't ready to go and file a lawsuit on April 8th like Dr. Ladinsky or Mr. Jeff Walker were. He didn't think that this law applied to him. But when he got a call on Monday, April 16th, from one of Dr. Ladinsky's lawyers, he was excited to -- I believe his phrase -- was make a difference.

But as we discussed earlier today, the good news and the bad news for Mr. Eknes-Tucker is that while he did help SBLC and Lightfoot get back into court, and his conduct does not violate the law, so he doesn't have to worry about that, the bad news is he likely doesn't have standing to be challenging this law. So he's going to have to make a difference some other way going forward.

Now, one thing to equities I want to address. Dr. Ladinsky stated that she would be concerned that if SB 184 goes into effect, her patients --

THE COURT: I will say I think you have kind of run through your time, but I was easy with Mr. Doss. I will be with you. But I would say we are close to wrapping it up.

MR. LACOUR: Very, very close, Your Honor. I am ready to go home myself. But I appreciate all of the time and consideration you have given to this very important case.

I will just say, Dr. Ladinsky was -- stated she was concerned that if SB 184 went into effect, her patients would

have to stop taking testosterone cold turkey.

Now, going back to language of the statute -- and this is something I have tried to emphasize in the cross-examination -- it says, do not engage in or cause the following practices for the purpose of attempting to in effect cause a gender transition.

Being responsible and tapering somebody off of these artificial hormones is not for the -- would not be using the hormones for that prohibited purpose. Just like using testosterone for that boy with the low T to get him up to a normal range is not an improper purpose, either. So we don't think that's something that anyone needs to worry about.

Now, in closing, Mr. Doss suggested that SB 184 is somehow a grand experiment. Now, with all due respect, I mean, there were only two of these clinics in 2007. UAB has only been on the scene for seven years.

In hitting the pause button, Alabama is halting an experiment on our kids, and nothing in the Constitution or federal law requires Alabama to expose children to these unproven and sterilizing treatments. For that reason, the preliminary injunction motions should be denied.

If you have any questions, I would be happy to answer them. Otherwise, we rest.

THE COURT: All right. I thank you all for your arguments. Let's talk housekeeping just for a minute.

Obviously, in the long term, we have got to put together a discovery plan and a trial track. Have the parties talked about that?

MR. LACOUR: We have not yet, Your Honor.

16:48:15 THE COURT: Do you want to give me your 30-second idea of how long you think how long a track this should be on? My guess is it should be expedited.

MR. LACOUR: Your Honor, there is a fair amount of discovery we think we would like to get, including some 16:48:31 third-party discovery. Plaintiffs have put at issue the credibility of the AAP, some of these other organizations. We have some questions about donations that the Endocrine Society might be receiving from the prescription drug manufacturers who are profiting off of this use of their puberty blockers and 16:48:49 their cross-sex hormones. That might be relevant assessing the credibility of these institutions.

I mean, we will certainly move with all deliberate speed, but we would want a chance to fully develop the record.

THE COURT: So give me a number.

16:49:06 MR. LACOUR: My colleague Mr. Davis is usually a little better at this. I'm just a humble appellate attorney.

THE COURT: All right.

MR. DAVIS: Mr. LaCour's welcome to correct me, but before we -- we would like the chance to confer about that. We 16:49:18 have been so focused on getting ready for this hearing --

THE COURT: I get that.

MR. DAVIS: -- we really haven't thought about what all we want to do. If we could have until the first of the week to talk about it amongst ourselves and let Your Honor know what our thoughts are.

16:49:29

THE COURT: Maybe you can confer with the plaintiffs and y'all can present a joint thought on that.

MR. DAVIS: I think we could be ready for like a Rule 26 conference the first of the week. Give us a chance to talk internally on each side, then with each other, then report to Your Honor by -- well, by middle of the week or end of the week.

16:49:42

THE COURT: Let me say this. Here is all I am trying to accomplish. You know, if we just want to put this on a regular trial track, I will just leave it to y'all, and we will go from there. I was just guessing that somebody might want this to be on an expedited track. And so that's why I am raising the issue.

16:49:55

MR. DOSS: That would be our preference, Your Honor. I mean, our thought just right now would be like maybe a six-month discovery window. I mean, I think we are going --

16:50:09

THE COURT: That was the number in my mind was six months. So, you know, to the extent --

MR. DAVIS: That might be fine with us after we confer.

16:50:23

THE COURT: All right.

MR. DAVIS: But I would like that chance to talk about that specifically.

THE COURT: I get it. No problem. No problem.

16:50:29 I will leave it to the parties to talk. To the extent you agree, great. To the extent you don't agree, we can sort that out.

All right. Thank you for your arguments. All very good. I appreciate every witness that we've had in the last two days.

16:50:47 Thank each of you.

Obviously, this was filed on April the 19th. My staff attorneys and I have done nothing since it was filed but work on this case. We will be doing nothing else but this case until we get an order.

16:51:02 Just like all of you, I want a well-reasoned order that is right on the law. And so I just ask that everybody be patient.

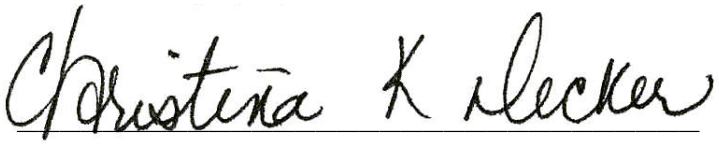
I can't say that it's going to be out tomorrow, or the next day, or the next day, except to say we are not going to work on anything until we get it out and we get it right.

16:51:22 So I thank you all. And we're adjourned.

(Whereupon, the above proceedings were concluded at 4:51 p.m.)

CERTIFICATE

I certify that the foregoing is a correct transcript from the record of proceedings in the above-entitled matter.



05-08-2022

Christina K. Decker, RMR, CRR — Date

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No. 22-11707

UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

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Plaintiffs-Appellees,

&

UNITED STATES OF AMERICA
Intervenor-Plaintiff-Appellee,

v.

GOVERNOR OF THE STATE OF ALABAMA, et al.,
Defendants-Appellants.

On Appeal from the United States District Court
for the Middle District of Alabama
Case No. 2:22-cv-184-LCB

APPELLANTS' APPENDIX VOLUME XII OF XIII
(FILED UNDER SEAL)

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UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

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	)	
Plaintiffs,	)	
	)	
v.	)	**Case No. 2:22-cv-184-LCB**
	)	
STEVE MARSHALL, *et al.*,	)	
	)	
Defendants.	)	

OPINION & ORDER

Several individuals and the United States challenge the constitutionality of the Alabama Vulnerable Child Compassion and Protection Act.[1] In part, the Act restricts transgender minors from utilizing puberty blockers and hormone therapies. Because the Supreme Court and the Court of Appeals for the Eleventh Circuit have made clear that: (1) parents have a fundamental right to direct the medical care of their children subject to accepted medical standards; and (2) discrimination based on gender-nonconformity equates to sex discrimination, the Court finds that there is a substantial likelihood that Section 4(a)(1)–(3) of the Act is unconstitutional and, thus, enjoins Defendants from enforcing that portion of the Act pending trial. However, all other provisions of the Act remain in effect, specifically: (1) the

[1] Based on their oral representations during a May 4, 2022 hearing, Plaintiffs seek to enjoin only Section 4(a)(1)–(3) of the Act. For purposes of this opinion, all references to "the Act" refer to these subdivisions unless noted otherwise.

provision that bans sex-altering surgeries on minors; (2) the provision prohibiting school officials from keeping certain gender-identity information of children secret from their parents; and (3) the provision that prohibits school officials from encouraging or compelling children to keep certain gender-identity information secret from their parents.

I. BACKGROUND

Regarding a child's belief that they might be transgender, Merriam-Webster's Dictionary defines a "transgender" person as one whose gender identity is different from the sex the person had or was identified as having at birth. *Transgender*, MERRIAM-WEBSTER UNABR. DICTIONARY (3rd ed. 2002). The Dictionary defines "gender identity" as a person's internal sense of being a male or a female. *Gender Identity*, MERRIAM-WEBSTER UNABR. DICTIONARY (3rd ed. 2002). These terms and definitions are largely consistent with those used by the parties. Accordingly, the Court relies on these terms throughout this opinion, but recognizes that they might mean different things to different people and in different contexts.

According to the uncontradicted record evidence, some transgender minors suffer from a mental health condition known as gender dysphoria. *Tr.* at 30.[2] Gender dysphoria is a clinically diagnosed incongruence between one's gender identity and

[2] "*Tr.*" is a consecutively paginated transcript of the two-day preliminary injunction hearing the Court held on May 5–6, 2022. For clarity, the Court cites to the internal pagination of the transcript rather than the ECF pagination.

assigned gender. *DSM-5* (Doc. 69-17) at 4. If untreated, gender dysphoria may cause or lead to anxiety, depression, eating disorders, substance abuse, self-harm, and suicide. *Tr.* at 20. According to the World Professional Association for Transgender Health (WPATH), an organization whose mission is to promote education and research about transgender healthcare, gender dysphoria in adolescents (minors twelve and over) is more likely to persist into adulthood than gender dysphoria in children (minors under twelve). *WPATH Standards of Care* (Doc. 69-18) at 17.[3]

In some cases, physicians treat gender dysphoria in minors with a family of medications known as GnRH agonists, commonly referred to as puberty blockers. *Id.* at 24; *Tr.* at 103. After a minor has been on puberty blockers for one to three years, doctors may then use hormone therapies to masculinize or feminize his or her body. *Tr.* at 108–11, 131. The primary effect of these treatments is to delay physical maturation, allowing transgender minors to socially transition their gender while they await adulthood. *Id.* at 105–06, 110–11. For clarity and conciseness, the Court refers to puberty blockers and hormone therapies used for these purposes as "transitioning medications."

Like all medications, transitioning medications come with risks. *Tr.* at 121–22. Known risks, for example, include loss of fertility and sexual function. *Id.*

[3] Plaintiffs, the State, and the United States individually introduced the WPATH standards into evidence during the May 5–6 preliminary injunction hearing.

at 132–33. Nevertheless, WPATH recognizes transitioning medications as established medical treatments and publishes a set of guidelines for treating gender dysphoria in minors with these medications. *WPATH Standards of Care* (Doc. 69-18) at 19. The American Medical Association, the American Pediatric Society, the American Psychiatric Association, the Association of American Medical Colleges, and at least eighteen additional major medical associations endorse these guidelines as evidence-based methods for treating gender dysphoria in minors. *Tr.* at 97–98; *Healthcare Amici Br.* (Doc. 91-1) at 15.[4]

The Alabama Vulnerable Child Compassion and Protection Act states in pertinent part:

> Section 4. (a) . . . [N]o person shall engage in or cause any of the following practices to be performed upon a minor if the practice is performed for the purpose of attempting to alter the appearance of or affirm the minor's perception of his or her gender or sex, if that appearance or perception is inconsistent with the minor's sex as defined in this act:
>
> > (1) Prescribing or administering puberty blocking medication to stop or delay normal puberty.
> >
> > (2) Prescribing or administering supraphysiologic doses of testosterone or other androgens to females.
> >
> > (3) Prescribing or administering supraphysiologic doses of estrogen to males.

[4] For a full list of the twenty-two major medical associations that endorse these guidelines, see *infra* note 12.

> (4) Performing surgeries that sterilize, including castration, vasectomy, hysterectomy, oophorectomy, orchiectomy, and penectomy.
>
> (5) Performing surgeries that artificially construct tissue with the appearance of genitalia that differs from the individual's sex, including metoidioplasty, phalloplasty, and vaginoplasty.
>
> (6) Removing any healthy or non-diseased body part or tissue, except for a male circumcision.

. . .

(c) A violation of this section is a Class C felony.

Section 5. No nurse, counselor, teacher, principal, or other administrative official at a public or private school attended by a minor shall do either of the following:

> (1) Encourage or coerce a minor to withhold from the minor's parent or legal guardian the fact that the minor's perception of his or her gender or sex is inconsistent with the minor's sex.
>
> (2) Withhold from a minor's parent or legal guardian information related to a minor's perception that his or her gender or sex is inconsistent with his or her sex.

S.B. 184, ALA. 2022 REG. SESS. §§ 4–5 (Ala. 2022). The Act defines a "minor" as anyone under the age of nineteen. *Id.* § 3(1); ALA. CODE § 43-8-1(18). The Act defines "sex" as "[t]he biological state of being male or female, based on the individual's sex organs, chromosomes, and endogenous hormone profiles." S.B. 184, ALA. 2022 REG. SESS. § 3(3) (Ala. 2022).

In support of these prohibitions, the Legislature made several legislative findings. *Id.* § 2. The Legislature found in part that "[s]ome in the medical community are aggressively pushing" minors to take transitioning medications, which the Act describes as "unproven, poorly studied . . . interventions" that cause "numerous harmful effects for minors, as well as risks of effects simply unknown due to the new and experimental nature of these interventions." *Id.* § 2(6), (11). The Legislature went on to find that "[m]inors, and often their parents, are unable to comprehend and fully appreciate the risk and life implications" of these treatments. *Id.* § 2(15). Thus, the Legislature concluded, "the decision to pursue" these treatments "should not be presented to or determined for minors[.]" *Id.* § 2(16).

Alabama legislators passed the Act on April 7, 2022.[5] Governor Kay Ivey signed the Act into law the following day.[6] In the week that followed, civil rights groups filed two lawsuits challenging the Act's constitutionality.[7] In *Ladinsky v. Ivey*, Case No. 2:22-cv-447 (N.D. Ala. 2022), several plaintiffs challenged the Act in the United States District Court of the Northern District of Alabama. The case

[5] Jo Yurcaba, *Alabama Passes Bills to Target Trans Minors and LGBTQ Classroom Discussion*, NBCNEWS.COM (Apr. 7, 2022, 4:22 PM), https://www.nbcnews.com/nbc-out/out-politics-and-policy/alabama-passes-bills-targeting-trans-minors-lgbtq-classroom-discussion-rcna23444.

[6] Madeleine Carlisle, *Alabama's Wave of Anti-LGBTQ Legislation Could Have National Consequences*, TIME.COM (Apr. 15, 2022, 11:40 AM), https://time.com/6167472/alabama-anti-lgbtq-legislation/.

[7] *Alabama Law Banning Transgender Medication Challenged in Two Lawsuits*, CBSNEWS.COM (Apr. 11, 2022, 10:05 PM), https://www.cbsnews.com/news/alabama-transgender-law-lawsuits/.

was randomly assigned to United States District Judge Anna M. Manasco. Judge Manasco recused, and the case was randomly reassigned to United States Magistrate Judge Staci G. Cornelius. After the parties declined to proceed before Judge Cornelius in accordance with 28 U.S.C. § 636(c), the case was randomly reassigned to the Honorable Annemarie C. Axon.

With *Ladinsky* pending, a separate set of plaintiffs challenged the Act in the United States District Court of the Middle District of Alabama. That case, styled *Walker v. Marshall*, Case No. 2:22-cv-167 (M.D. Ala. 2022), was randomly assigned to Chief United States District Judge Emily C. Marks. The *Walker* plaintiffs moved to enjoin enforcement of the Act and moved to reassign the case to United States District Judge Myron H. Thompson, alleging that he had previously presided over a similar case. The parties, however, later consented to transferring the case to the Northern District of Alabama for consolidation with *Ladinsky*. At that time, the *Walker* plaintiffs withdrew their motion to reassign.

On April 15, 2022, Chief Judge Marks transferred *Walker* to the Northern District of Alabama in accordance with the "first-filed" rule and 28 U.S.C. § 1404(a). The case was randomly assigned to this Court. Judge Axon then transferred *Ladinsky* to this Court for consolidation with *Walker*. That same day, at 6:24 p.m. CDT, the *Walker* plaintiffs filed a notice of voluntary dismissal without prejudice under Federal Rule of Civil Procedure 41(a)(1)(A)(i). The *Ladinsky* plaintiffs voluntarily

dismissed their case nine minutes later. Neither the *Walker* plaintiffs nor the *Ladinsky* plaintiffs explained their respective dismissals, but counsel for *Ladinsky* informed the press: "We do plan to refile imminently[.]"[8]

Sure enough, on April 19, four transgender minors (Minor Plaintiffs), their parents (Parent Plaintiffs), a child psychologist and a pediatrician (Healthcare Plaintiffs), and Reverend Paul A. Eknes-Tucker filed this suit in the United States District Court of the Middle District of Alabama and moved to enjoin the Act's enforcement pending trial. The case was randomly assigned to United States District Judge R. Austin Huffaker, Jr. Due to this Court's familiarity with *Ladinsky* and *Walker*, Judge Huffaker reassigned the case to this Court to expedite disposition of Plaintiffs' motion for preliminary injunction. With the Act set to take effect on May 8, the Court entered an abbreviated briefing schedule and set a hearing on Plaintiffs' motion for May 5–6.

Just days before the hearing, the United States moved to intervene on behalf of Plaintiffs under Federal Rule of Civil Procedure 24.[9] In the process, the United States filed its own motion to enjoin enforcement of the Act and requested to

[8] Paul Gattis, *Lawsuits Seeking to Overturn New Alabama Transgender Law Dropped, Could be Refiled*, AL.COM, https://www.al.com/news/2022/04/lawsuits-seeking-to-overturn-new-alabama-transgender-law-dropped-could-be-refiled.html (last updated Apr. 16, 2022, 9:22 PM).

[9] The United States's amended intervenor complaint does not add any additional claims, name any new defendants, or seek to expand the relief sought by Plaintiffs. *Compare Am. Intervenor Compl.* (Doc. 92) at 4–5, 13–14, *with Compl.* (Doc. 1) at 6–8, 28–35.

participate in the preliminary injunction hearing. Additionally, fifteen states moved for leave to proceed as *amici curiae*[10] and to file a brief in support of Defendants.[11] Twenty-two healthcare organizations also moved for leave to proceed as *amici curiae* and to file a brief in support of Plaintiffs.[12] Ultimately, the Court granted these motions in full, took the *amici* briefs under advisement, and gave the United States leave to participate during the preliminary injunction hearing.

During that hearing, the parties submitted hundreds of pages of medical evidence and called several live witnesses. Plaintiffs tendered Dr. Linda Hawkins and Dr. Morissa Ladinsky as experts in the treatment of gender dysphoria in minors. *Tr.* at 16, 92. Dr. Hawkins and Dr. Ladinsky testified that at least twenty-two major

[10] *Amici curiae*, Latin for "friends of the court," refers to a group of people or institutions who are not parties to a lawsuit, but petition the court (or are requested by the court) to file a brief in the action because they have "a strong interest in the subject matter." *Amicus Curiae*, BLACK'S LAW DICTIONARY (11th ed. 2019).

[11] The State *Amici* are the States of Arkansas, Alaska, Arizona, Georgia, Indiana, Louisiana, Mississippi, Missouri, Montana, Nebraska, Oklahoma, South Carolina, Texas, Utah, and West Virginia.

[12] The Healthcare *Amici* are the American Academy of Pediatrics; the Alabama Chapter of the American Academy of Pediatrics; the Academic Pediatric Association; the American Academy of Child and Adolescent Psychiatry; the American Academy of Family Physicians; the American Academy of Nursing; the American Association of Physicians for Human Rights, Inc. *d/b/a* Health Professionals Advancing LGBTQ Equality; the American College of Obstetricians and Gynecologists; the American College of Osteopathic Pediatricians; the American College of Physicians; the American Medical Association; the American Pediatric Society; the American Psychiatric Association; the Association of American Medical Colleges; the Association of Medical School Pediatric Department Chairs; the Endocrine Society; the National Association of Pediatric Nurse Practitioners; the Pediatric Endocrine Society; the Society for Adolescent Health and Medicine; the Society for Pediatric Research; the Society of Pediatric Nurses; the Societies for Pediatric Urology; and the World Professional Association for Transgender Health.

medical associations in the United States endorse transitioning medications as well-established, evidence-based methods for treating gender dysphoria in minors. *Id.* at 25, 97–98, 126–27. They opined that there are risks associated with transitioning medications, but that the benefits of treating minors with these medications outweigh these risks in certain cases. *Id.* at 57–58, 121–22, 136, 170. They also explained that minors and their parents undergo a thorough screening process and give informed consent before any treatment regimen begins. *Id.* at 41, 59, 132; *see also Consent Form* (Doc. 78-41) at 1–14. Finally, they testified that, without these medications, minors with gender dysphoria suffer significant deterioration in their familial relationships and educational performance. *Tr.* at 35, 112–13.

Plaintiffs also called Healthcare Plaintiff Dr. Rachel Koe (a licensed pediatrician), Plaintiff Eknes-Tucker, and Parent Plaintiff Megan Poe to testify about their personal knowledge and experiences regarding the treatment of gender dysphoria in minors. *Id.* at 150–51, 170–71, 195. Parent Plaintiff Megan Poe specifically described the positive effects transitioning treatments have had on her fifteen-year-old transgender daughter, Minor Plaintiff Allison Poe. *Id.* at 157–68.

According to Megan, Allison was born a male, but has shown evidence of identifying as a female since she was two-years-old. *Id.* at 153–54. During her early adolescent years, Allisson suffered from severe depression and suicidality due to gender dysphoria. *Id.* at 156–57. She began taking transitioning medications at the

end of her sixth-grade year, and her health significantly improved as a result. *Id.* at 163. Megan explained that the medications have had no adverse effects on Allison and that Allison is now happy and "thriving." *Id.* at 166–67. When asked what would occur if her daughter stopped taking the medications, Megan responded that she feared her daughter would commit suicide. *Id.* at 167.

Intervening on behalf of Plaintiffs, the United States tendered Dr. Armand H. Antommaria as an expert in bioethics and treatment protocols for adolescents suffering from gender dysphoria. *Id.* at 213–26. He reiterated that transitioning medications are well-established, evidence-based methods for treating gender dysphoria in minors. *Id.* at 120–21.

Defendants called two witnesses. *Id.* at 253, 337. First, Defendants tendered Dr. James Cantor—a private psychologist in Toronto, Canada—to testify as an expert on psychology, human sexuality, research methodology, and the state of the research literature on gender dysphoria and its treatment. *Id.* at 253–54. Dr. Cantor opined that, due to the risks of transitioning medications, doctors should use a "watchful waiting" approach to treat gender dysphoria in minors. *Id.* at 281. That approach, according to Dr. Cantor, "refers specifically to withholding any decision about medical interventions until [doctors] have a better idea or feel more confident" that the minor's gender dysphoria will persist without medical intervention other than counseling. *Id.* Dr. Cantor further testified that several European countries have

restricted treating minors with transitioning medications due to growing concern about the medications' risks. *Id.* at 296–97.

On cross examination, however, Dr. Cantor admitted that: (1) his patients are, on average, thirty years old; (2) he had never provided care to a transgender minor under the age of sixteen; (3) he had never diagnosed a child or adolescent with gender dysphoria; (4) he had never treated a child or adolescent for gender dysphoria; (5) he had no personal experience monitoring patients receiving transitioning medications; and (6) he had no personal knowledge of the assessments or treatment methodologies used at any Alabama gender clinic. *Id.* at 306–09. Accordingly, the Court gave his testimony regarding the treatment of gender dysphoria in minors very little weight. Dr. Cantor also testified that no country in Europe (or elsewhere) has categorically banned treating gender dysphoria in minors with transitioning medications. *Id.* at 326–28. Unlike the Act, Dr. Cantor added, those countries allow such treatments under certain circumstances and for research purposes. *Id.* at 327–28.

Defendants' other witness was Sydney Wright, a twenty-three-year-old woman who took hormone therapies for gender dysphoria for roughly a year beginning when she was nineteen. *Id.* at 338, 351, 357. She testified that she now believes taking the medication was a mistake and that she no longer believes gender dysphoria is a legitimate medical diagnosis. *Id.* at 348–49, 355. She also testified

that she received her treatments in Georgia and never visited a gender clinic in Alabama. *Id.* at 359–61.

II. LEGAL STANDARDS

The purpose of a preliminary injunction "is to preserve the positions of the parties" pending trial. *Bloedorn v. Grube*, 631 F.3d 1218, 1229 (11th Cir. 2011). When a federal court preliminarily enjoins a state law passed by duly elected officials, the court effectively overrules a decision "of the people and, thus, in a sense interferes with the processes of democratic government." *Ne. Fla. Chapter of Ass'n of Gen. Contractors of Am. v. City of Jacksonville*, 896 F.2d 1283, 1285 (11th Cir. 1990). This is an extraordinary and drastic remedy. *McDonald's Corp. v. Robertson*, 147 F.3d 1301, 1306 (11th Cir. 1998).

To receive a preliminary injunction, a movant must show that: (1) he or she has a substantial likelihood of success on the merits; (2) he or she will suffer irreparable injury absent injunctive relief; (3) the threatened injury to him or her "outweighs whatever damage the proposed injunction may cause the opposing party; and (4) if issued, the injunction would not be adverse to the public interest." *Siegel v. LePore*, 234 F.3d 1163, 1176 (11th Cir. 2000) (en banc). The movant bears the burden of persuasion on each element. *State of Fla. v. Dep't of Health & Hum. Servs.*, 19 F.4th 1271, 1279 (11th Cir. 2021).

III. DISCUSSION

Plaintiffs and the United States seek to enjoin Section 4(a)(1)–(3) of the Act pending trial under Federal Rule of Civil Procedure 65. *Pls.' Mot.* (Doc. 7) at 2; *Intervenor Pl.'s Mot.* (Doc. 62) at 2. Under this rule, a court may issue a preliminary injunction only after giving notice to the adverse party. FED. R. CIV. P. 65(a)(1). Where injunctive relief is appropriate, the movant must give security "to pay the costs and damages sustained by any party found to have been wrongfully enjoined or restrained." *Id.* at 65(c). Here, Defendants have received proper notice. The Court addresses whether Plaintiffs are entitled to preliminary injunctive relief before turning to the issue of security.

A. Substantial Likelihood of Success on the Merits

The Court first considers whether Plaintiffs are substantially likely to succeed on their claims. When a plaintiff brings multiple claims, a reviewing court must consider the plaintiff's likelihood of success on each claim. *See N. Am. Med. Corp. v. Axiom Worldwide, Inc.*, 522 F.3d 1211, 1226 (11th Cir. 2008). Here, Plaintiffs bring five causes of action: four constitutional claims and one preemption claim. The Court begins with Plaintiffs' constitutional claims.

1. Plaintiffs' Constitutional Claims

Plaintiffs' constitutional claims arise under the Civil Rights Act of 1871, 42 U.S.C. § 1983. *Compl.* (Doc. 1) at 28–30, 33–35. That statute guarantees "a

federal forum for claims of unconstitutional treatment at the hands of state officials[.]" *Heck v. Humphrey*, 512 U.S. 477, 480 (1994). To state a claim under § 1983, a plaintiff must allege: (1) the defendant deprived him of a right secured under federal law or the Constitution; and (2) such deprivation occurred under color of state law. *Richardson v. Johnson*, 598 F.3d 734, 737 (11th Cir. 2010) (per curiam).

Parent Plaintiffs claim that the Act violates their constitutional right to direct the medical care of their children under the Due Process Clause of the Fourteenth Amendment. *Compl.* (Doc. 1) at 28–29. Minor Plaintiffs assert that the Act discriminates against them based on their sex in violation of the Fourteenth Amendment. *Id.* at 29–30. Plaintiffs collectively allege that the Act is void for vagueness under the Fifth and Fourteenth Amendments. *Id.* at 34–35. Finally, Plaintiffs collectively claim that the Act unlawfully restricts their speech under the First Amendment. *Id.* at 33–34. The Court addresses Plaintiffs' claims in that order.

i. Substantive Due Process Claim

Parent Plaintiffs assert that the Act violates their constitutional right to direct the medical care of their children under the Fourteenth Amendment. *Compl.* (Doc. 1) at 28–29.[13] The Due Process Clause provides that no State shall "deprive any person of life, liberty, or property, without due process of law." U.S. CONST. AMEND. XIV.

[13] Based on the record evidence, the Court finds that Parent Plaintiffs have standing to bring their Substantive Due Process Claim. Defendants raise no opposition to this conclusion.

The Clause protects against governmental violations of "certain fundamental rights and liberty interests." *Washington v. Glucksberg*, 521 U.S. 702, 719–20 (1997). Fundamental rights are "those guaranteed by the Bill of Rights as well as certain 'liberty' and privacy interests implicit in the [D]ue [P]rocess [C]lause and the penumbra of constitutional rights." *Doe v. Moore*, 410 F.3d 1337, 1343 (11th Cir. 2005).

A parent's right "to make decisions concerning the care, custody, and control of their children" is one of "the oldest of the fundamental liberty interests" recognized by the Supreme Court. *Troxel v. Granville*, 530 U.S. 57, 65–66 (2000). Encompassed within this right is the more specific right to direct a child's medical care. *See Bendiburg v. Dempsey*, 909 F.2d 463, 470 (11th Cir. 1990) (recognizing "the right of parents to generally make decisions concerning the treatment to be given to their children").[14] Accordingly, parents "retain plenary authority to seek such care for their children, subject to a physician's independent examination and medical judgment." *Parham v. J.R.*, 442 U.S. 584, 604 (1979).

Against this backdrop, Parent Plaintiffs are substantially likely to show that they have a fundamental right to treat their children with transitioning medications subject to medically accepted standards and that the Act infringes on that right. The

[14] *See also PJ ex rel. Jensen v. Wagner*, 603 F.3d 1182, 1197 (10th Cir. 2010) (explaining that "the Due Process Clause provides some level of protection for parents' decisions regarding their children's medical care").

Act prevents Parent Plaintiffs from choosing that course of treatment for their children by criminalizing the use of transitioning medications to treat gender dysphoria in minors, even at the independent recommendation of a licensed pediatrician. Accordingly, Parent Plaintiffs are substantially likely to show that the Act infringes on their fundamental right to treat their children with transitioning medications subject to medically accepted standards.

The State counters that parents have no fundamental right to treat their children with experimental medications. *Defs.' Br.* (Doc. 74) at 120. To be sure, the parental right to autonomy is not limitless; the State may limit the right and intercede on a child's behalf when the child's health or safety is in jeopardy. *Bendiburg*, 909 F.2d at 470. But the fact that a pediatric treatment "involves risks does not automatically transfer the power" to choose that treatment "from the parents to some agency or officer of the state." *Parham*, 442 U.S. at 603.

Defendants produce no credible evidence to show that transitioning medications are "experimental." While Defendants offer some evidence that transitioning medications pose certain risks, the uncontradicted record evidence is that at least twenty-two major medical associations in the United States endorse transitioning medications as well-established, evidence-based treatments for gender dysphoria in minors. *Tr.* at 25, 97–98, 126–27. Indeed, according to Defendants' own expert, no country or state in the world categorically bans their use as Alabama

has. Certainly, the science is quickly evolving and will likely continue to do so. But this is true of almost every medical treatment regimen. Risk alone does not make a medication experimental.

Moreover, the record shows that medical providers have used transitioning medications for decades to treat medical conditions other than gender dysphoria, such as central precocious puberty, a condition in which a child enters puberty at a young age. Doctors have also long used hormone therapies for patients whose natural hormone levels are below normal. Based on the current record, Defendants fail to show that transitioning medications are experimental. Thus, Parent Plaintiffs are substantially likely to show that the Act violates their fundamental right to treat their children with transitioning medications subject to medically accepted standards.

Statutes that infringe on fundamental rights are constitutional only when they satisfy the most demanding standard of judicial review, strict scrutiny. *Williams v. Pryor*, 240 F.3d 944, 947 (11th Cir. 2001). To satisfy strict scrutiny, a statute must be "narrowly tailored" to achieve "a compelling state interest." *Reno v. Flores*, 507 U.S. 292, 302 (1993). The State's interest in "safeguarding the physical and psychological well-being of a minor is a compelling one." *Globe Newspaper Co. v. Superior Ct. for Norfolk Cnty.*, 457 U.S. 596, 607 (1982) (cleaned up).

Defendants proffer that the purpose of the Act is "to protect children from experimental medical procedures," the consequences of which neither they nor their parents often fully appreciate or understand. *Defs.' Br.* (Doc. 74) at 129; *see also* S.B. 184, ALA. 2022 REG. SESS. § 2(13)–(15) (Ala. 2022). Defendants also allege that the Act halts medical associations from "aggressively pushing" transitioning medications on minors. *Defs.' Br.* (Doc. 74) at 114; *see also* S.B. 184, ALA. 2022 REG. SESS. § 2(6) (Ala. 2022).

But as explained above, Defendants fail to produce evidence showing that transitioning medications jeopardize the health and safety of minors suffering from gender dysphoria. Nor do Defendants offer evidence to suggest that healthcare associations are aggressively pushing these medications on minors. Instead, the record shows that at least twenty-two major medical associations in the United States endorse transitioning medications as well-established, evidence-based treatments for gender dysphoria in minors. *Tr.* at 25, 97–98, 126–27. The record also indicates that parents undergo a thorough screening and consent process before they may choose these medications for their children.

Undoubtedly, transitioning medications carry risks. But again, the fact that pediatric medication "involves risks does not automatically transfer the power" to choose that medication "from the parents to some agency or officer of the state." *Parham*, 442 U.S. at 603. Parents, pediatricians, and psychologists—not the State or

this Court—are best qualified to determine whether transitioning medications are in a child's best interest on a case-by-case basis. Defendants' proffered purposes—which amount to speculative, future concerns about the health and safety of unidentified children—are not genuinely compelling justifications based on the record evidence. For this reason alone, the Act cannot survive strict scrutiny at this stage of litigation.

But even if Defendants' proffered purposes are genuinely compelling, the Act is not narrowly tailored to achieve those interests. A narrowly tailored statute employs the "least restrictive means" necessary to achieve its purpose. *Holt v. Hobbs*, 574 U.S. 352, 364 (2015). A statute is not narrowly tailored when "numerous and less-burdensome alternatives" are available to advance the statute's purpose. *FF Cosms. FL, Inc. v. City of Miami Beach*, 866 F.3d 1290, 1299 (11th Cir. 2017). Put differently, "if a less restrictive means is available for the Government to achieve its goals, the Government must use it." *United States v. Playboy Ent. Grp., Inc.*, 529 U.S. 803, 815 (2000).

Defendants applaud the efforts of several European countries to restrict minors from taking transitioning medications, but unlike Alabama's Act, these countries allow minors to take transitioning medications in exceptional circumstances on a case-by-case basis. *Defs.' Br.* (Doc. 74) at 76–82. According to Dr. Cantor, Defendants' own expert witness, no state or country in the entire world

has enacted a blanket ban of these medications other than Alabama. *Tr.* at 328. The Act, unlike the cited European regulations, does not even permit minors to take transitioning medications for research purposes, even though Defendants adamantly maintain that more research on them is needed. *Id.* at 326–27; *Defs.' Br.* (Doc. 74) at 116. Because Defendants themselves offer several less restrictive ways to achieve their proffered purposes, the Act is not narrowly tailored at this stage of litigation.

In sum, Parent Plaintiffs have a fundamental right to direct the medical care of their children. This right includes the more specific right to treat their children with transitioning medications subject to medically accepted standards. The Act infringes on that right and, as such, is subject to strict scrutiny. At this stage of litigation, the Act falls short of that standard because it is not narrowly tailored to achieve a compelling government interest. Accordingly, Parent Plaintiffs are substantially likely to succeed on their Substantive Due Process claim.

ii. Equal Protection Claim

Minor Plaintiffs claim that the Act discriminates against them based on their sex in violation of the Fourteenth Amendment. *Compl.* (Doc. 1) at 29–30.[15] The Equal Protection Clause provides that no State shall "deny to any person within its

[15] Based on the record evidence, the Court finds that Minor Plaintiffs have standing to bring their Equal Protection claim. Defendants raise no opposition to this conclusion. However, Parent Plaintiffs, Healthcare Plaintiffs, and Plaintiff Eknes-Tucker do not explain—nor is it readily apparent—how they have standing to bring an Equal Protection claim and, thus, are not substantially likely to succeed on the merits of their claim.

jurisdiction the equal protection of the laws." U.S. CONST. AMEND. XIV, § 1. The Clause's chief purpose "is to secure every person within the State's jurisdiction against intentional and arbitrary discrimination, whether occasioned by express terms of a statute or by its improper execution through duly constituted agents." *Vill. of Willowbrook v. Olech*, 528 U.S. 562, 564 (2000) (per curiam) (quoting *Sioux City Bridge Co. v. Dakota Cnty.*, 260 U.S. 441, 445 (1923)).

As the Supreme Court recently explained, "it is impossible to discriminate against a person for being homosexual or transgender without discriminating against that individual based on sex." *Bostock v. Clayton Cnty.*, 140 S. Ct. 1731, 1741 (2020). Governmental classification based on an individual's gender nonconformity equates to a sex-based classification for purposes of the Equal Protection Clause. *Glenn v. Brumby*, 663 F.3d 1312, 1320 (11th Cir. 2011). Here, the Act prohibits transgender minors—and only transgender minors—from taking transitioning medications due to their gender nonconformity. *See* S.B. 184, ALA. 2022 REG. SESS. § 4(a)(1)–(3) (Ala. 2022). The Act therefore constitutes a sex-based classification for purposes of the Fourteenth Amendment.

The State views things differently. The State argues that the Act creates two categories of people: (1) minors who seek transitioning medications "for the purpose of attempting to alter the appearance of or affirm the minor's perception of his or her gender or sex, if that appearance or perception is inconsistent with the minor's sex";

and (2) "all other minors." *Defs.' Br.* (Doc. 74) at 93. (quoting S.B. 184, ALA. 2022 REG. SESS. § 4(a) (Ala. 2022)). Because transgender minors fall into both categories, the State reasons, the Act is not a sex-based classification. *Id.* at 94.

The fundamental flaw in this argument is that the first category consists entirely of transgender minors. The Act categorically prohibits transgender minors from taking transitioning medications due to their gender nonconformity. In this way, the Act places a special burden on transgender minors because their gender identity does not match their birth sex. The Act therefore amounts to a sex-based classification for purposes of the Equal Protection Clause. *See Glenn*, 663 F.3d at 1317 (explaining that "discrimination against a transgender individual because of her gender-nonconformity is sex discrimination").

Sex-based classifications are constitutional only when they satisfy a heightened standard of review known as intermediate scrutiny. *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 440 (1985). To satisfy this standard, a classification must substantially relate to an important government interest. *Miss. Univ. for Women v. Hogan*, 458 U.S. 718, 724 (1982). The State bears the burden to proffer an exceedingly persuasive justification for the classification. *Sessions v. Morales-Santana*, 137 S. Ct. 1678, 1690 (2017). An exceedingly persuasive justification is one that is "genuine, not hypothesized or invented *post hoc* in response to litigation." *United States v. Virginia*, 518 U.S. 515, 533 (1996).

The State again argues that the Act's purpose is to protect minors from experimental medications and to stop medical providers from "aggressively pushing" these medications on minors. *Defs.' Br.* (Doc. 74) at 109–120. As explained above, the State puts on no evidence to show that transitioning medications are "experimental." The record indicates that at least twenty-two major medical associations in the United States endorse these medications as well-established, evidence-based methods for treating gender dysphoria in minors. *Tr.* at 25, 97–98, 126–27. Finally, nothing in the record shows that medical providers are pushing transitioning medications on minors. Accordingly, the State's proffered justifications are hypothesized, not exceedingly persuasive. Thus, Minor Plaintiffs are substantially likely to succeed on their Equal Protection claim.

iii. Void-for-Vagueness Claim

Plaintiffs collectively claim that the Act is void for vagueness under the Fifth and Fourteenth Amendments because it does not sufficiently define "what actions constitute 'caus[ing]' any of the proscribed activities upon a minor." *Compl.* (Doc. 1) at 34–35. Under the void-for-vagueness doctrine, a penal statute must "define the criminal offense with sufficient definiteness that ordinary people can understand what conduct is prohibited and in a manner that does not encourage arbitrary and discriminatory enforcement." *United States v. Marte*, 356 F.3d 1336, 1342 (11th Cir. 2004) (quoting *United States v. Fisher*, 289 F.3d 1329, 1333

(11th Cir. 2002)). A federal court reviews a void-for-vagueness claim only when the litigant alleges a constitutional harm. *Bankshot Billiards, Inc. v. City of Ocala*, 634 F.3d 1340, 1349–50 (11th Cir. 2011).

In this context, constitutional harm comes in two forms: (1) where a criminal defendant violates a vague statute, comes under prosecution, and then moves to dismiss the charges on the grounds that he or she lacked notice that his or her conduct was unlawful; and (2) where a civil plaintiff is "chilled from engaging in constitutional activity" due to a vague statute. *Dana's R.R. Supply v. Att'y Gen.*, 807 F.3d 1235, 1241 (11th Cir. 2015). Here, Plaintiffs' void-for-vagueness claim falls into the second category.

Plaintiffs, however, are not substantially likely to succeed on their claim. Under ALA. CODE § 13A-2-5(a), a person is liable for causing a crime "if the result would not have occurred but for his conduct, operating either alone or concurrently with another cause, unless the concurrent cause was sufficient to produce the result and the conduct of the actor clearly insufficient." The fact that the Act has a scienter requirement greatly weighs against Plaintiffs' void-for-vagueness claim. *See, e.g.*, *Gonzales v. Carhart*, 550 U.S. 124, 149 (2007) ("The Court has made clear that scienter requirements alleviate vagueness concerns."); *Colautti v. Franklin*, 439 U.S. 379, 395 (1979) ("This Court has long recognized that the constitutionality of a

vague statutory standard is closely related to whether that standard incorporates a requirement of mens rea.").

Also weighing against Plaintiffs' claim is the State's interpretation of the Act. During the preliminary injunction hearing, Alabama Solicitor General Edmund LaCour explained that a person must administer or prescribe transitioning medications to violate the Act. *Tr.* at 409–11. General LaCour opined that a person cannot violate the Act simply by advising a minor to take transitioning medications or by driving a minor to a gender clinic where transitioning medications are administered. *Id.* at 410.

Additionally, the statutory scienter requirement and the State's interpretation both align with the modern, plain-language definition of the word cause. According to Merriam-Webster's Dictionary, "cause" means to "effect by command, authority, or force" or "bring into existence" an action. *Cause*, MERRIAM-WEBSTER UNABR. DICTIONARY (3rd ed. 2002). Based on the record evidence, Plaintiffs do not show that they have been chilled from engaging in constitutional activity due to the Act. Plaintiffs are therefore not substantially likely to succeed on their void-for-vagueness claim at this stage of litigation.

iv. Free Speech Claim

Plaintiffs collectively claim that the Act violates their First Amendment right to free speech by prohibiting "any 'person,' including physicians, healthcare

professionals, or even parents, from engaging in speech that would 'cause' a transgender minor to receive medical treatment for gender dysphoria." *Compl.* (Doc. 1) at 33–34. The First Amendment provides that "Congress shall make no law . . . abridging the freedom of speech[.]" U.S. CONST. AMEND. I. At its core, "the First Amendment means that government" generally "has no power to restrict expression because of its message, its ideas, its subject matter, or its content." *Police Dep't of City of Chicago v. Mosley*, 408 U.S. 92, 95 (1972).

The Amendment, however, offers no protection to words that incite or constitute criminal activity. For example, sexually derogatory remarks may violate Title VII's general prohibition of sexual discrimination in the workplace. 42 U.S.C. § 2000-e2; *see also* 29 C.F.R. § 1604.11(a) (explaining that, under certain circumstances, "[u]nwelcome sexual advances, *requests* for sexual favors, and other *verbal* or physical conduct of a sexual nature" are actionable as sexual harassment under Title VII (emphasis added)). Likewise, "[s]peech attempting to arrange the sexual abuse of children is no more constitutionally protected than speech attempting to arrange any other type of crime." *United States v. Hornaday*, 392 F.3d 1306, 1311 (11th Cir. 2004). More examples abound, but the point is this: Where the State "does not target conduct on the basis of its expressive content, acts are not shielded from regulation merely because they express a discriminatory idea or philosophy." *R.A.V. v. City of St. Paul*, 505 U.S. 377, 390 (1992).

As explained *supra* Section III.A.1.iii, the Act does not criminalize speech that could indirectly lead to a minor taking transitioning medications. Rather, the only speech criminalized by Act is that which compels the administration or prescription of transitioning medications to minors. Accordingly, the Act targets conduct (administration and prescription), not speech. Plaintiffs are therefore not substantially likely to succeed on their First Amendment claim.

2. Plaintiffs' Preemption Claim

Parent Plaintiffs, Minor Plaintiffs, and Healthcare Plaintiffs bring their preemption claim under Section 1557 of the Affordable Care Act, 42 U.S.C. § 18116. *Compl.* (Doc. 1) at 31. Section 1557, through its incorporation of the Title IX, prohibits discrimination based on sex and the denial of benefits based on sex in any health program or activity that receives federal funding. 42 U.S.C. § 18116(a); 20 U.S.C. § 1681 *et seq.* Here, Plaintiffs generally rely on the same arguments Minor Plaintiffs made in support of their Equal Protection claim. *Pls.' Br.* (Doc. 8) at 49–52; *Tr.* at 379.

At this stage of litigation, Plaintiffs' preemption claim fails. As explained *supra* Section III.A.1.ii, only Minor Plaintiffs are substantially likely to succeed on their Equal Protection claim. Additionally, Section 1557—by incorporating the enforcement mechanism of Title IX—"is enforceable against institutions and programs that receive federal funds, but does not authorize suits against individuals."

Hill v. Cundiff, 797 F.3d 948, 977 (11th Cir. 2015). It is presently unclear how Plaintiffs may bring their preemption claim against Defendants who are state officials, not institutions. Due to these concerns, Plaintiffs are not substantially likely to succeed on their preemption claim.

B. Irreparable Harm

The Court next considers whether Parent Plaintiffs and Minor Plaintiffs will suffer irreparable harm absent injunctive relief.[16] Harm "is 'irreparable' only if it cannot be undone through monetary remedies." *Ne. Fla. Chapter of Ass'n of Gen. Contractors of Am.*, 896 F.2d at 1285. An irreparable harm is one that is "actual and imminent, not remote or speculative." *Odebrecht Const., Inc. v. Sec'y, Fla. Dep't of Transp.*, 715 F.3d 1268, 1288 (11th Cir. 2013). The risk of suffering severe medical harm constitutes irreparable harm. *See, e.g.*, *Bowen v. City of New York*, 476 U.S. 467, 483 (1986) (explaining that a risk of suffering "a severe medical setback" is an irreparable injury); *Blaine v. N. Brevard Cnty. Hosp. Dist.*, 312 F. Supp. 3d 1295, 1306 (M.D. Fla. 2018) (finding irreparable harm where doctor plaintiffs could not provide necessary medical care to their patients).

The Act prevents Parent Plaintiffs from treating their children with transitioning medications subject to medically accepted standards. S.B. 184, ALA.

[16] *See Church v. City of Huntsville*, 30 F.3d 1332, 1342 (11th Cir. 1994) (explaining that a court need not consider whether a plaintiff shows irreparable harm if he or she does not show a substantial likelihood of success on his or her claims).

2022 REG. SESS. § 4(a)(1)–(3) (Ala. 2022). The record shows that, without these medications, Minor Plaintiffs will suffer severe medical harm, including anxiety, depression, eating disorders, substance abuse, self-harm, and suicidality. *Tr.* at 20, 167. Additionally, the evidence shows that Minor Plaintiffs will suffer significant deterioration in their familial relationships and educational performance. *Id.* at 35, 112–13. The Court therefore concludes that Parent Plaintiffs and Minor Plaintiffs will suffer irreparable harm absent injunctive relief.

C. Balance of Harms & Public Interests

The Court now considers the final two elements together. To satisfy the third and fourth elements of a preliminary injunction, a plaintiff must show that the harm she will likely suffer without an injunction outweighs any harm that her opponent will suffer from the injunction and that the injunction would not disserve (or be adverse to) the public interest. *Scott v. Roberts*, 612 F.3d 1279, 1290 (11th Cir. 2010). These factors merge when the State is the opponent. *Swain v. Junior*, 958 F.3d 1081, 1091 (11th Cir. 2020) (per curiam).

This case largely presents two competing interests. On one hand, "preliminary injunctions of legislative enactments—because they interfere with the democratic process and lack the safeguards against abuse or error that come with a full trial on the merits—must be granted reluctantly and only upon a clear showing that the injunction before trial is definitely demanded by the Constitution and by the other

strict legal and equitable principles that restrain courts." *Ne. Fla. Chapter of Ass'n of Gen. Contractors of Am.*, 896 F.2d at 1285. On the other hand, "[a] democratic society rests, for its continuance, upon the healthy, well-rounded growth of young people into full maturity as citizens, with all that implies." *Prince v. Massachusetts*, 321 U.S. 158, 168–69 (1944).

Based on the record evidence, the Court finds that the imminent threat of harm to Parent Plaintiffs and Minor Plaintiffs—i.e., severe physical and/or psychological harm—outweighs the harm the State will suffer from an injunction. The Court further finds that an injunction is not adverse to the public interest. To the contrary, enjoining the Act upholds and reaffirms the "enduring American tradition" that parents—not the States or federal courts—play the primary role in nurturing and caring for their children. *Wisconsin v. Yoder*, 406 U.S. 205, 232 (1972). Accordingly, the final two factors favor injunctive relief.

IV. SECURITY

Defendants argue that, if injunctive relief is appropriate, the Court should require each Healthcare Plaintiff to post a $1 million security. *Defs.' Br.* (Doc. 74) at 159–60.[17] Calculating the "amount of an injunction bond is within the sound discretion of the district court." *Carillon Importers, Ltd. v. Frank Pesce Int'l Grp.*,

[17] According to Defendants, this amount represents that "by which [Healthcare] Plaintiffs will be unjustly enriched should they be allowed to administer profitable (and illegal) medical procedures to kids." *Defs.' Br.* (Doc. 74) at 160.

112 F.3d 1125, 1127 (11th Cir. 1997) (per curiam). Here, the Court finds that a security bond is not necessary for three reasons. First, as explained *supra* Part III, Healthcare Plaintiffs themselves are not entitled to preliminary injunctive relief. Second, Federal Rule of Civil Procedure 65 does not require the United States to pay security. FED. R. CIV. P. 65(c). Finally, Defendants do not allege that they will suffer any cost or economic harm if they are wrongly enjoined from enforcing the Act. *Defs.' Br.* (Doc. 74) at 159–60. The Court therefore relieves Plaintiffs from posting security under Rule 65.

V. CONCLUSION

For these reasons, the Court **GRANTS** in part Plaintiffs' motion for preliminary injunction (Doc. 7) and **ENJOINS** Defendants from enforcing Section 4(a)(1)–(3) of the Act pending trial. The Court **GRANTS** in part the United States's motion for preliminary injunction (Doc. 62) to the same degree and effect. All other provisions of the Act remain enforceable.

DONE and **ORDERED** May 13, 2022.

LILES C. BURKE
UNITED STATES DISTRICT JUDGE

DOC. 108

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

REV. PAUL A. EKNES-TUCKER, *et al.*,	)	
Plaintiffs,	)	
&	)	
UNITED STATES OF AMERICA,	)	
Plaintiff-Intervenor,	)	
v.	)	No. 2:22-cv-00184-LCB
STEVE MARSHALL, in his official capacity as Attorney General of the State of Alabama, *et al.*,	)	
Defendants.	)	

DEFENDANTS' NOTICE OF APPEAL OF ORDER GRANTING PRELIMINARY INJUNCTION (DOC. 107)

Notice is hereby given that all Defendants in the above-captioned case appeal to the United States Court of Appeals for the Eleventh Circuit from this Court's May 13, 2022 Preliminary Injunction Opinion and Order (Doc. 107).

Respectfully submitted,

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Attorney General

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MAY 16, 2022

CERTIFICATE OF SERVICE

I certify that I electronically filed this document using the Court's CM/ECF system on May 16, 2022, which will serve all counsel of record.

s/ Edmund G. LaCour Jr.
Counsel for Defendants

DOC. 112

UNITED STATES DISTRICT COURT

MIDDLE DISTRICT OF ALABAMA

OFFICE OF THE CLERK

ONE CHURCH STREET, RM B-110

MONTGOMERY, ALABAMA 36104

DEBRA P. HACKETT, CLERK

TELEPHONE (334) 954-3600

May 19, 2022

NOTICE OF CORRECTION

From: **Clerk's Office**

Case Style: **Eknes-Tucker et al v. Marshall et al**

Case Number: **2:22-cv-00184-LCB**

This Notice of Correction was filed in the referenced case this date to attach the correct main PDF document to correct syntax.

The correct PDF document is attached to this notice for your review. Reference is made to document #107 filed on 5/13/2022.

DOC. 112-1

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

PAUL A. EKNES-TUCKER, *et al.*,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	**Case No. 2:22-cv-184-LCB**
	)	
STEVE MARSHALL, *et al.*,	)	
	)	
Defendants.	)	

OPINION & ORDER

Several individuals and the United States challenge the constitutionality of the Alabama Vulnerable Child Compassion and Protection Act.[1] In part, the Act restricts transgender minors from utilizing puberty blockers and hormone therapies. Because the Supreme Court and the Court of Appeals for the Eleventh Circuit have made clear that: (1) parents have a fundamental right to direct the medical care of their children subject to accepted medical standards; and (2) discrimination based on gender-nonconformity equates to sex discrimination, the Court finds that there is a substantial likelihood that Section 4(a)(1)–(3) of the Act is unconstitutional and, thus, enjoins Defendants from enforcing that portion of the Act pending trial. However, all other provisions of the Act remain in effect, specifically: (1) the

[1] Based on their oral representations during a May 4, 2022 hearing, Plaintiffs seek to enjoin only Section 4(a)(1)–(3) of the Act. For purposes of this opinion, all references to "the Act" refer to these subdivisions unless noted otherwise.

provision that bans sex-altering surgeries on minors; (2) the provision prohibiting school officials from keeping certain gender-identity information of children secret from their parents; and (3) the provision that prohibits school officials from encouraging or compelling children to keep certain gender-identity information secret from their parents.

I. BACKGROUND

Regarding a child's belief that they might be transgender, Merriam-Webster's Dictionary defines a "transgender" person as one whose gender identity is different from the sex the person had or was identified as having at birth. *Transgender*, MERRIAM-WEBSTER UNABR. DICTIONARY (3rd ed. 2002). The Dictionary defines "gender identity" as a person's internal sense of being a male or a female. *Gender Identity*, MERRIAM-WEBSTER UNABR. DICTIONARY (3rd ed. 2002). These terms and definitions are largely consistent with those used by the parties. Accordingly, the Court relies on these terms throughout this opinion, but recognizes that they might mean different things to different people and in different contexts.

According to the uncontradicted record evidence, some transgender minors suffer from a mental health condition known as gender dysphoria. *Tr.* at 30.[2] Gender dysphoria is a clinically diagnosed incongruence between one's gender identity and

[2] "*Tr.*" is a consecutively paginated transcript of the two-day preliminary injunction hearing the Court held on May 5–6, 2022. For clarity, the Court cites to the internal pagination of the transcript rather than the ECF pagination.

assigned gender. *DSM-5* (Doc. 69-17) at 4. If untreated, gender dysphoria may cause or lead to anxiety, depression, eating disorders, substance abuse, self-harm, and suicide. *Tr.* at 20. According to the World Professional Association for Transgender Health (WPATH), an organization whose mission is to promote education and research about transgender healthcare, gender dysphoria in adolescents (minors twelve and over) is more likely to persist into adulthood than gender dysphoria in children (minors under twelve). *WPATH Standards of Care* (Doc. 69-18) at 17.[3]

In some cases, physicians treat gender dysphoria in minors with a family of medications known as GnRH agonists, commonly referred to as puberty blockers. *Id.* at 24; *Tr.* at 103. After a minor has been on puberty blockers for one to three years, doctors may then use hormone therapies to masculinize or feminize his or her body. *Tr.* at 108–11, 131. The primary effect of these treatments is to delay physical maturation, allowing transgender minors to socially transition their gender while they await adulthood. *Id.* at 105–06, 110–11. For clarity and conciseness, the Court refers to puberty blockers and hormone therapies used for these purposes as "transitioning medications."

Like all medications, transitioning medications come with risks. *Tr.* at 121–22. Known risks, for example, include loss of fertility and sexual function. *Id.*

[3] Plaintiffs, the State, and the United States individually introduced the WPATH standards into evidence during the May 5–6 preliminary injunction hearing.

at 132–33. Nevertheless, WPATH recognizes transitioning medications as established medical treatments and publishes a set of guidelines for treating gender dysphoria in minors with these medications. *WPATH Standards of Care* (Doc. 69-18) at 19. The American Medical Association, the American Pediatric Society, the American Psychiatric Association, the Association of American Medical Colleges, and at least eighteen additional major medical associations endorse these guidelines as evidence-based methods for treating gender dysphoria in minors. *Tr.* at 97–98; *Healthcare Amici Br.* (Doc. 91-1) at 15.[4]

The Alabama Vulnerable Child Compassion and Protection Act states in pertinent part:

> Section 4. (a) . . . [N]o person shall engage in or cause any of the following practices to be performed upon a minor if the practice is performed for the purpose of attempting to alter the appearance of or affirm the minor's perception of his or her gender or sex, if that appearance or perception is inconsistent with the minor's sex as defined in this act:
>
> > (1) Prescribing or administering puberty blocking medication to stop or delay normal puberty.
> >
> > (2) Prescribing or administering supraphysiologic doses of testosterone or other androgens to females.
> >
> > (3) Prescribing or administering supraphysiologic doses of estrogen to males.

[4] For a full list of the twenty-two major medical associations that endorse these guidelines, see *infra* note 12.

> (4) Performing surgeries that sterilize, including castration, vasectomy, hysterectomy, oophorectomy, orchiectomy, and penectomy.
>
> (5) Performing surgeries that artificially construct tissue with the appearance of genitalia that differs from the individual's sex, including metoidioplasty, phalloplasty, and vaginoplasty.
>
> (6) Removing any healthy or non-diseased body part or tissue, except for a male circumcision.

. . .

(c) A violation of this section is a Class C felony.

Section 5. No nurse, counselor, teacher, principal, or other administrative official at a public or private school attended by a minor shall do either of the following:

> (1) Encourage or coerce a minor to withhold from the minor's parent or legal guardian the fact that the minor's perception of his or her gender or sex is inconsistent with the minor's sex.
>
> (2) Withhold from a minor's parent or legal guardian information related to a minor's perception that his or her gender or sex is inconsistent with his or her sex.

S.B. 184, ALA. 2022 REG. SESS. §§ 4–5 (Ala. 2022). The Act defines a "minor" as anyone under the age of nineteen. *Id.* § 3(1); ALA. CODE § 43-8-1(18). The Act defines "sex" as "[t]he biological state of being male or female, based on the individual's sex organs, chromosomes, and endogenous hormone profiles." S.B. 184, ALA. 2022 REG. SESS. § 3(3) (Ala. 2022).

In support of these prohibitions, the Legislature made several legislative findings. *Id.* § 2. The Legislature found in part that "[s]ome in the medical community are aggressively pushing" minors to take transitioning medications, which the Act describes as "unproven, poorly studied . . . interventions" that cause "numerous harmful effects for minors, as well as risks of effects simply unknown due to the new and experimental nature of these interventions." *Id.* § 2(6), (11). The Legislature went on to find that "[m]inors, and often their parents, are unable to comprehend and fully appreciate the risk and life implications" of these treatments. *Id.* § 2(15). Thus, the Legislature concluded, "the decision to pursue" these treatments "should not be presented to or determined for minors[.]" *Id.* § 2(16).

Alabama legislators passed the Act on April 7, 2022.[5] Governor Kay Ivey signed the Act into law the following day.[6] In the week that followed, civil rights groups filed two lawsuits challenging the Act's constitutionality.[7] In *Ladinsky v. Ivey*, Case No. 2:22-cv-447 (N.D. Ala. 2022), several plaintiffs challenged the Act in the United States District Court of the Northern District of Alabama. The case

[5] Jo Yurcaba, *Alabama Passes Bills to Target Trans Minors and LGBTQ Classroom Discussion*, NBCNEWS.COM (Apr. 7, 2022, 4:22 PM), https://www.nbcnews.com/nbc-out/out-politics-and-policy/alabama-passes-bills-targeting-trans-minors-lgbtq-classroom-discussion-rcna23444.

[6] Madeleine Carlisle, *Alabama's Wave of Anti-LGBTQ Legislation Could Have National Consequences*, TIME.COM (Apr. 15, 2022, 11:40 AM), https://time.com/6167472/alabama-anti-lgbtq-legislation/.

[7] *Alabama Law Banning Transgender Medication Challenged in Two Lawsuits*, CBSNEWS.COM (Apr. 11, 2022, 10:05 PM), https://www.cbsnews.com/news/alabama-transgender-law-lawsuits/.

was randomly assigned to United States District Judge Anna M. Manasco. Judge Manasco recused, and the case was randomly reassigned to United States Magistrate Judge Staci G. Cornelius. After the parties declined to proceed before Judge Cornelius in accordance with 28 U.S.C. § 636(c), the case was randomly reassigned to the Honorable Annemarie C. Axon.

With *Ladinsky* pending, a separate set of plaintiffs challenged the Act in the United States District Court of the Middle District of Alabama. That case, styled *Walker v. Marshall*, Case No. 2:22-cv-167 (M.D. Ala. 2022), was randomly assigned to Chief United States District Judge Emily C. Marks. The *Walker* plaintiffs moved to enjoin enforcement of the Act and moved to reassign the case to United States District Judge Myron H. Thompson, alleging that he had previously presided over a similar case. The parties, however, later consented to transferring the case to the Northern District of Alabama for consolidation with *Ladinsky*. At that time, the *Walker* plaintiffs withdrew their motion to reassign.

On April 15, 2022, Chief Judge Marks transferred *Walker* to the Northern District of Alabama in accordance with the "first-filed" rule and 28 U.S.C. § 1404(a). The case was randomly assigned to this Court. Judge Axon then transferred *Ladinsky* to this Court for consolidation with *Walker*. That same day, at 6:24 p.m. CDT, the *Walker* plaintiffs filed a notice of voluntary dismissal without prejudice under Federal Rule of Civil Procedure 41(a)(1)(A)(i). The *Ladinsky* plaintiffs voluntarily

dismissed their case nine minutes later. Neither the *Walker* plaintiffs nor the *Ladinsky* plaintiffs explained their respective dismissals, but counsel for *Ladinsky* informed the press: "We do plan to refile imminently[.]"[8]

Sure enough, on April 19, four transgender minors (Minor Plaintiffs), their parents (Parent Plaintiffs), a child psychologist and a pediatrician (Healthcare Plaintiffs), and Reverend Paul A. Eknes-Tucker filed this suit in the United States District Court of the Middle District of Alabama and moved to enjoin the Act's enforcement pending trial. The case was randomly assigned to United States District Judge R. Austin Huffaker, Jr. Due to this Court's familiarity with *Ladinsky* and *Walker*, Judge Huffaker reassigned the case to this Court to expedite disposition of Plaintiffs' motion for preliminary injunction. With the Act set to take effect on May 8, the Court entered an abbreviated briefing schedule and set a hearing on Plaintiffs' motion for May 5–6.

Just days before the hearing, the United States moved to intervene on behalf of Plaintiffs under Federal Rule of Civil Procedure 24.[9] In the process, the United States filed its own motion to enjoin enforcement of the Act and requested to

[8] Paul Gattis, *Lawsuits Seeking to Overturn New Alabama Transgender Law Dropped, Could be Refiled*, AL.COM, https://www.al.com/news/2022/04/lawsuits-seeking-to-overturn-new-alabama-transgender-law-dropped-could-be-refiled.html (last updated Apr. 16, 2022, 9:22 PM).

[9] The United States's amended intervenor complaint does not add any additional claims, name any new defendants, or seek to expand the relief sought by Plaintiffs. *Compare Am. Intervenor Compl.* (Doc. 92) at 4–5, 13–14, *with Compl.* (Doc. 1) at 6–8, 28–35.

participate in the preliminary injunction hearing. Additionally, fifteen states moved for leave to proceed as *amici curiae*[10] and to file a brief in support of Defendants.[11] Twenty-two healthcare organizations also moved for leave to proceed as *amici curiae* and to file a brief in support of Plaintiffs.[12] Ultimately, the Court granted these motions in full, took the *amici* briefs under advisement, and gave the United States leave to participate during the preliminary injunction hearing.

During that hearing, the parties submitted hundreds of pages of medical evidence and called several live witnesses. Plaintiffs tendered Dr. Linda Hawkins and Dr. Morissa Ladinsky as experts in the treatment of gender dysphoria in minors. *Tr.* at 16, 92. Dr. Hawkins and Dr. Ladinsky testified that at least twenty-two major

[10] *Amici curiae*, Latin for "friends of the court," refers to a group of people or institutions who are not parties to a lawsuit, but petition the court (or are requested by the court) to file a brief in the action because they have "a strong interest in the subject matter." *Amicus Curiae*, BLACK'S LAW DICTIONARY (11th ed. 2019).

[11] The State *Amici* are the States of Arkansas, Alaska, Arizona, Georgia, Indiana, Louisiana, Mississippi, Missouri, Montana, Nebraska, Oklahoma, South Carolina, Texas, Utah, and West Virginia.

[12] The Healthcare *Amici* are the American Academy of Pediatrics; the Alabama Chapter of the American Academy of Pediatrics; the Academic Pediatric Association; the American Academy of Child and Adolescent Psychiatry; the American Academy of Family Physicians; the American Academy of Nursing; the American Association of Physicians for Human Rights, Inc. *d/b/a* Health Professionals Advancing LGBTQ Equality; the American College of Obstetricians and Gynecologists; the American College of Osteopathic Pediatricians; the American College of Physicians; the American Medical Association; the American Pediatric Society; the American Psychiatric Association; the Association of American Medical Colleges; the Association of Medical School Pediatric Department Chairs; the Endocrine Society; the National Association of Pediatric Nurse Practitioners; the Pediatric Endocrine Society; the Society for Adolescent Health and Medicine; the Society for Pediatric Research; the Society of Pediatric Nurses; the Societies for Pediatric Urology; and the World Professional Association for Transgender Health.

medical associations in the United States endorse transitioning medications as well-established, evidence-based methods for treating gender dysphoria in minors. *Id.* at 25, 97–98, 126–27. They opined that there are risks associated with transitioning medications, but that the benefits of treating minors with these medications outweigh these risks in certain cases. *Id.* at 57–58, 121–22, 136, 170. They also explained that minors and their parents undergo a thorough screening process and give informed consent before any treatment regimen begins. *Id.* at 41, 59, 132; *see also Consent Form* (Doc. 78-41) at 1–14. Finally, they testified that, without these medications, minors with gender dysphoria suffer significant deterioration in their familial relationships and educational performance. *Tr.* at 35, 112–13.

Plaintiffs also called Healthcare Plaintiff Dr. Rachel Koe (a licensed pediatrician), Plaintiff Eknes-Tucker, and Parent Plaintiff Megan Poe to testify about their personal knowledge and experiences regarding the treatment of gender dysphoria in minors. *Id.* at 150–51, 170–71, 195. Parent Plaintiff Megan Poe specifically described the positive effects transitioning treatments have had on her fifteen-year-old transgender daughter, Minor Plaintiff Allison Poe. *Id.* at 157–68.

According to Megan, Allison was born a male, but has shown evidence of identifying as a female since she was two-years-old. *Id.* at 153–54. During her early adolescent years, Allisson suffered from severe depression and suicidality due to gender dysphoria. *Id.* at 156–57. She began taking transitioning medications at the

end of her sixth-grade year, and her health significantly improved as a result. *Id.* at 163. Megan explained that the medications have had no adverse effects on Allison and that Allison is now happy and "thriving." *Id.* at 166–67. When asked what would occur if her daughter stopped taking the medications, Megan responded that she feared her daughter would commit suicide. *Id.* at 167.

Intervening on behalf of Plaintiffs, the United States tendered Dr. Armand H. Antommaria as an expert in bioethics and treatment protocols for adolescents suffering from gender dysphoria. *Id.* at 213–26. He reiterated that transitioning medications are well-established, evidence-based methods for treating gender dysphoria in minors. *Id.* at 120–21.

Defendants called two witnesses. *Id.* at 253, 337. First, Defendants tendered Dr. James Cantor—a private psychologist in Toronto, Canada—to testify as an expert on psychology, human sexuality, research methodology, and the state of the research literature on gender dysphoria and its treatment. *Id.* at 253–54. Dr. Cantor opined that, due to the risks of transitioning medications, doctors should use a "watchful waiting" approach to treat gender dysphoria in minors. *Id.* at 281. That approach, according to Dr. Cantor, "refers specifically to withholding any decision about medical interventions until [doctors] have a better idea or feel more confident" that the minor's gender dysphoria will persist without medical intervention other than counseling. *Id.* Dr. Cantor further testified that several European countries have

restricted treating minors with transitioning medications due to growing concern about the medications' risks. *Id.* at 296–97.

On cross examination, however, Dr. Cantor admitted that: (1) his patients are, on average, thirty years old; (2) he had never provided care to a transgender minor under the age of sixteen; (3) he had never diagnosed a child or adolescent with gender dysphoria; (4) he had never treated a child or adolescent for gender dysphoria; (5) he had no personal experience monitoring patients receiving transitioning medications; and (6) he had no personal knowledge of the assessments or treatment methodologies used at any Alabama gender clinic. *Id.* at 306–09. Accordingly, the Court gave his testimony regarding the treatment of gender dysphoria in minors very little weight. Dr. Cantor also testified that no country in Europe (or elsewhere) has categorically banned treating gender dysphoria in minors with transitioning medications. *Id.* at 326–28. Unlike the Act, Dr. Cantor added, those countries allow such treatments under certain circumstances and for research purposes. *Id.* at 327–28.

Defendants' other witness was Sydney Wright, a twenty-three-year-old woman who took hormone therapies for gender dysphoria for roughly a year beginning when she was nineteen. *Id.* at 338, 351, 357. She testified that she now believes taking the medication was a mistake and that she no longer believes gender dysphoria is a legitimate medical diagnosis. *Id.* at 348–49, 355. She also testified

that she received her treatments in Georgia and never visited a gender clinic in Alabama. *Id.* at 359–61.

II. LEGAL STANDARDS

The purpose of a preliminary injunction "is to preserve the positions of the parties" pending trial. *Bloedorn v. Grube*, 631 F.3d 1218, 1229 (11th Cir. 2011). When a federal court preliminarily enjoins a state law passed by duly elected officials, the court effectively overrules a decision "of the people and, thus, in a sense interferes with the processes of democratic government." *Ne. Fla. Chapter of Ass'n of Gen. Contractors of Am. v. City of Jacksonville*, 896 F.2d 1283, 1285 (11th Cir. 1990). This is an extraordinary and drastic remedy. *McDonald's Corp. v. Robertson*, 147 F.3d 1301, 1306 (11th Cir. 1998).

To receive a preliminary injunction, a movant must show that: (1) he or she has a substantial likelihood of success on the merits; (2) he or she will suffer irreparable injury absent injunctive relief; (3) the threatened injury to him or her "outweighs whatever damage the proposed injunction may cause the opposing party; and (4) if issued, the injunction would not be adverse to the public interest." *Siegel v. LePore*, 234 F.3d 1163, 1176 (11th Cir. 2000) (en banc). The movant bears the burden of persuasion on each element. *State of Fla. v. Dep't of Health & Hum. Servs.*, 19 F.4th 1271, 1279 (11th Cir. 2021).

III. DISCUSSION

Plaintiffs and the United States seek to enjoin Section 4(a)(1)–(3) of the Act pending trial under Federal Rule of Civil Procedure 65. *Pls.' Mot.* (Doc. 7) at 2; *Intervenor Pl.'s Mot.* (Doc. 62) at 2. Under this rule, a court may issue a preliminary injunction only after giving notice to the adverse party. FED. R. CIV. P. 65(a)(1). Where injunctive relief is appropriate, the movant must give security "to pay the costs and damages sustained by any party found to have been wrongfully enjoined or restrained." *Id.* at 65(c). Here, Defendants have received proper notice. The Court addresses whether Plaintiffs are entitled to preliminary injunctive relief before turning to the issue of security.

A. Substantial Likelihood of Success on the Merits

The Court first considers whether Plaintiffs are substantially likely to succeed on their claims. When a plaintiff brings multiple claims, a reviewing court must consider the plaintiff's likelihood of success on each claim. *See N. Am. Med. Corp. v. Axiom Worldwide, Inc.*, 522 F.3d 1211, 1226 (11th Cir. 2008). Here, Plaintiffs bring five causes of action: four constitutional claims and one preemption claim. The Court begins with Plaintiffs' constitutional claims.

1. Plaintiffs' Constitutional Claims

Plaintiffs' constitutional claims arise under the Civil Rights Act of 1871, 42 U.S.C. § 1983. *Compl.* (Doc. 1) at 28–30, 33–35. That statute guarantees "a

federal forum for claims of unconstitutional treatment at the hands of state officials[.]" *Heck v. Humphrey*, 512 U.S. 477, 480 (1994). To state a claim under § 1983, a plaintiff must allege: (1) the defendant deprived him of a right secured under federal law or the Constitution; and (2) such deprivation occurred under color of state law. *Richardson v. Johnson*, 598 F.3d 734, 737 (11th Cir. 2010) (per curiam).

Parent Plaintiffs claim that the Act violates their constitutional right to direct the medical care of their children under the Due Process Clause of the Fourteenth Amendment. *Compl.* (Doc. 1) at 28–29. Minor Plaintiffs assert that the Act discriminates against them based on their sex in violation of the Fourteenth Amendment. *Id.* at 29–30. Plaintiffs collectively allege that the Act is void for vagueness under the Fifth and Fourteenth Amendments. *Id.* at 34–35. Finally, Plaintiffs collectively claim that the Act unlawfully restricts their speech under the First Amendment. *Id.* at 33–34. The Court addresses Plaintiffs' claims in that order.

i. Substantive Due Process Claim

Parent Plaintiffs assert that the Act violates their constitutional right to direct the medical care of their children under the Fourteenth Amendment. *Compl.* (Doc. 1) at 28–29.[13] The Due Process Clause provides that no State shall "deprive any person of life, liberty, or property, without due process of law." U.S. CONST. AMEND. XIV.

[13] Based on the record evidence, the Court finds that Parent Plaintiffs have standing to bring their Substantive Due Process Claim. Defendants raise no opposition to this conclusion.

The Clause protects against governmental violations of "certain fundamental rights and liberty interests." *Washington v. Glucksberg*, 521 U.S. 702, 719–20 (1997). Fundamental rights are "those guaranteed by the Bill of Rights as well as certain 'liberty' and privacy interests implicit in the [D]ue [P]rocess [C]lause and the penumbra of constitutional rights." *Doe v. Moore*, 410 F.3d 1337, 1343 (11th Cir. 2005).

A parent's right "to make decisions concerning the care, custody, and control of their children" is one of "the oldest of the fundamental liberty interests" recognized by the Supreme Court. *Troxel v. Granville*, 530 U.S. 57, 65–66 (2000). Encompassed within this right is the more specific right to direct a child's medical care. *See Bendiburg v. Dempsey*, 909 F.2d 463, 470 (11th Cir. 1990) (recognizing "the right of parents to generally make decisions concerning the treatment to be given to their children").[14] Accordingly, parents "retain plenary authority to seek such care for their children, subject to a physician's independent examination and medical judgment." *Parham v. J.R.*, 442 U.S. 584, 604 (1979).

Against this backdrop, Parent Plaintiffs are substantially likely to show that they have a fundamental right to treat their children with transitioning medications subject to medically accepted standards and that the Act infringes on that right. The

[14] *See also PJ ex rel. Jensen v. Wagner*, 603 F.3d 1182, 1197 (10th Cir. 2010) (explaining that "the Due Process Clause provides some level of protection for parents' decisions regarding their children's medical care").

Act prevents Parent Plaintiffs from choosing that course of treatment for their children by criminalizing the use of transitioning medications to treat gender dysphoria in minors, even at the independent recommendation of a licensed pediatrician. Accordingly, Parent Plaintiffs are substantially likely to show that the Act infringes on their fundamental right to treat their children with transitioning medications subject to medically accepted standards.

The State counters that parents have no fundamental right to treat their children with experimental medications. *Defs.' Br.* (Doc. 74) at 120. To be sure, the parental right to autonomy is not limitless; the State may limit the right and intercede on a child's behalf when the child's health or safety is in jeopardy. *Bendiburg*, 909 F.2d at 470. But the fact that a pediatric treatment "involves risks does not automatically transfer the power" to choose that treatment "from the parents to some agency or officer of the state." *Parham*, 442 U.S. at 603.

Defendants produce no credible evidence to show that transitioning medications are "experimental." While Defendants offer some evidence that transitioning medications pose certain risks, the uncontradicted record evidence is that at least twenty-two major medical associations in the United States endorse transitioning medications as well-established, evidence-based treatments for gender dysphoria in minors. *Tr.* at 25, 97–98, 126–27. Indeed, according to Defendants' own expert, no country or state in the world categorically bans their use as Alabama

has. Certainly, the science is quickly evolving and will likely continue to do so. But this is true of almost every medical treatment regimen. Risk alone does not make a medication experimental.

Moreover, the record shows that medical providers have used transitioning medications for decades to treat medical conditions other than gender dysphoria, such as central precocious puberty, a condition in which a child enters puberty at a young age. Doctors have also long used hormone therapies for patients whose natural hormone levels are below normal. Based on the current record, Defendants fail to show that transitioning medications are experimental. Thus, Parent Plaintiffs are substantially likely to show that the Act violates their fundamental right to treat their children with transitioning medications subject to medically accepted standards.

Statutes that infringe on fundamental rights are constitutional only when they satisfy the most demanding standard of judicial review, strict scrutiny. *Williams v. Pryor*, 240 F.3d 944, 947 (11th Cir. 2001). To satisfy strict scrutiny, a statute must be "narrowly tailored" to achieve "a compelling state interest." *Reno v. Flores*, 507 U.S. 292, 302 (1993). The State's interest in "safeguarding the physical and psychological well-being of a minor is a compelling one." *Globe Newspaper Co. v. Superior Ct. for Norfolk Cnty.*, 457 U.S. 596, 607 (1982) (cleaned up).

Defendants proffer that the purpose of the Act is "to protect children from experimental medical procedures," the consequences of which neither they nor their parents often fully appreciate or understand. *Defs.' Br.* (Doc. 74) at 129; *see also* S.B. 184, ALA. 2022 REG. SESS. § 2(13)–(15) (Ala. 2022). Defendants also allege that the Act halts medical associations from "aggressively pushing" transitioning medications on minors. *Defs.' Br.* (Doc. 74) at 114; *see also* S.B. 184, ALA. 2022 REG. SESS. § 2(6) (Ala. 2022).

But as explained above, Defendants fail to produce evidence showing that transitioning medications jeopardize the health and safety of minors suffering from gender dysphoria. Nor do Defendants offer evidence to suggest that healthcare associations are aggressively pushing these medications on minors. Instead, the record shows that at least twenty-two major medical associations in the United States endorse transitioning medications as well-established, evidence-based treatments for gender dysphoria in minors. *Tr.* at 25, 97–98, 126–27. The record also indicates that parents undergo a thorough screening and consent process before they may choose these medications for their children.

Undoubtedly, transitioning medications carry risks. But again, the fact that pediatric medication "involves risks does not automatically transfer the power" to choose that medication "from the parents to some agency or officer of the state." *Parham*, 442 U.S. at 603. Parents, pediatricians, and psychologists—not the State or

this Court—are best qualified to determine whether transitioning medications are in a child's best interest on a case-by-case basis. Defendants' proffered purposes—which amount to speculative, future concerns about the health and safety of unidentified children—are not genuinely compelling justifications based on the record evidence. For this reason alone, the Act cannot survive strict scrutiny at this stage of litigation.

But even if Defendants' proffered purposes are genuinely compelling, the Act is not narrowly tailored to achieve those interests. A narrowly tailored statute employs the "least restrictive means" necessary to achieve its purpose. *Holt v. Hobbs*, 574 U.S. 352, 364 (2015). A statute is not narrowly tailored when "numerous and less-burdensome alternatives" are available to advance the statute's purpose. *FF Cosms. FL, Inc. v. City of Miami Beach*, 866 F.3d 1290, 1299 (11th Cir. 2017). Put differently, "if a less restrictive means is available for the Government to achieve its goals, the Government must use it." *United States v. Playboy Ent. Grp., Inc.*, 529 U.S. 803, 815 (2000).

Defendants applaud the efforts of several European countries to restrict minors from taking transitioning medications, but unlike Alabama's Act, these countries allow minors to take transitioning medications in exceptional circumstances on a case-by-case basis. *Defs.' Br.* (Doc. 74) at 76–82. According to Dr. Cantor, Defendants' own expert witness, no state or country in the entire world

has enacted a blanket ban of these medications other than Alabama. *Tr.* at 328. The Act, unlike the cited European regulations, does not even permit minors to take transitioning medications for research purposes, even though Defendants adamantly maintain that more research on them is needed. *Id.* at 326–27; *Defs.' Br.* (Doc. 74) at 116. Because Defendants themselves offer several less restrictive ways to achieve their proffered purposes, the Act is not narrowly tailored at this stage of litigation.

In sum, Parent Plaintiffs have a fundamental right to direct the medical care of their children. This right includes the more specific right to treat their children with transitioning medications subject to medically accepted standards. The Act infringes on that right and, as such, is subject to strict scrutiny. At this stage of litigation, the Act falls short of that standard because it is not narrowly tailored to achieve a compelling government interest. Accordingly, Parent Plaintiffs are substantially likely to succeed on their Substantive Due Process claim.

ii. Equal Protection Claim

Minor Plaintiffs claim that the Act discriminates against them based on their sex in violation of the Fourteenth Amendment. *Compl.* (Doc. 1) at 29–30.[15] The Equal Protection Clause provides that no State shall "deny to any person within its

[15] Based on the record evidence, the Court finds that Minor Plaintiffs have standing to bring their Equal Protection claim. Defendants raise no opposition to this conclusion. However, Parent Plaintiffs, Healthcare Plaintiffs, and Plaintiff Eknes-Tucker do not explain—nor is it readily apparent—how they have standing to bring an Equal Protection claim and, thus, are not substantially likely to succeed on the merits of their claim.

jurisdiction the equal protection of the laws." U.S. CONST. AMEND. XIV, § 1. The Clause's chief purpose "is to secure every person within the State's jurisdiction against intentional and arbitrary discrimination, whether occasioned by express terms of a statute or by its improper execution through duly constituted agents." *Vill. of Willowbrook v. Olech*, 528 U.S. 562, 564 (2000) (per curiam) (quoting *Sioux City Bridge Co. v. Dakota Cnty.*, 260 U.S. 441, 445 (1923)).

As the Supreme Court recently explained, "it is impossible to discriminate against a person for being homosexual or transgender without discriminating against that individual based on sex." *Bostock v. Clayton Cnty.*, 140 S. Ct. 1731, 1741 (2020). Governmental classification based on an individual's gender nonconformity equates to a sex-based classification for purposes of the Equal Protection Clause. *Glenn v. Brumby*, 663 F.3d 1312, 1320 (11th Cir. 2011). Here, the Act prohibits transgender minors—and only transgender minors—from taking transitioning medications due to their gender nonconformity. *See* S.B. 184, ALA. 2022 REG. SESS. § 4(a)(1)–(3) (Ala. 2022). The Act therefore constitutes a sex-based classification for purposes of the Fourteenth Amendment.

The State views things differently. The State argues that the Act creates two categories of people: (1) minors who seek transitioning medications "for the purpose of attempting to alter the appearance of or affirm the minor's perception of his or her gender or sex, if that appearance or perception is inconsistent with the minor's sex";

and (2) "all other minors." *Defs.' Br.* (Doc. 74) at 93. (quoting S.B. 184, ALA. 2022 REG. SESS. § 4(a) (Ala. 2022)). Because transgender minors fall into both categories, the State reasons, the Act is not a sex-based classification. *Id.* at 94.

The fundamental flaw in this argument is that the first category consists entirely of transgender minors. The Act categorically prohibits transgender minors from taking transitioning medications due to their gender nonconformity. In this way, the Act places a special burden on transgender minors because their gender identity does not match their birth sex. The Act therefore amounts to a sex-based classification for purposes of the Equal Protection Clause. *See Glenn*, 663 F.3d at 1317 (explaining that "discrimination against a transgender individual because of her gender-nonconformity is sex discrimination").

Sex-based classifications are constitutional only when they satisfy a heightened standard of review known as intermediate scrutiny. *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 440 (1985). To satisfy this standard, a classification must substantially relate to an important government interest. *Miss. Univ. for Women v. Hogan*, 458 U.S. 718, 724 (1982). The State bears the burden to proffer an exceedingly persuasive justification for the classification. *Sessions v. Morales-Santana*, 137 S. Ct. 1678, 1690 (2017). An exceedingly persuasive justification is one that is "genuine, not hypothesized or invented *post hoc* in response to litigation." *United States v. Virginia*, 518 U.S. 515, 533 (1996).

The State again argues that the Act's purpose is to protect minors from experimental medications and to stop medical providers from "aggressively pushing" these medications on minors. *Defs.' Br.* (Doc. 74) at 109–120. As explained above, the State puts on no evidence to show that transitioning medications are "experimental." The record indicates that at least twenty-two major medical associations in the United States endorse these medications as well-established, evidence-based methods for treating gender dysphoria in minors. *Tr.* at 25, 97–98, 126–27. Finally, nothing in the record shows that medical providers are pushing transitioning medications on minors. Accordingly, the State's proffered justifications are hypothesized, not exceedingly persuasive. Thus, Minor Plaintiffs are substantially likely to succeed on their Equal Protection claim.

iii. Void-for-Vagueness Claim

Plaintiffs collectively claim that the Act is void for vagueness under the Fifth and Fourteenth Amendments because it does not sufficiently define "what actions constitute 'caus[ing]' any of the proscribed activities upon a minor." *Compl.* (Doc. 1) at 34–35. Under the void-for-vagueness doctrine, a penal statute must "define the criminal offense with sufficient definiteness that ordinary people can understand what conduct is prohibited and in a manner that does not encourage arbitrary and discriminatory enforcement." *United States v. Marte*, 356 F.3d 1336, 1342 (11th Cir. 2004) (quoting *United States v. Fisher*, 289 F.3d 1329, 1333

(11th Cir. 2002)). A federal court reviews a void-for-vagueness claim only when the litigant alleges a constitutional harm. *Bankshot Billiards, Inc. v. City of Ocala*, 634 F.3d 1340, 1349–50 (11th Cir. 2011).

In this context, constitutional harm comes in two forms: (1) where a criminal defendant violates a vague statute, comes under prosecution, and then moves to dismiss the charges on the grounds that he or she lacked notice that his or her conduct was unlawful; and (2) where a civil plaintiff is "chilled from engaging in constitutional activity" due to a vague statute. *Dana's R.R. Supply v. Att'y Gen.*, 807 F.3d 1235, 1241 (11th Cir. 2015). Here, Plaintiffs' void-for-vagueness claim falls into the second category.

Plaintiffs, however, are not substantially likely to succeed on their claim. Under ALA. CODE § 13A-2-5(a), a person is liable for causing a crime "if the result would not have occurred but for his conduct, operating either alone or concurrently with another cause, unless the concurrent cause was sufficient to produce the result and the conduct of the actor clearly insufficient." The fact that the Act has a scienter requirement greatly weighs against Plaintiffs' void-for-vagueness claim. *See, e.g.*, *Gonzales v. Carhart*, 550 U.S. 124, 149 (2007) ("The Court has made clear that scienter requirements alleviate vagueness concerns."); *Colautti v. Franklin*, 439 U.S. 379, 395 (1979) ("This Court has long recognized that the constitutionality of a

vague statutory standard is closely related to whether that standard incorporates a requirement of mens rea.").

Also weighing against Plaintiffs' claim is the State's interpretation of the Act. During the preliminary injunction hearing, Alabama Solicitor General Edmund LaCour explained that a person must administer or prescribe transitioning medications to violate the Act. *Tr.* at 409–11. General LaCour opined that a person cannot violate the Act simply by advising a minor to take transitioning medications or by driving a minor to a gender clinic where transitioning medications are administered. *Id.* at 410.

Additionally, the statutory scienter requirement and the State's interpretation both align with the modern, plain-language definition of the word cause. According to Merriam-Webster's Dictionary, "cause" means to "effect by command, authority, or force" or "bring into existence" an action. *Cause*, MERRIAM-WEBSTER UNABR. DICTIONARY (3rd ed. 2002). Based on the record evidence, Plaintiffs do not show that they have been chilled from engaging in constitutional activity due to the Act. Plaintiffs are therefore not substantially likely to succeed on their void-for-vagueness claim at this stage of litigation.

iv. Free Speech Claim

Plaintiffs collectively claim that the Act violates their First Amendment right to free speech by prohibiting "any 'person,' including physicians, healthcare

professionals, or even parents, from engaging in speech that would 'cause' a transgender minor to receive medical treatment for gender dysphoria." *Compl.* (Doc. 1) at 33–34. The First Amendment provides that "Congress shall make no law . . . abridging the freedom of speech[.]" U.S. CONST. AMEND. I. At its core, "the First Amendment means that government" generally "has no power to restrict expression because of its message, its ideas, its subject matter, or its content." *Police Dep't of City of Chicago v. Mosley*, 408 U.S. 92, 95 (1972).

The Amendment, however, offers no protection to words that incite or constitute criminal activity. For example, sexually derogatory remarks may violate Title VII's general prohibition of sexual discrimination in the workplace. 42 U.S.C. § 2000-e2; *see also* 29 C.F.R. § 1604.11(a) (explaining that, under certain circumstances, "[u]nwelcome sexual advances, *requests* for sexual favors, and other *verbal* or physical conduct of a sexual nature" are actionable as sexual harassment under Title VII (emphasis added)). Likewise, "[s]peech attempting to arrange the sexual abuse of children is no more constitutionally protected than speech attempting to arrange any other type of crime." *United States v. Hornaday*, 392 F.3d 1306, 1311 (11th Cir. 2004). More examples abound, but the point is this: Where the State "does not target conduct on the basis of its expressive content, acts are not shielded from regulation merely because they express a discriminatory idea or philosophy." *R.A.V. v. City of St. Paul*, 505 U.S. 377, 390 (1992).

As explained *supra* Section III.A.1.iii, the Act does not criminalize speech that could indirectly lead to a minor taking transitioning medications. Rather, the only speech criminalized by Act is that which compels the administration or prescription of transitioning medications to minors. Accordingly, the Act targets conduct (administration and prescription), not speech. Plaintiffs are therefore not substantially likely to succeed on their First Amendment claim.

2. Plaintiffs' Preemption Claim

Parent Plaintiffs, Minor Plaintiffs, and Healthcare Plaintiffs bring their preemption claim under Section 1557 of the Affordable Care Act, 42 U.S.C. § 18116. *Compl.* (Doc. 1) at 31. Section 1557, through its incorporation of the Title IX, prohibits discrimination based on sex and the denial of benefits based on sex in any health program or activity that receives federal funding. 42 U.S.C. § 18116(a); 20 U.S.C. § 1681 *et seq.* Here, Plaintiffs generally rely on the same arguments Minor Plaintiffs made in support of their Equal Protection claim. *Pls.' Br.* (Doc. 8) at 49–52; *Tr.* at 379.

At this stage of litigation, Plaintiffs' preemption claim fails. As explained *supra* Section III.A.1.ii, only Minor Plaintiffs are substantially likely to succeed on their Equal Protection claim. Additionally, Section 1557—by incorporating the enforcement mechanism of Title IX—"is enforceable against institutions and programs that receive federal funds, but does not authorize suits against individuals."

Hill v. Cundiff, 797 F.3d 948, 977 (11th Cir. 2015). It is presently unclear how Plaintiffs may bring their preemption claim against Defendants who are state officials, not institutions. Due to these concerns, Plaintiffs are not substantially likely to succeed on their preemption claim.

B. Irreparable Harm

The Court next considers whether Parent Plaintiffs and Minor Plaintiffs will suffer irreparable harm absent injunctive relief.[16] Harm "is 'irreparable' only if it cannot be undone through monetary remedies." *Ne. Fla. Chapter of Ass'n of Gen. Contractors of Am.*, 896 F.2d at 1285. An irreparable harm is one that is "actual and imminent, not remote or speculative." *Odebrecht Const., Inc. v. Sec'y, Fla. Dep't of Transp.*, 715 F.3d 1268, 1288 (11th Cir. 2013). The risk of suffering severe medical harm constitutes irreparable harm. *See, e.g.*, *Bowen v. City of New York*, 476 U.S. 467, 483 (1986) (explaining that a risk of suffering "a severe medical setback" is an irreparable injury); *Blaine v. N. Brevard Cnty. Hosp. Dist.*, 312 F. Supp. 3d 1295, 1306 (M.D. Fla. 2018) (finding irreparable harm where doctor plaintiffs could not provide necessary medical care to their patients).

The Act prevents Parent Plaintiffs from treating their children with transitioning medications subject to medically accepted standards. S.B. 184, ALA.

[16] *See Church v. City of Huntsville*, 30 F.3d 1332, 1342 (11th Cir. 1994) (explaining that a court need not consider whether a plaintiff shows irreparable harm if he or she does not show a substantial likelihood of success on his or her claims).

2022 REG. SESS. § 4(a)(1)–(3) (Ala. 2022). The record shows that, without these medications, Minor Plaintiffs will suffer severe medical harm, including anxiety, depression, eating disorders, substance abuse, self-harm, and suicidality. *Tr.* at 20, 167. Additionally, the evidence shows that Minor Plaintiffs will suffer significant deterioration in their familial relationships and educational performance. *Id.* at 35, 112–13. The Court therefore concludes that Parent Plaintiffs and Minor Plaintiffs will suffer irreparable harm absent injunctive relief.

C. Balance of Harms & Public Interests

The Court now considers the final two elements together. To satisfy the third and fourth elements of a preliminary injunction, a plaintiff must show that the harm she will likely suffer without an injunction outweighs any harm that her opponent will suffer from the injunction and that the injunction would not disserve (or be adverse to) the public interest. *Scott v. Roberts*, 612 F.3d 1279, 1290 (11th Cir. 2010). These factors merge when the State is the opponent. *Swain v. Junior*, 958 F.3d 1081, 1091 (11th Cir. 2020) (per curiam).

This case largely presents two competing interests. On one hand, "preliminary injunctions of legislative enactments—because they interfere with the democratic process and lack the safeguards against abuse or error that come with a full trial on the merits—must be granted reluctantly and only upon a clear showing that the injunction before trial is definitely demanded by the Constitution and by the other

strict legal and equitable principles that restrain courts." *Ne. Fla. Chapter of Ass'n of Gen. Contractors of Am.*, 896 F.2d at 1285. On the other hand, "[a] democratic society rests, for its continuance, upon the healthy, well-rounded growth of young people into full maturity as citizens, with all that implies." *Prince v. Massachusetts*, 321 U.S. 158, 168–69 (1944).

Based on the record evidence, the Court finds that the imminent threat of harm to Parent Plaintiffs and Minor Plaintiffs—i.e., severe physical and/or psychological harm—outweighs the harm the State will suffer from an injunction. The Court further finds that an injunction is not adverse to the public interest. To the contrary, enjoining the Act upholds and reaffirms the "enduring American tradition" that parents—not the States or federal courts—play the primary role in nurturing and caring for their children. *Wisconsin v. Yoder*, 406 U.S. 205, 232 (1972). Accordingly, the final two factors favor injunctive relief.

IV. SECURITY

Defendants argue that, if injunctive relief is appropriate, the Court should require each Healthcare Plaintiff to post a $1 million security. *Defs.' Br.* (Doc. 74) at 159–60.[17] Calculating the "amount of an injunction bond is within the sound discretion of the district court." *Carillon Importers, Ltd. v. Frank Pesce Int'l Grp.*,

[17] According to Defendants, this amount represents that "by which [Healthcare] Plaintiffs will be unjustly enriched should they be allowed to administer profitable (and illegal) medical procedures to kids." *Defs.' Br.* (Doc. 74) at 160.

112 F.3d 1125, 1127 (11th Cir. 1997) (per curiam). Here, the Court finds that a security bond is not necessary for three reasons. First, as explained *supra* Part III, Healthcare Plaintiffs themselves are not entitled to preliminary injunctive relief. Second, Federal Rule of Civil Procedure 65 does not require the United States to pay security. FED. R. CIV. P. 65(c). Finally, Defendants do not allege that they will suffer any cost or economic harm if they are wrongly enjoined from enforcing the Act. *Defs.' Br.* (Doc. 74) at 159–60. The Court therefore relieves Plaintiffs from posting security under Rule 65.

V. CONCLUSION

For these reasons, the Court **GRANTS** in part Plaintiffs' motion for preliminary injunction (Doc. 7) and **ENJOINS** Defendants from enforcing Section 4(a)(1)–(3) of the Act pending trial. The Court **GRANTS** in part the United States's motion for preliminary injunction (Doc. 62) to the same degree and effect. All other provisions of the Act remain enforceable.

DONE and **ORDERED** May 13, 2022.

LILES C. BURKE
UNITED STATES DISTRICT JUDGE

DOC. 129

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

REV. PAUL A. EKNES-TUCKER, et al.,	*	
Plaintiffs,	*	2:22-cv-00184-LCB
	*	May 5, 2022
vs.	*	Montgomery, Alabama
	*	9:00 a.m.
KAY IVEY, in her official capacity as Governor of the State of Alabama, et al.,	*	
Defendant.	*	

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TESTIMONY OF RACHEL KOE, MD

TRANSCRIPT OF PRELIMINARY INJUNCTION HEARING
VOLUME I
BEFORE THE HONORABLE LILES C. BURKE
UNITED STATES DISTRICT JUDGE

Proceedings recorded by OFFICIAL COURT REPORTER, Qualified pursuant to 28 U.S.C. 753(a) & Guide to Judiciary Policies and Procedures Vol. VI, Chapter III, D.2. Transcript produced by computerized stenotype.

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I N D E X

P R O C E E D I N G S

(In open court.)

MR. RAY: We call Dr. Rachel Koe.

RACHEL KOE, MD,

having been first duly sworn by the courtroom deputy clerk, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. RAY:

Q Good afternoon, Doctor.

A Hey.

15:49:44 Q Are you using a pseudonym here today?

A I am.

Q What is that pseudonym?

A Dr. Rachel Koe.

Q Dr. Koe, would you please introduce yourself to the Court?

15:49:54 A Yes. I am a pediatrician in southeast Alabama. I did my medical school and graduate school in Alabama. During which time, I met my husband, and we spent a short time out of the state of Alabama when I completed my pediatric training as a resident physician at a large children's hospital.

15:50:17 And then after that, we looked for a place to start our career and our family. And southeast Alabama was that place. So we moved back to southeast Alabama where I have been a board certified pediatrician and a licensed physician in Alabama for the last ten years.

15:50:33 Q Would you please describe your current practice to the Court?

A Yeah. So I practice in a rural town in southeast Alabama. But I see patients from all over southeast Alabama. And I see patients from birth until they graduate my practice at 19 and

15:50:54 364 days.

And I take care of all conditions. So I take care of children when they're well, and that's how we like to keep them. But I also take care of children with any kind of medical or mental health disorder.

15:51:07 Q Do you sometimes encounter conditions that you cannot treat yourself?

A Absolutely. So I would say frequently pediatricians encounter conditions that we can't treat ourselves, and I am no exception.

15:51:25 So while general pediatricians are experts in a wide variety of things, we cannot stay up to date on every single topic. And so when we are presented with a condition that is rare, we usually rely upon specialists to help us out.

But also if there are conditions that require more 15:51:47 comprehensive care that I cannot provide all those levels of care in my office -- for example, if a patient has cystic fibrosis, those patients require not only to see a pediatrician, but also a pulmonologist, and a GI doctor, and nutritionist. And we like to send those patients -- you can 15:52:05 imagine that seeing all those different physicians is easier done if it's done in the same place. So we like to send those patients to centers where they can receive all of that care in the same place.

Q So could you give an overview, then, of the process that 15:52:19 you go through when you are considering referring or presenting

the option of a referral to a patient and their family?
A Absolutely. So when I need to make a referral for a patient -- which I don't like to do if I don't have to because you know that means extra travel and extra cost for my
15:52:39 patients, as well.

When I need to make a referral for my patient, first and foremost, I want to make sure that the level of care that they are getting or the quality of care that they're getting is at least as good as the quality of care that I am giving them in
15:52:53 my office.

I, you know, pride myself on being a physician who attempts to provide highest quality evidence-based care for all of my patients, regardless of how they present to me. And so I want to make sure those patients get that same quality of care.

15:53:12 And so when I am considering a referral, you know, I -- the first -- I have to present the referral to the family. And I usually will explain why I think they need a referral to somebody else, why I cannot provide all of the care that they need. And if there are options of multiple places where I can
15:53:33 refer them, I will give them multiple options.

Some cases there are no options, there's just one place that I can refer, and then I will tell them that.

But I also try to ensure that whoever I am making that referral to, whoever I am recommending a referral to or
15:53:48 suggesting a referral to is someone that I -- that I trust.

And so I am looking for a specialist who has, you know, adequate training, that has experience taking care of the condition that -- for which I'm making the referral, and that has -- has had good outcomes. And so that their reputation is 15:54:10 that they've had good outcomes treating that -- treating that condition.

Q When was the first time that you treated a transgender patient?

A Yeah. It's a -- much to my surprise, the first time that 15:54:23 I treated a transgender patient was about two years into my career. It was eight years ago. Although to be fair, I had been treating him since I moved to southeast Alabama. I just did not know that he was transgender.

And so I had a patient that I had developed a relationship 15:54:45 with right when I moved to southeast Alabama. He was one of my first patients that I had an encounter with. We developed a relationship over time.

And I was caring for him for a variety of conditions, so I saw him for his well-child checkups. But he was also 15:55:02 presenting to me with migraines. And so I took care of him for his migraine disorders. And he presented to me with anxious thoughts and depressed thoughts and thoughts of self-harm. And so I was caring for him, as well.

Initially for those things, I referred him to what -- he 15:55:20 was already seeing his pastor for some pastoral care, and I

referred him to a counselor. And I started him on some medical treatments for migraines and depression. But those medical treatments were proving ineffective. And he continued to have escalating concerns.

15:55:37 And so I eventually referred him to a psychiatrist and a neurologist, as well. And it was about that time, you know, a year or so into seeing the psychiatrist and neurologist and he was still not getting anywhere that he and his parents came to me and revealed to me that he was transgender.

15:55:58 Q Let me stop you there.

A Yeah.

Q So just to sum up, this particular patient you had seen for two years at this point in time?

A Uh-huh.

15:56:07 Q And they were -- this patient was seeing a therapist, a psychiatrist, and a pastoral counselor; is that right?

A That's correct.

Q And were they on the psychiatric medication at this time, as well?

15:56:21 A Yeah.

Q What were they on?

A By this point, they were on Zoloft and Topamax.

Q And how would you describe the dosages of these medications at this time?

15:56:30 A The doses were higher than I would have felt comfortable

with. Those are not medications -- those are medications that I have prescribed, but not at those doses.

Q Despite these treatments, was care and the level -- was the mental health of this patient improving?

15:56:55 A No. In fact, when he presented to me at that time, you know, two years into our relationship, that was the concern that he and his mom presented to me with was that we weren't getting anywhere. And they could see the medicines he was on, and they could see that, you know, he had all these different

15:57:17 doctors' appointments, but they were concerned that he was still suffering from thoughts of self-harm and he was not making any -- any gains.

Q And so at this time, did the patient express to you -- what did the patient say about thoughts of self-harm?

15:57:39 A Yeah. It was actually -- well, he told me that he was thinking that he would be better off dead. But it was his mom that really first told me that he was thinking of hurting himself. And she was really concerned.

They had a good relationship, and she said, you know, I

15:57:59 think I'm going to lose my son. But he said he wasn't trying -- he didn't want to commit suicide. But he wished he was better off dead.

Q At the time that this patient's issues around gender were revealed to you, what else did you learn about their history

15:58:18 with these issues?

A So this was the time when kind of all of the pieces of the puzzle started to come together for me. I had learned from his mom that he had been saying he was a boy since he was a young child, even wishing on his fourth birthday candles that people would know that he was a boy. She had allowed him to present this way at home. It just made him look like a tomboy, and that, you know, wasn't problematic in their community.

But over time as he approached puberty, it had been getting worse. And that's when I had come into the picture. But, again, not knowing the gender concerns, I didn't have that piece of the puzzle at the time.

And he -- but it had been getting worse since puberty started. They had actually taken him out of school, and he was being home schooled because he did not feel comfortable presenting as a female at school. And so they were trying to home school. But his grades were in decline. And so was his mental health.

Q At this point in time, then, did you consider referring the patient and the family to the specialist?

A Absolutely.

So at this time is when I began to make the diagnosis of gender dysphoria. Gender dysphoria obviously is a diagnosis that is not a snapshot in time, but he presented with those -- the pieces that we had been seeing for years.

And with that history of long-standing gender dysphoria

and really was able to put that together for me, that that was where -- why his mental health -- or may have been one of the reasons why his mental health was in decline.

I had heard about transgender medicine when I was in residency, but the --

16:00:15

THE COURT: Ma'am, you're kind of getting into answers that his questions are not calling for.

THE WITNESS: I'm so sorry.

THE COURT: That's okay. Just listen very carefully to what he's asking you. Make sure you are not giving a narrative response. Just answer just what he asks you, okay.

16:00:25

THE WITNESS: Absolutely.

BY MR. RAY:

Q So you choose at this point in time to engage in a referral process. How did that conversation go with the family?

16:00:40

A Yes. So I told the family that I understood that this patient was transgender, but that I -- and I knew that that was not in and of itself pathological. So I reassured them of that. But I did not know what other help to offer them because that was not my specialty. And, but I told them that I could find someone who did know more about gender health if they were interested in learning more about transgender medicine.

16:01:03

Q And to whom did you -- and what was the family's reaction to this?

16:01:25

A The parent at the time said, absolutely, we want to know as much as we can because we're not getting anywhere right now.

THE COURT: Mr. Ray, how much longer is your direct going to be?

16:01:38 MR. RAY: It will be another ten minutes, Your Honor.

THE COURT: Okay.

BY MR. RAY:

Q And to whom did you then refer this patient?

A I referred the patient to Dr. Latif at UAB.

16:01:48 Q So did you keep up with your patient after the referral?

A Absolutely. I --

Q And from your perspective as the primary pediatrician, how did the condition of the patient change after they began going to the UAB clinic?

16:02:12 A Over time, he was able to come off of medication for his migraines. He was able to come off of medication for his depression. And he was able to see his counselor less and less frequently over the years. And he graduated from high school with honors and did well.

16:02:32 Q During this time, as well, did you administer any care to this patient regarding their gender dysphoria?

A Yes. He did not feel comfortable giving himself the testosterone injections, and so our clinic provided -- we did not prescribe the testosterone, but we gave the testosterone

16:03:01 injections, and we performed any labs that the gender clinic

needed. And I would review those labs before sending any information on to the gender clinic and kept up with his blood pressure and basic health.

Q Have you kept up with this patient in recent months or years?

A Yes. I -- I see his mother frequently because she brings in her other grandchildren to see me.

Q And what is -- what do you understand about how this experience has been for your patient at the gender clinic?

A So he is a thriving healthy adult and has no regrets and is doing well.

Q In subsequent experiences, have you had occasion to encounter patients who at least are expressing ideas of gender diversity?

A Yes.

Q And how do you deal with those patients who express those ideas, but without, you know, demonstrating severe distress?

A Yeah. So in, especially in prepubertally, we simply talk to the families and reassure them that gender diversity is not pathological.

We talk about allowing children to present as however they feel comfortable in dress and name and pronouns, however they feel comfortable, and if -- even if there's not a significant amount of psychological distress, if there is some distress within the family, then we make a referral for -- so that they

can receive mental health care, see a counselor.
Q So when you have a patient who is experiencing these types of symptoms, you don't automatically refer them to the gender clinic?
16:04:58 A No.
Q When you, however, have a different situation, what are you seeing in some of the patients who you believe are experiencing gender dysphoria?
A Yeah. So when a patient -- typically at the time that
16:05:18 they're entering puberty or during or after puberty is experiencing significant mental health concerns and they have -- they are transgender, and they explain to me that that is related and that's part of why they are suffering from their depressed and anxious thoughts, then I will share with them and
16:05:41 their family that there are gender experts out there that can help guide them if they need more information or want to pursue other options.
Q Have you ever had a patient with gender dysphoria that later desisted?
16:05:56 A No, I have not had that experience.
Q Have you ever had any of your transgender patients express regret over gender-affirming treatment?
A No.
Q Dr. Koe, what will happen to your transgender patients if
16:06:20 the law SB 184 goes into effect?

A So I have patients -- or a patient that is on hormone therapy right now. I am -- that therapy has been very effective for her.

I am concerned that because it is so effective that she is not going to stop therapy, but she's going to find some other not great ways to get the therapy. And that -- you know, less safe.

So, you know, she may get estrogen from a source that is not reputable. She is not going to be followed by a physician for side effects or for efficacy or even for dosing. And so I am concerned about that.

And then future patients, I'm concerned that I won't have more than that I can do for them when they come to me with dysphoria that is not being effectively treated by mental health therapy alone.

Q And specifically to the parents of your patients, how do you perceive the enactment of this law will affect them?

A I -- I can't read minds, of course. But my first family, when they came to me for -- to express to me that gender dysphoria was the issue, the mom felt lost and hopeless, and that's what she told me. She said, you know, I don't know what else I can do. I don't know where to go from here.

And so I -- if they don't have other options, and they don't have experts in the state that they can talk to about this issue, or options for other treatments that have been

shown to be effective, I imagine that they will stay feeling hopeless and lost.

Q Final question.

A Uh-huh.

16:08:16 Q Doctor, what do you believe this law will do to you in your practice?

A Well, as I already mentioned, I strive to provide the highest level of evidence-based care that I can. And I imagine that I will continue to see transgender patients. I have had

16:08:35 five in my ten years. And I don't see that stopping.

And so I imagine that I will be stuck in a place where I don't know how to proceed. Do I counsel them on therapies that exist in other states? Do I make those referrals? What are the legal consequences to that? Do I, you know, do I not

16:09:02 provide them what is known to be evidence-based care? Am I providing discriminatory care in that situation?

You know, I don't -- I won't know what to do with these patients. And I'm afraid --

THE COURT: Hold on just a minute.

16:09:19 So I have got a question for Mr. LaCour, whoever wants to field it on your end. We may have covered this yesterday, and maybe I am not clear on it.

But does the State of Alabama consider a referral to trip the law?

16:09:35 MR. LACOUR: Your Honor, I don't think simply

referring someone to another doctor would be causing treatment. There would still be -- the cause would still ultimately be whatever the other doctor does at the end of the day. So...

THE COURT: Is there anything that you have seen in what she's just described on the record that she does in her practice that would trip the law?

MR. LACOUR: Well, administering could -- I mean, that would be directly -- directly administering the drugs would be covered by the law. But...

16:10:19 THE COURT: Anything other than that?

MR. LACOUR: No. Your Honor, I don't believe so.

THE COURT: Okay. All right. Sorry to interrupt.

MR. RAY: That's all right.

Thank you, doctor. No further questions.

16:10:40 THE COURT: Who is handling cross?

MR. MILLS: I am, Your Honor.

THE COURT: Are we tendering the witness? Hello?

MS. EAGAN: I'm sorry, Your Honor. May I consult with him just a minute, please?

16:10:57 THE COURT: You can.

MS. EAGAN: Thank you.

MR. RAY: Nothing further.

CROSS-EXAMINATION

BY MR. MILLS:

16:11:25 Q Good morning, Doctor. My name is Christopher Mills, and I

represent the State defendants. I have just a few questions for you. If any of them are not clear, please just let me know.

Have you been a plaintiff in any other cases involving this law?

A No.

Q In your practice, do you discriminate against patients based on their sex?

A No.

Q In one of your declarations in this case -- we can pull it up if you want, but I don't think we need to -- you said, My practice group recommends that parents vaccinate their children. Why do you recommend vaccination?

A Because it is evidence based and proven to be safe and effective.

Q And the FDA has approved those vaccinations?

A And the FDA has approved those vaccinations.

Q Are you familiar with RSV?

A I am familiar with RSV.

Q What is it?

A RSV is respiratory syncytial virus. It is a virus that causes the common cold in most people, but occasionally can put children in the hospital.

Q Can it result in children dying?

A Yes.

Q Is there a vaccine?
A Yes. But it is not a vaccine actually. It's an immunologic agent, but people call it a vaccine.
Q Is that recent?
16:12:41 A There has been a vaccine for a some time. There -- so it is not recent. I mean --
Q And --
A -- there's been a vaccine -- as long as I have been in practice, there has been some sort of a vaccine.
16:12:56 Q Starting at what age can that be given?
A At birth. I mean, so it depends. But it depends on what the situation is.
Q And does it prevent RSV?
A It does not prevent RSV. Again, it is not an actual
16:13:10 vaccine. It is a like an antibody against RSV. So if you are exposed to RSV, then it stops -- it attacks the RSV for you.
Q Sure. So I'm just going to ask you to -- sort of a thought question.
If there were a vaccine that would completely prevent RSV
16:13:29 in young children under five, but sterilized 5 percent of children who got it, would you give the vaccine?
A Probably not. And I don't think it would be routinely recommended.
Q You are not aware of any FDA-approved vaccine like that?
16:13:47 A I'm not aware of any FDA-approved vaccine like that.

Q I'd like you to look -- and I will put it up on the monitor for you. This is Plaintiffs' Exhibit 4. This was the declaration you submitted. And I have underlined a line there.

Would you be able to read that line for me?

16:14:10 A Yes. If I were to comply with the Act, I would be limited to referring her for counseling and psychiatry -- or and a psychiatrist.

Q So you would agree if the Act went into effect, you could refer patients for counseling and psychiatric help?

16:14:24 A Correct.

Q You choose to accept federal funding through Alabama Medicaid; is that right?

A Correct.

Q You are not required to accept federal funding?

16:14:34 A No.

Q In your well-child visits, do you give testicular exams to teens who are biological males?

A Yes.

Q Do you give testicular exams to teens who are biological

16:14:48 females?

A Yes. Sorry. No. Obviously. I apologize. I did not listen to the question correctly.

Q And, okay. Do you perform Tanner stage assessments?

A I do perform Tanner stage assessments.

16:15:02 Q What are you looking for in biological males?

A In biological males, I am looking for pubic hair where pubic hair is located and the description of the pubic hair and I am looking for the size of the testicles.
Q And what are you looking for in biological females?
16:15:18 A In -- I would be looking for absence of testicles in females. But I am also looking for breast staging. And so breast growth. And I am looking for pubic hair development.
And then signs of estrogenation, which are like increased thickness of the labia and increased thickness of the vaginal
16:15:45 walls, and things like that.
Q The declaration you submitted in this case, you were talking about your current patient, your current transgender patient. You mentioned that that patient is prescribed estrogen; is that right?
16:15:58 A Uh-huh.
Q Why aren't you administering testosterone to this patient?
A I'm sorry. I did not understand the question.
Q Sure. Why are you administering estrogen and not testosterone to this patient?
16:16:15 A The patient is a transgender female.
Q And your original -- your first patient who we talked about a few minutes ago?
A Right.
Q You talked about they came to your office to have
16:16:27 testosterone administered. Why was testosterone administered

and not estrogen?
A Because they are a transgender male.
Q So for each of the treatments we just talked about -- testicular exams, Tanner stage assessments, cross-sex
16:16:43 hormones -- do you consider your treatment to be discrimination based on sex?
A I do not.
Q Why is that?
A Discrimination is not a medical term. So I -- I don't
16:17:04 know if I'm applying it correctly, but I am using -- I am giving each patient the care for which their -- their sex and gender requires.
I still do Tanner stage patients with -- that are transgender. I still do examinations on those patients. I do
16:17:26 not -- not do -- you know, general exams on those patients.
But understanding that they are transgender and so their genital exam is going to look different than somebody else's genital exam.
Q I apologize. These seem a bit silly.
16:17:41 Have you been investigated for discrimination on the basis of sex because you only give biological males testicular exams?
A Nope.
Q Have you been sued for that basis?
A No.
16:17:52 Q Has the federal government threatened to revoke your

funding for that reason?
A No.
Q Do you agree that this Act that we're talking about here today prohibits you from prescribing or administering puberty blockers for purposes of gender transition to both boys and girls?
A Can you repeat that for me, please?
Q Sure. The Act we're here today talking about --
A Uh-huh.
Q -- do you agree that that would prohibit you from prescribing or administering puberty blockers to biological males or females?
A Yes.
Q So both your original patient and your newest patient?
A Yes.
Q And the same is true for a cross-sex hormones; is that right?
A Yes.
Q You talked about your first patient was struggling with gender dysphoria, but you didn't know that originally. So how old was that patient when you started seeing them?
A About 12.
Q And then how old were they when you determined that they were transgender?
A When they told me they were transgender was at 14.

Q And you hadn't seen a sign of that beforehand?
A Well, he presented himself as a male, but often we expect gender diverse presentation among children. And so it did not -- it shows my ignorance that it did not occur to me to ask him if he was transgender.
16:19:16
Q Your declaration mentions four more transgender patients since that first one.
You said, when those patients first came to see me, most had just started expressing that they were transgender. About how old were they at those points?
16:19:32
A So there have been four. So one already was actually transitioning. But another was 14. Another was 12. And then the other is -- gosh. I have to count.
So about 12.
Q And what was the biological sex of those patients?
16:20:00
A Their natal sex was male, male, female, sorry. My -- I'm trying to think through all my patients now.
So female, male, male, male.
Q You mentioned in your declaration that not all those patients went for experimental procedures at the UAB gender clinic. What happened to those patients who did not go for these procedures?
16:20:42
A Well, one is no longer -- was -- I only was able to see briefly as they were in the care of the State, and I do not know what happened to her.
16:21:04

One was -- is still in counseling.
Q And is that -- would you consider that patient to be healthy?
A Currently, yes.
16:21:20 Q So counseling has been sufficient to address that patient's gender dysphoria?
A Yes, which speaks to the diverse nature, the diverse trajectory of gender dysphoria in all children.
Q Your declaration mentions the necessity of regular blood
16:21:42 tests and lab work for individuals using these treatments. Why is that necessary?
A All medications can have side effects. So it really depends on their medication. Some of the lab work is actually for their psychiatric medications they were on prior to
16:21:58 starting -- starting the gender treatments. But to, you know, monitor normal things, kidney function and lipids that we know change during puberty. So when we start somebody on puberty, we need to monitor those things.
THE COURT: Mr. Mills, how long do you think the
16:22:19 continuation of your cross will be?
MR. MILLS: Four minutes.
THE COURT: That's a good number.
BY MR. MILLS:
Q And are there particular risks of estrogen or testosterone
16:22:31 in this context?

A There are risks of estrogen and testosterone always.
Q You would agree that at least some childhood gender dysphoria desists by adulthood, right?
A If it presents prepubertally, yes.
16:22:49 Q And you would agree that some individuals who transition their gender choose to detransition; is that right?
A I have never had that experience.
Q You think no -- you think no person like that exists?
A No, I don't -- I have not met such a person, but I don't
16:23:06 know if they exist.
Q You have never heard of that happening?
A I have heard of that happening, but by reputation only. I don't know. And I don't know anything about that person's medical care.
16:23:16 Q Because you don't treat patients past the age 19, you wouldn't necessarily know if one of your patients decided to detransition, right?
A Correct. Except that we live in southeast Alabama, and I know my patients for a very long time.
16:23:30 Q Do you think that children have the same decision-making abilities as adults?
A No.
Q Are they better or worse?
A That's a good question. But they're different. They do
16:23:49 not have executive functioning, so they do not always think

through consequences. And that is why we rely upon their parents to help consent for them.

Q Okay.

MR. MILLS: No more questions.

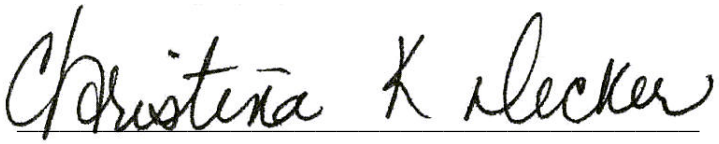
16:24:04 THE COURT: Any further redirect?

MR. RAY: No, Your Honor.

(End of testimony of Dr. Rachel Koe, MD.)

CERTIFICATE

I certify that the foregoing is a correct transcript from the record of proceedings in the above-entitled matter.



Christina K. Decker, RMR, CRR

Federal Official Court Reporter

ACCR#: 255

05-08-2022

Date

CERTIFICATE OF SERVICE

I certify that on July 5, 2022, I electronically filed this document using the Court's CM/ECF system, which will serve all counsel of record.

s/ Edmund G. LaCour Jr.
Edmund G. LaCour Jr.
Counsel for State Defendants