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**UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO**

PAM POE, et al.,

Plaintiffs,

v.

RAÚL LABRADOR, et. al.,

Defendants.

Case No. 1:23-cv-00269-BLW

**PLAINTIFFS' REPLY MEMORANDUM
OF LAW IN SUPPORT OF THEIR
MOTION FOR A PRELIMINARY
INJUNCTION [DKT. NO. 32]**

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INTRODUCTION

The State¹ has not come close to meeting its heavy burden under heightened scrutiny to justify overriding parents’ medical decisions made in consultation with their children’s doctors and following treatment protocols endorsed by *every* major U.S. medical association. The State misreads settled equal protection and due process precedent concerning the level of scrutiny. And its asserted justifications for H.B. 71 (the “Ban”) are unsupported by the evidence and fail to explain why the Ban prohibits all, and *only*, gender-affirming medical care, when it is supported by the same type of evidence and presents the same type of risks as many other medical treatments. The Ban lacks a close means-end fit to any asserted justification. Even the State’s own expert agrees that the care prohibited by the Ban could sometimes be appropriate and beneficial. Cantor Dep. at 130:8–25, 146:1–147:2. In its baseless protest that it just wants to protect kids, the State overlooks the severe harms experienced by adolescents with gender dysphoria who are unable to access the medical treatments it bans.

FACTUAL BACKGROUND

A. Gender-Affirming Medical Care Is Effective

The record evidence shows that gender-affirming medical care can alleviate gender dysphoria in adolescents and the State’s proffered evidence fails to refute that.

There are at least a dozen empirical, peer-reviewed studies on the use of puberty blockers and gender affirming hormones to treat adolescents with gender dysphoria and this research shows that these treatments provide significant mental health benefits. Rebuttal Declaration of Jack Turban (“Turban Reb.”) ¶ 11. The State’s response is to quibble with the methodology of some

¹ Plaintiffs refer to Defendants Attorney General Labrador and the Individual Members of the Idaho Code Commission collectively as “the State”.

of these studies.² While all studies in medicine have strengths and limitations, the body of research as a whole shows clear mental health benefits of this care.³ Turban Reb. ¶ 12.⁴ There is *no evidence* that psychotherapy alone treats gender dysphoria. The studies suggest the opposite: that minors treated with both medical and psychological care benefitted from the medical care. Turban Reb. ¶¶ 13–15. To be sure, psychological support can improve psychosocial functioning (which both WPATH and the Endocrine Society endorse and encourage). But even the study the State cites (Costa 2015) actually concludes those patients who went on to puberty blockers improved to be comparable with their cisgender peers while those who received only psychological support did not. *Id.* ¶¶ 14–15; Rebuttal Declaration of Christine Brady (“Brady Reb.”) ¶ 14.

This research showing the benefits of the banned care is consistent with decades of clinical experience, including the experience of Plaintiffs’ experts. *E.g.*, Dkt. 32-6 ¶ 38; Dkt. 32-7 ¶¶ 30, 31.⁵ And each Minor Plaintiff has provided sworn, un rebutted testimony about how gender-

² The State’s expert, Dr. Weiss, complains that the research is unreliable because it is “low quality” under the GRADE assessment of the quality of evidence. Dkt. 56-3 ¶¶ 59–61. But that label is generally used for studies that lack a randomized placebo control; it would be unethical to conduct a study depriving treatment to minors with gender dysphoria. Rebuttal Declaration of Kara Connelly (“Connelly Reb.”) ¶ 16; *see also* Dkt. 32-7 ¶¶ 55–56; Turban Reb. ¶ 18. For this reason, many medical treatments are recommended based on “low quality” evidence. Connelly Reb. ¶ 15.

³ The State insists that Dr. Connelly’s own study, which did not show impact on patients’ depression and anxiety in the first few months of treatment contradicts her opinion that gender affirming care has mental health benefits. But those patients *did* improve over time, as their bodies began to match their gender. Connelly Reb. ¶ 17.

⁴ Notably, the State’s experts cannot agree even with each other about whether hormone therapy benefits adult patients. Dr. Cantor believes the research demonstrates the effectiveness of hormone therapy for adults with gender dysphoria. Cantor Dep. at 144:18–24; *see also id.* at 135:11–138:12. Dr. Weiss, in contrast, believes hormone therapy does not help and, instead, harms adults as well. Weiss Dep. 190:23–192:18.

⁵ The State dismisses the clinical experience of Drs. Connelly and Brady, who together have seen more than 1700 minors with gender dysphoria and the impact of gender-affirming medical care on their patients’ well-being. Dkt. 32-7 ¶ 10; Dkt. 32-6 ¶ 12. Such valuable experience is often relied on by courts. *See, e.g., Primiano v. Cook*, 598 F.3d 558, 565–67 (9th Cir. 2010).

affirming medical care “saved [her] life,” Dkt. 32-2 ¶ 20; Dkt. 32-4 ¶ 21, and their parents attested to the benefits they observed in their children from the care. Dkt. 32-3 ¶¶ 16, 19; Dkt. 32-5 ¶¶ 12, 15–16, 19. Every major medical association in the U.S. therefore supports gender-affirming medical care for adolescents with gender dysphoria. Dkt. 32-7 ¶ 19; *see also* Amicus Br. Dkt. No. 33. Without anything to counter this uniform support, the State points to European systematic reviews discussing certain limitations in the research and, trumpeting systematic reviews as the “highest form of medical evidence.” Dkt. 66 at 8–9. But a systematic review just means the authors pre-defined the search terms they used when conducting literature reviews in databases, and it is not guaranteed to identify every study. Turban Reb. ¶ 24. The reliability of the review authors’ description and analysis of the literature can also vary. *Id.*; *see also* Cantor Dep. at 198:9–199:17 (with systematic reviews, there can be “discrepant judgments between intelligent and well-informed review authors.”).

More fundamentally, identifying limitations in evidence does not mean treatment should be prohibited. Clinical practice guidelines, such as the WPATH SOC and the Endocrine Society Guideline, advise doctors on how to provide care based on the available evidence.⁶ Dkt. 32-7 ¶ 16. And unlike Idaho, none of the European countries the State points to has **banned** care; rather, their health organizations have made changes to how care is delivered, e.g. some providing that care should occur in clinical research settings. Turban Reb. ¶ 23.⁷

Finally, lack of FDA approval for a specific indication of a medication says nothing about

⁶ WPATH and the Endocrine Society engaged in reviews of the evidence when preparing their clinical practice guidelines. Dkt. 32-7 ¶ 15.

⁷ Courts have recognized this. *See, e.g., Brandt v. Rutledge*, 47 F.4th 661, 671 (8th Cir. 2022); *K.C. v. Individual Members of Med. Lic. Bd. of Ind.*, --- F. Supp. 3d ---, 2023 WL 4054086, at *11–12 (S.D. Ind. June 16, 2023) (“[N]o European country that has conducted a systematic review responded with a ban on the use of puberty blockers and cross-sex hormone therapy.”).

the FDA's views of the treatment. *See* Dkt. 66 at 9 (citing *L.W. v. Skrametti*, 73 F.4th 408, 418 (6th Cir. 2023)). Off-label use is pervasive in medicine and does not imply anything about evidence of efficacy or safety. Connelly Reb. ¶ 19. That is because the FDA approves a drug for a particular indication only if a pharmaceutical company seeks that approval. Where a drug has already been approved, there is a markedly lower incentive to expend the resources to seek further approvals. Instead, “[o]nce the FDA approves a drug, healthcare providers generally may prescribe the drug for an unapproved use when they judge that it is medically appropriate for their patient.” *Id.* (quoting FDA publication).

B. The Risks of Gender-Affirming Medical Care for Adolescents Are Similar to the Kinds of Risks Families Weigh When Considering Other Medical Treatments

No one contends that gender affirming medical care is risk-free. As the State concedes, risk is inherent in medical care and a medical treatment's risks must be viewed in the context of its benefits. Dkt. 66 at 7–8. As with other medical treatments, the potential risks and benefits are explained to parents and patients as part of the informed consent process. *See* Dkt. 32-7 ¶ 29.

Moreover, the drugs used for puberty blockade and gender-affirming hormone therapy are well known and have been used for decades with youth. Dkt. 32-7 ¶¶ 56, 58. Puberty blockers when used for central precocious puberty do not result in any observed or measured negative impact on cognitive development. Connelly Reb. ¶ 2. Although the State speculates there may be some unknown impact on cognitive development when puberty is delayed,⁸ the evidence shows no such risk. *Id.* ¶ 3. As for the asserted concern about osteoporosis, while pubertal suppression can delay the peak accrual of bone mineralization that occurs during puberty, bone mineral density

⁸ Adolescents with gender dysphoria treated with blockers start puberty at ages when some of their peers are still starting puberty. *Id.* ¶ 3.

increases again when blockers are stopped and puberty resumes endogenously, or with gender-affirming hormone therapy. *Id.* ¶ 5.

Potential risks of testosterone or estrogen therapy, such as cardiovascular risks and hormone dependent cancers are identical when given to transgender or cisgender adolescents. *Id.* ¶ 7. And these risks are minimal (for cisgender or transgender patients) when treatment is monitored by a doctor. *Id.* Additionally, hormone therapy puts transgender girls’ risk profile more in line with that of cisgender girls and puts transgender boys’ risk profile more in line with that of cisgender boys. *Id.* Thus, for example, transgender girls will have higher risk of breast cancer than cisgender boys, although less than cisgender girls. *Id.* ¶ 8.

While hormone therapy (but not puberty blockers on their own) can affect fertility, families are counseled about these risks before making treatment decisions, just as cisgender people are counseled about fertility implications of other medical decisions. *See* Dkt. 32-7 ¶¶ 46, 50; Connelly Reb. ¶ 9. Moreover, and contrary to the State’s assertion, sterility is *not* a “near certainty”⁹ and treatment can be tailored to minimize the risk to fertility where that is important to the family; for example, allowing some progression of puberty for transgender girls prior to starting puberty blockers so that they are able to preserve sperm, or temporarily stopping testosterone in transgender males to preserve eggs or try to get pregnant. Connelly Reb. ¶ 9.¹⁰

C. Risk of Detransition and Regret is Minimal

Studies of “detransitioners” and those who regret gender-affirming medical care

⁹ There are many reports of transgender men who, after taking and stopping testosterone, are able to conceive children, with or without fertility treatment. For this reason, Dr. Connelly advises transgender male adolescent patients that testosterone is not an effective contraception and they could become pregnant. Connelly Reb. ¶ 9.

¹⁰ The State also says individuals who receive treatment may never be able to orgasm. Dkt. 66 at 5. But the evidence does not support that. *See* Connelly Reb. ¶¶ 10–11.

demonstrate that their numbers are exceedingly low. Turban Reb. ¶ 37. The State asserts that the rate of regret is as high as 30% because it conflates pausing or stopping medical treatment with a change in gender identity and treatment regret. Turban Reb. ¶ 40. There are many reasons why individuals pause or stop treatment, such as being satisfied with their results or a change in insurance coverage. *Id.* ¶¶ 38, 41; Connelly Reb. ¶ 12. Low rates of regret are consistent with the clinical experience of Drs. Connelly and Brady, who have each seen only two patients out of hundreds come to identify with their birth-assigned sex after treatment; none regretted the care. Brady Reb. ¶ 12; Connelly Reb. ¶ 12. Dr. Weiss could not recall even one of his 100 transgender patients ever expressing regret for their hormone therapy. Weiss Dep. 313:3–313:6.¹¹

The State speculates that “social contagion”—peer influence and social media—could be responsible for the increase in birth-assigned females presenting for care. But this increase is not surprising given the increased visibility of transgender people, particularly transgender men, and better information relating to medical care for transgender people, and improvements in insurance coverage. Turban Reb. ¶¶ 35. If there are any youth who seek care at gender clinics because of social influence, under the WPATH and Endocrine Society guidelines, they would be given a comprehensive psychosocial evaluation prior to even considering any medical interventions, and would not be offered such treatments absent a diagnosis of gender dysphoria and a determination

¹¹ The State’s experts also point to the so-called “desistance” research on prepubertal children to suggest that most of those who receive gender-affirming medical care would naturally come to identify with their birth-assigned sex if not treated. *See* Dkt. 56-3 ¶ 35. But the studies they rely on assessed gender non-conforming children who, under the prior diagnosis of Gender Identity Disorder, did not need to identify as a sex that differed from their assigned sex to meet criteria. So it was not surprising that many did not identify as transgender at follow up. Additionally, those studies evaluated prepubertal children and provide no evidence that *adolescents*—those who would be eligible for gender affirming medical care—are likely to desist. After puberty, it is very unlikely for a transgender person to desist. Turban Reb. ¶¶ 25–28; Brady Reb. ¶ 11; Dkt. 56-4 ¶ 245 (desistance less likely to occur after age 12).

that treatment is appropriate. Brady Reb. ¶ 7; *see* Dkt. 32–7 ¶ 27.

D. The State’s “Expert” Witness Opinions Should Not be Given Weight.

Dr. Weiss is an adult endocrinologist who, by his own admission, is not an expert in mental health and has no training or clinical experience in the treatment of gender dysphoria in minors. Weiss Dep. 39:7–10; 42:12–44:10; 51:8–52:6; 57:18–19; 62:13–18; 65:7–18. He offers his own personal views about gender dysphoria that are at odds with those of actual mental health authorities—including the DSM and the American Psychological Association—and even the State’s position in this case. Dkt. 66 at 3; Brady Reb. ¶ 5. For example, he opines that gender dysphoria is not a real condition and is exclusively a symptom of other mental health issues which, if resolved, would resolve the gender dysphoria. Weiss Dep. 71:4–72:19; 213:6–215:8. The foundation of his opinions was his “common sense” and “rationality,” from which he concocted a theory that young girls who are sexually abused seek out transition so as not to “encourage any more sexual abuse.” Dkt. 56-3 ¶ 19; Weiss Dep. 92:15–93:24; 148:11–151:17. He described this as a “straightforward... obvious...explanation” for the existence of trans men. (He had no explanation for why trans *women*, who were assigned male at birth, would choose to make themselves *more* vulnerable to sexual assault, nor for all the cisgender survivors of sexual abuse.) Weiss Dep. 148:11–151:17.

Dr. Weiss also repeatedly misrepresents his sources. As just one example, he cites a paper for the proposition that “desistance is frequent” when the paper specifically states that it did *not* assess prevalence. Dkt. 56-3 ¶ 35; Turban Reb. ¶ 39. He also relies on overtly biased materials, basing key claims on various Internet forums (e.g. “parents for inconvenient truths about trans”), and suggests the number of accounts “following” a Reddit forum on the subject of detransition was somehow evidence of the number of people who *have* detransitioned. Weiss Dep. 196:4–196:18; 219:3–19; 322:4–25. Ultimately, he was forced to admit that one of his five primary

opinions—that suicidality is not improved by gender affirming medical care—is not supported by his cited literature, which calls into doubt the reliability of his other opinions. *Id.* at 240:14-245:13.

Most astonishingly, while Dr. Weiss opines that gender-affirming hormone therapy is ineffective and harmful for individuals of any age—a view he says he has held for at least a decade—he continued to provide hormone therapy to adult transgender patients until last year without ever informing them that he believed the treatment he was providing them was ineffective and causing them harm. Weiss Dep. 160:16–161:23; 186:5–188:19.

Dr. Cantor is a psychologist and sexologist who has treated just between 14 and 16 adolescents with gender dysphoria. Cantor Dep. 45:16–54:5. His opinions are proffered in substantially the same form in several cases challenging similar bans across the country, and his testimony has been assigned “less weight as to the medical conclusions that can reasonably be drawn from the evidence for the treatment of gender dysphoria in minors” due in part to his minimal experience in treating adolescents with gender dysphoria and his work’s focus on a completely different subject—pedophilia and other “atypical sexualities.” *See, e.g., Koe v. Noggle*, --- F. Supp. 3d ---, 2023 WL 5339281, at *21 n.8 (N.D. Ga. Aug. 20, 2023); *Eknes-Tucker v. Marshall*, 603 F. Supp. 3d 1131, 1142–43 (M.D. Ala. 2022), *vacated*, -- F.4th --, 2023 WL 5344981 (11th Cir. Aug. 21, 2023).

ARGUMENT

I. Plaintiffs Have a Likelihood of Success on the Merits

A. Plaintiffs Have a Likelihood of Success on their Equal Protection Claims

1. Heightened Scrutiny Applies

(a) The Ban classifies based on transgender status

The State does not dispute that the law of this Circuit is that classifications based on transgender status are subject to heightened scrutiny. Dkt. 66 at 16. It instead argues that Ninth

Circuit law does not establish that the regulation of treatment for gender dysphoria classifies based on transgender status. But the Ban is not a regulation of treatment for gender dysphoria; it does not even mention gender dysphoria. The law is targeted at treatments that are inconsistent with a person’s “biological sex” without regard for the reason. This is a classification based on transgender status. *See M.H. v. Jeppesen*, No. 1:22-CV-00409-REP, 2023 WL 4080542, at *12 (D. Idaho June 20, 2023) (excluding gender-affirming medical procedure cannot be understood without reference to sex, gender, or transgender status). The State offers no basis for a rule that says transgender-based classifications trigger heightened scrutiny *unless* the classification involves medical treatments for gender dysphoria.¹² Contrary to the State’s arguments, it is irrelevant to the question of applicable level of scrutiny that gender dysphoria is a psychological, rather than physical condition. The nature of a medical condition is irrelevant to whether the law classifies based on transgender status.

(b) The Ban classifies based on sex

“If one must know the sex of a person to know whether or how a provision applies to the person, the provision draws a line based on sex.” *Dekker v. Weida*, No. 4:22-CV-325-RH-MAF, 2023 WL 4102243, at *11 (N.D. Fla. June 21, 2023) (citing *Bostock v. Clayton Country*, 140 S. Ct. 1731, 1737 (2020)). To know whether the treatments at issue in this case are permissible for a patient under H.B. 71, one must know the patient’s sex; the relevant provisions of the Ban classify along explicitly sex and gender-based lines, proscribing treatments to “alter the appearance of or affirm the child’s perception of the child’s sex if that perception is inconsistent with the child’s biological sex.” H.B. 71 § 1(3). *See Brandt v. Rutledge*, 47 F.4th 661, 669 (8th Cir. 2022) (“the

¹² Even if the Ban were a regulation of treatment of gender dysphoria, this Court has recognized that regulation of treatment of gender dysphoria can be both proxy discrimination and facial discrimination against transgender people. *M.H.*, 2023 WL 4080542 at *12–13.

minor’s [assigned] sex at birth determines whether or not the minor can receive certain types of medical care under the law.”).

The State contends that the Ban does not discriminate based on sex because “it applies to both males and females the same.” Dkt. 66 at 12. But the Supreme Court has already made clear that there is no exception to heightened scrutiny for classifications that apply “equally” to both sexes. *See J.E.B. v. Alabama ex rel. T.B.*, 511 U.S. 127, 142 n.13 (1994). Equal application of discriminatory treatment based on sex—injuring both transgender men and transgender women—does not immunize the law from heightened scrutiny.

Citing *Dobbs v. Jackson Women’s Health Organization*, 142 S. Ct. 2228, 2245 (2022), the State argues that a statute “is not a sex-based classification[]” “solely because it mentions sex”. Dkt. 66 at 13–14. But H.B. 71 does not merely “mention” sex—the question of whether medical treatment is permissible or criminal under H.B. 71 turns *entirely* on sex.

Relying on *Dobbs* and *Geduldig v. Aiello*, 417 U.S. 484 (1974), the State argues that “a statute regulating medical procedures does not trigger heightened scrutiny when it acknowledges sex-based distinctions.” Dkt. 66 at 13. But the Supreme Court has merely observed that *if* a law is a facially neutral regulation of a medical procedure, that law does not always receive heightened scrutiny solely because it disparately impacts members of one sex. *See Geduldig*, 417 U.S. at 494–96. Here, as discussed, the law at issue is *not* facially neutral. And equal protection jurisprudence has long drawn a clear distinction between sex-neutral classifications, which trigger heightened scrutiny only when enacted, at least in part, for a discriminatory purpose, and facial sex classifications—such as the Ban—which *always* trigger heightened scrutiny. *See Pers. Adm’r of Mass. v. Feeney*, 442 U.S. 256, 273–74 (1979). Nor is this a law that regulates procedures only one sex can undergo. Dkt. 66 at 13. The procedures at issue are currently undergone by all sexes,

and H.B. 71 bans each procedure only for certain patients and only on the basis of their sex.

The Ban also discriminates based on sex stereotypes—specifically, it bans care that would cause a minor to not conform to sex expectations while “allow[ing] the same treatment for cisgender minors as long as the desired results conform with the stereotype of their biological sex.” *Brandt v. Rutledge*, 551 F. Supp. 3d 882, 891 (E.D. Ark. 2021), *aff’d*, 47 F.4th 661 (8th Cir. 2022); *Bostock*, 140 S. Ct. at 1741–42. The State responds that biological differences between the sexes are not sex stereotypes, citing *Tuan Anh Nguyen v. INS*, 533 U.S. 53 (2001). Dkt. 66 at 14. But in *Nguyen*, the court still applied heightened scrutiny even though the differential treatment of mothers and fathers was based on biological differences. *Id.* at 60–61. The court held that the government satisfied its burden, but the biological differences did not create a carve-out from the rule that sex classifications are subject to heightened scrutiny.

2. The Law Is Unconstitutional Under Any Level of Scrutiny

The State has not met its demanding burden of showing an exceedingly persuasive justification and a close means-ends fit for the law. Dkt. 32-1 at 16. The State asserts it has a compelling interest in “protecting children and adolescents” from medical treatments “for which there is uncertainty regarding benefits, recent surges in use, and irreversible effects.” Dkt. 66 at 19 (quoting *Eknes-Tucker*, 2023 WL 5344981 at *13). The State’s arguments come down to that the ban is justified by (i) a lack of evidence of efficacy of treatment; (ii) treatment risks; and (iii) the possibility of detransition and regret. None withstand heightened scrutiny because the allegations are either unsupported by the evidence or do not explain why only gender-affirming medical care (and all such care) is singled out for prohibition.

As discussed above, *see* Sections A–B, *supra*, the State’s assertion that there is no reliable evidence of efficacy is simply not supported by the evidence. Because research and decades of clinical experience have shown the benefits of gender-affirming medical care to adolescents with

gender dysphoria, this care is supported by every major medical association in the United States. And contrary to the State’s suggestion, this care is provided in countries across the globe.

The State’s assertions regarding potential health risks of treatment fail to acknowledge that the risks are low and well-managed when treatment is monitored by a doctor, and they apply equally to the use of puberty blockers, testosterone, and estrogen for other purposes for which they are permitted. The potential risk to fertility for hormone therapy (but not puberty blockers alone) is different, but risks—including the risk of infertility—are common in medicine. Patients and their parents, in consultation with their doctors, ordinarily are free to weigh the potential risks and benefits and decide on a course of treatment. *See* Dkt. 32-7 ¶¶ 50–51. In addition, treatment can be tailored to preserve fertility when that is important to the family. Dkt. 32-7 ¶ 50; Connelly Reb. ¶ 9. There is not a close means-end fit between the law and protecting minors from medical treatments that have potential risks.

The State’s assertions about “social contagion,” increases in gender-affirming medical care, and the risk of detransition and regret, do not meet their burden. As detailed above, no evidence supports their narrative and regret rates are very low. The possibility of regret, which exists in all medical care, does not justify singling out this care for prohibition. Connelly Reb. ¶ 14.

The State’s assertion that the Ban of *all* gender-affirming medical care for *all* minors, without exception, is necessary to protect children is also belied by their own expert’s admissions that he would favor an exception for research (Cantor Dep. at 130:8–25), and that for some adolescents gender affirming healthcare could possibly be beneficial. *Id.* at 146:1–147:2.

Even if the Ban were subject to only rational basis review, it would fail. It does not protect children; it harms some of the most vulnerable of them. *See* Dkt. 32-1 at 17 There is no rational basis to conclude that allowing minors to receive gender-affirming medical care that they, their

parents, and their doctors agree is medically necessary “would threaten legitimate interests of [Idaho] in a way that” allowing other types of medical care “would not.” *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 448 (1985). Other medical care is supported by comparable evidence and has comparable risks, but is not banned. *See* Section B, *supra*; Dkt. 32-1 at 20–21.

B. Parent Plaintiffs Are Likely to Succeed on Their Due Process Claims

The Fourteenth Amendment’s right to direct the upbringing of one’s children includes “the right of parents to make important medical decisions for their children, and of children to have those decisions made by their parents rather than the state.” *Wallis v. Spencer*, 202 F.3d 1126, 1141 (9th Cir. 2000) (citing *Parham v. J.R.*, 422 U.S. 584, 602 (1979)). Idaho has recognized that “[t]he interests and role of parents in the care, custody and control of their children are both implicit in the concept of ordered liberty and deeply rooted in our nation’s history and tradition,” I.C. §32-1010(2), and the State itself recently argued it has “an important and compelling interest in protecting a parent’s right to make healthcare decisions for their children.” Korberg Decl. Ex. C at 6; Korberg Decl. Ex. D at 37:19–38:4; 44:22–45:25. But the State now argues for an exception to this core principle *because* HB 71 outlaws gender-affirming medical care for minors. The State cannot in one breath speak to the fundamental rights of parents, but in the next argue that parents have no rights here *because* the State has trampled on those rights.

The State cites exclusively out-of-circuit, non-binding interpretations of Supreme Court case law and criticizes the Parent Plaintiffs for “rais[ing] the level of generality for the right they are asserting.” Dkt. 66 at 17–18. But the plaintiffs are not asserting “a right to new medical treatments” as the State argues. *See id.* at 17–19. At issue are parents’ rights to make medical decisions for their children to receive treatments that adults are already permitted to access. And that right—as Idaho law recognizes and as the Supreme Court has affirmed (*see* Dkt. 32-1 at 22–24)—is a fundamental one that the State cannot infringe without surviving strict scrutiny. Because,

for the reasons stated above, the State failed to meet its burden under heightened scrutiny, it has not met the more onerous burden of satisfying strict scrutiny. *See id.* at 24; Section I.B., *supra*.

II. The Remaining Factors Support a Preliminary Injunction

The State has not even attempted to address the harms identified by the Plaintiffs should the law take effect. Plaintiffs will indisputably suffer irreparable harm and the balance of the equities and public interest favor an injunction. The State’s contention that Plaintiffs would suffer less harm because they can “draw down their medication” is particularly contemptible. Dkt. 66 at 28. It ignores the uncontested declarations from all Plaintiffs regarding (i) the unquestionable benefits the healthcare has had for the minor Plaintiffs; (ii) the harm caused to the Plaintiffs by the fear of having this healthcare discontinued; and (iii) their intent to uproot their families and lives from Idaho to continue this care if the law takes effect. *See* Dkt. 32-1 at 25–26.

The State implausibly contends it is the State that will suffer irreparable harm here, citing *Latta v. Otter*, 771 F.3d 496, 500 (9th Cir. 2014), as “noting authority for the proposition ‘that a state suffers irreparable injury whenever an enactment of its people or their representatives is enjoined.’” Dkt. 66 at 27. But in the very next sentence, the court explicitly *rejected* that premise. *See Latta*, 771 F.3d at 500 & n.1. Instead, the court relied on longstanding Supreme Court authority “that a deprivation of constitutional rights, ‘for even minimal periods of time, unquestionably constitutes irreparable injury.’” *Id.* (citing *Elrod v. Burns*, 427 U.S. 347, 373 (1976)); *see also Hecox v. Little*, 79 F.4th 1009, 1035–36 (9th Cir. 2023).

III. Bennetts Does Not Dispute the Merits of Plaintiffs’ Claims

Bennetts filed a separate opposition from the State and did not join in their brief. Thus, Bennetts’ only argument against granting Plaintiffs’ Motion is that “the Court lacks subject matter jurisdiction over claims against her, and that Plaintiffs have failed to state a claim against her,” incorporating by reference her own motion to dismiss. Dkt. 55 at 1. Plaintiffs have responded to

these arguments in their opposition to Bennetts’ motion to dismiss, Dkt. 60, and incorporate those responses here. The preliminary injunction record further supports Plaintiffs’ arguments that Plaintiffs live and receive healthcare in Ada County. *See, e.g.*, Dkt. 32-2 ¶¶ 1, 2, 12–14, 17, 19, 20, 23; Dkt. 32-4 ¶¶ 1, 2, 13–17, 24, 26.

IV. The Requested Scope of the Injunction Is Appropriate

An injunction limited to just the Plaintiffs is insufficient because they cannot receive complete relief without an injunction allowing third parties to provide the prohibited medical care. *See Bresgal v. Brock*, 843 F.2d 1163, 1170–71 (9th Cir. 1987) (finding a nationwide injunction not “overbroad” because limiting enforcement of the law to a particular group would not give the prevailing parties relief); *see also Easyriders Freedom F.I.G.H.T. v. Hannigan*, 92 F.3d 1486, 1501–02 (9th Cir. 1996). Because there are no exceptions in the Ban, healthcare practitioners and pharmacists in the State from whom Plaintiffs may pursue care will predictably cease providing these treatments out of fear of incarceration. Statewide relief is necessary to prevent irreparable harm. *See Brandt*, 47 F.4th at 672. And the Ninth Circuit has recognized that statewide relief is an appropriate remedy where there is a challenge to the constitutionality of a state statute. *See* Dkt. 32-1 at 28–29.

CONCLUSION

Plaintiffs respectfully request that the Court grant their motion for a preliminary injunction.

Date: October 13, 2023

Respectfully submitted,

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**UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO**

PAM POE, et al.,

Plaintiffs,

v.

RAÚL LABRADOR, et. al.,

Defendants.

Case No. 1:23-cv-00269-BLW

**DECLARATION OF ALEXIA D.
KORBERG (EXHIBITS FOR
REPLY IN SUPPORT OF MOTION
FOR PRELIMINARY
INJUNCTION)**

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Attorneys for Plaintiffs

I, Alexia D. Korberg, declare under penalty of perjury as follows:

1. I am one of the attorneys for the plaintiffs in this case.

2. **Exhibit A** to this declaration is a complete, certified transcript of the deposition of James M. Cantor, Ph.D., taken in this case on September 21, 2023.

3. **Exhibit B** to this declaration is a complete, certified transcript of the deposition of Dr. Daniel Weiss, taken in this case on September 22, 2023.

4. **Exhibit C** to this declaration is a true and correct copy of General Raúl Labrador's Opposition to Plaintiffs' Motion for a Temporary Restraining Order or, In the Alternative, a Preliminary Injunction filed August 28, 2023, in *Matsumoto v. Labrador*, No. 1:23-cv-323-DKG.

5. **Exhibit D** to this declaration is a complete, certified transcript of the hearing on plaintiffs' motion for a preliminary injunction held on September 14, 2023, in *Matsumoto v. Labrador*, No. 1:23-cv-323-DKG.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

EXECUTED ON October 13, 2023.

Respectfully submitted,

/s/ Alexia D. Korberg
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**UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO**

PAM POE, et al.,

Plaintiffs,

v.

RAÚL LABRADOR, et. al.,

Defendants.

Case No. 1:23-cv-00269-BLW

**DECLARATION OF RICHARD
EPPINK (EXHIBITS FOR REPLY
IN SUPPORT OF MOTION FOR
PRELIMINARY INJUNCTION)**

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Attorneys for Plaintiffs

I, Richard Eppink, declare under penalty of perjury as follows:

1. I am one of the attorneys for the plaintiffs in this case.

2. **Exhibit A** to this declaration is a complete, certified transcript of the deposition of James M. Cantor, Ph.D., taken in this case on September 21, 2023.

3. **Exhibit B** to this declaration is a complete, certified transcript of the deposition of Dr. Daniel Weiss, taken in this case on September 22, 2023.

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Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

EXECUTED ON October 13, 2023.

/s/ Richard Eppink

Richard Eppink

Exhibit A

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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO
SOUTHERN DIVISION
Case No. 1:23-cv-00269
-----x
PAM POE, by and through her parents
and next friends, Penny and Peter Poe;
PENNY POE; PETER POE; JANE DOE, by and
through her parents and next friends,
Joan and John Doe; JOAN DOE; JOHN DOE,

Plaintiffs,

-against-

RAÚL LABRADOR, in his official capacity
as Attorney General of the State of
Idaho; JAN M. BENNETTS, in her official
capacity as County Prosecuting Attorney
for Ada, Idaho; and the INDIVIDUAL
MEMBERS OF THE IDAHO CODE COMMISSION,
in their official capacities,

Defendants.
-----x
September 21, 2023
10:04 a.m.

Remote Videotaped Deposition
of JAMES M. CANTOR, Ph.D., an Expert
Witness, taken by Plaintiffs, before Dawn
Matera, a Certified Shorthand Reporter
and Notary Public for the State of New
York.

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9 Attorneys for the State Defendants
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11 By: LINCOLN WILSON, ESQ.

12
13 Also Present:

14 CHRIS HANLON, Videographer

15 ROB BENIMOFF, Concierge

16 ~oOo~

1 THE VIDEOGRAPHER: Good morning.
2 We are going on the record. The date
3 today is September 21st, 2023. The
4 time is 10:04 a.m. Eastern Time. This
5 is media unit number 1 of the
6 video-recorded deposition of Dr. James
7 Cantor taken in the matter of Pam Poe,
8 et al., versus Raúl Labrador, et al.,
9 filed in the U.S. District Court for
10 the District of Idaho Southern
11 Division. This is case number
12 1:23-CV-00269.

13 My name is Christopher Hanlon, I
14 am a certified legal videographer.
15 Our court reporter today is Dawn
16 Matera and we are with Veritext New
17 York.

18 At this time I would just note
19 that I cannot go off the video record
20 unless both parties agree. And I
21 would now ask counsel to please state
22 your appearances for the record,
23 starting with the noticing attorney,
24 please.

25 MR. MAY: Good morning. My name

1 is Philip May from the law firm of
2 Groombridge, Wu, Baughman & Stone in
3 Washington D.C. And I represent the
4 Plaintiffs.

5 MR. RAMER: Good morning, my
6 name is John Ramer with the law firm
7 Cooper & Kirk in Washington D.C. and I
8 represent the State Defendants.

9 MR. WILSON: Good morning,
10 Lincoln Wilson with the Idaho Attorney
11 General's office representing the
12 State Defendants.

13 THE VIDEOGRAPHER: Thank you,
14 counsel. All other counsel will be
15 noted on the stenographic record.

16 At this time I would ask our
17 court reporter, Ms. Matera, to please
18 administer the oath and we can
19 proceed.

20 J A M E S M. C A N T O R, the Witness
21 herein, having first been duly sworn by
22 the Notary Public, was examined and
23 testified as follows:

24 EXAMINATION BY MR. MAY:

25 Q. Good morning, Dr. Cantor.

1 A. Good morning.

2 Q. As you heard my name is Philip
3 May. I represent the plaintiffs here and
4 I am going to be asking you some
5 questions today.

6 I understand that you have been
7 deposed before, right?

8 A. That's correct.

9 Q. So some of these rules, I am
10 just going to go over some ground rules.
11 You may be familiar with them already but
12 I would like to make sure we are all on
13 the same page.

14 For today I ask that you give a
15 verbal answer to all of my questions.
16 Either a yes or a no. No shaking of the
17 head. No nodding, as our court reporter
18 can't take down a shake or a nod; is that
19 okay?

20 A. I understand.

21 Q. And also since there is a court
22 reporter we want to make sure that there
23 is a clean record of who is talking at
24 what time. So please, let's endeavor not
25 to talk over each other, okay?

1 A. Understood.

2 Q. As I said I am going to ask
3 some questions today. I will do my best
4 to ask clear questions; however, I am not
5 always successful in that goal. If at
6 any time you don't understand my question
7 or you need any clarification, please ask
8 for that clarification, okay?

9 A. Yup.

10 Q. And if you don't ask for
11 clarification of any of my questions I
12 will assume that you understood them as
13 posed; do you understand that?

14 A. Yes.

15 Q. Is there any reason you can't
16 testify truthfully and honestly today?

17 A. No.

18 Q. And you understand that you're
19 testifying today under oath?

20 A. Yes.

21 Q. And you understand that oath is
22 the same oath that you would take in a
23 courtroom in front of a judge?

24 A. Yes.

25 Q. Since this deposition is

1 happening remotely today I do just have a
2 couple additional kind of housekeeping
3 questions to ask you.

4 On your computer you don't have
5 any e-mail or messaging applications open
6 or actively open on your computer; is
7 that right?

8 A. That's correct. Although my
9 calendar window was open. Let me get
10 that out of the way. All set.

11 Q. If anything happens, you think
12 you've closed out of Teams but all of a
13 sudden you get a message, please just let
14 us know that you need to take care of
15 that and address that, okay?

16 A. You said Teams? The software
17 package that opened I think was Zoom.

18 Q. Right. Sorry. So we're doing
19 the deposition on Zoom. But if -- Teams
20 was an example. If, for example, you get
21 a message through like a work messaging
22 application or something like that or an
23 e-mail pops up that you thought you had
24 closed out of, just let us know?

25 A. I understand.

1 Q. Okay. And do you have any
2 papers or materials with you today for
3 your deposition?

4 A. I brought a blank page and pen
5 in case I needed it. A clean,
6 unannotated copy of my initial
7 declaration, and water.

8 Q. Great. I brought some coffee
9 as well, so.

10 A. Mine is in the next room.

11 Q. So Dr. Cantor, you said you
12 have been deposed before, right?

13 A. That is correct, yes.

14 Q. Approximately how many times
15 have you been deposed in the past?

16 A. About six.

17 Q. And have those all been in
18 cases regarding transgender care and
19 transgender youth?

20 MR. RAMER: Objection to the
21 form.

22 A. When I say six I was limiting
23 specifically to transgender-related
24 cases. I have been an expert witness for
25 several cases, usually revolving --

1 involving some other type of atypical
2 sexuality, typically in the context of
3 sex offenders.

4 I don't think, now that I am
5 running through them in my head, I don't
6 think they included a deposition.
7 Usually they were -- that was testimony
8 for Frye hearings.

9 Q. So six depositions related to
10 transgender issues; is that right?

11 A. Roughly. Again, I would have
12 to check through my notes to be sure.
13 Give or take one, roughly six.

14 Q. What did you do to prepare for
15 today's deposition?

16 A. Reread my report and the major
17 supporting documentation such as the --
18 at least the summaries and my own notes
19 of the various systematic reviews and of
20 the various policies that are still in
21 place by, in the U.S., by the major
22 associations that have put forth clinical
23 guidelines.

24 Q. Which of the associations in
25 the U.S. do you consider the major

1 associations that have put forth clinical
2 guidelines?

3 A. The Endocrine Society. The
4 World Professional Association of
5 Transgender Health. And the one for
6 which I published a peer-reviewed fact
7 check, the American Academy of
8 Pediatrics.

9 Q. In addition to rereading your
10 report and the documentation and your
11 notes, what else did you do to prepare
12 for today?

13 A. I had two two-hour meetings
14 with state defendants' representatives.
15 I think those were the major activities
16 specific to this case.

17 But of course, because I do
18 several of these cases and they are
19 overlapping in time, it's a little
20 difficult to isolate what is in regards
21 to what when I read a new paper or
22 something else comes out that's pertinent
23 to all of them regardless of which, which
24 case triggered my reading of that
25 particular -- that particular document.

1 Q. You said you met with the
2 state's defendants' representatives; who
3 were those individuals?

4 A. Mr. Wilson and Mr. Ramer.

5 Q. Was anyone else involved in
6 those meetings besides Mr. Wilson and
7 Mr. Ramer?

8 A. Not that I recall, no.

9 Q. So in addition to reviewing
10 your report, materials in these meetings,
11 what else did you do to prepare for
12 today's deposition?

13 MR. RAMER: Objection to the
14 form. Asked and answered.

15 A. I think that's about it other
16 than the usual get a good night sleep,
17 double-check my alarm clock and other
18 typical just be prepared for a big day
19 kinds of activities.

20 Q. And Mr. Ramer's objection just
21 reminded me of another ground rule I
22 wanted to clarify with you. Apologies
23 for not doing this earlier.

24 In the event your counsel makes
25 an objection, you understand that you

1 still have to answer my question unless
2 you're specifically instructed not to?

3 A. Yes, I understand.

4 Q. Okay. In preparing for your
5 deposition today, did you speak with any
6 of the state's other experts?

7 A. No, I did not.

8 Q. Have you ever spoken with any
9 of the state's -- strike that.

10 Do you know who the state's
11 other experts are in this case?

12 A. I guess I have to say no.
13 Again, because there are repeatedly
14 overlapping experts for the plaintiffs in
15 several of these cases in several states
16 and overlapping expert witnesses for the
17 defense in several of these cases, all
18 involving highly overlapping material. I
19 would lose track of whose witness -- who
20 is a witness in which one.

21 So I guess I would have to say
22 no and that I don't remember who is
23 specific to this particular case.

24 Q. I think we will talk a little
25 bit more about the other experts later.

1 When were you retained for this
2 case on behalf of the State of Idaho?

3 A. I would have to, again, check
4 my notes to be sure. This is the second
5 of -- actually, I don't remember which is
6 first. So this is one of two cases for
7 which I am retained by the state. I
8 believe they were in June. I would have
9 to check, again, my notes for the exact
10 date.

11 Q. And which is the other case
12 that you're retained by Idaho for?

13 A. I don't remember the case's
14 name. It's essentially a case about
15 single-sex restroom use.

16 Q. And have you provided a
17 deposition or an expert report in that
18 case yet?

19 A. I have submitted an expert
20 report, yes.

21 Q. Have you sat for a deposition
22 in that case yet?

23 A. Again, I would have to check my
24 notes to make sure I am not confusing
25 cases because these are concurrent cases

1 all with overlapping material. I believe
2 a deposition was waived in that one.

3 Again, I would have to check my
4 notes to make sure that I am not
5 confusing it with another one of the
6 simultaneous cases.

7 Q. You understand that this case
8 pertains to an Idaho law known as HB 71?

9 A. Yes, I do.

10 Q. Have you ever publicly spoken
11 about HB 71?

12 A. No, I have not.

13 Q. Have you ever taken a public
14 position on HB 71?

15 A. No, I have not.

16 Q. Outside the context of this
17 litigation, have you ever spoken with
18 anyone about HB 71?

19 A. No.

20 Q. For purposes of today I think
21 we are going to be talking about a lot of
22 different issues. So there are a couple
23 terms up front I wanted to just address
24 and make sure we are on the same page
25 about.

1 One of those terms I think that
2 will be referred to interchangeably in
3 some literature and also during
4 questioning, I believe, a term, I think
5 you use frequently is "natal male."

6 Do you also understand that
7 term to mean -- do you understand that to
8 be the same thing as someone assigned
9 male at birth?

10 MR. RAMER: Objection to the
11 form.

12 A. Yes, in general. Sometimes the
13 context can indicate that somebody is
14 either using a term in an ambiguous way,
15 in a novel way or an idiosyncratic way,
16 and generally I double-check that we're
17 using the same idea. If there is a
18 particular phrasing that insinuates an
19 argument or insinuates information that
20 isn't pertinent, again, I tend to make
21 that explicit.

22 But in general that tells me
23 what the person is -- what the person is
24 thinking. That's a pretty standard,
25 technique is a strong word, that's a

1 standard method that we have to do, those
2 of us that do sex research, especially in
3 controversial questions where different
4 modes of thought, different people,
5 different experts use different terms to
6 refer to the same thing. When it's
7 ambiguous, I just clarify for purposes of
8 definitions and then we start out, and
9 then in general I -- in general I do my
10 best to translate in my head what
11 everybody means by it.

12 I guess what I am saying is
13 simultaneously, I have -- they're usually
14 synonyms. When it's not clear something
15 is meant as a synonym I try to make that
16 explicit.

17 Q. Great. So just to be clear, we
18 will understand each other, assigned male
19 at birth and natal male are generally
20 interchangeable unless you note
21 otherwise; is that fair?

22 A. Yes. The other term I
23 frequently use is biological male and
24 female.

25 Q. And yes, that would be the

1 exact same thing as assigned female as
2 birth, natal female, biological female?

3 MR. RAMER: Objection to form.

4 A. Yes, those are -- excusing the
5 occasional exception, those are basically
6 synonyms.

7 Q. So we will treat those as
8 synonymously unless there is a specific
9 reason that you want to clarify to
10 explain why they are different; is that
11 fair?

12 A. Yes, that's fair.

13 Q. All right. I believe in your
14 exhibit folder you should already have
15 Exhibit 1.

16 (Exhibit 1, Expert declaration
17 of Dr. Cantor, was so marked for
18 identification, as of this date.)

19 Q. So if you can go ahead and open
20 it up, Exhibit 1, and just confirm for me
21 that you have that open.

22 A. Yes, I have that open.

23 Q. Exhibit 1 is a copy of your --
24 what's marked as your expert report is an
25 expert declaration that was filed in this

1 case?

2 A. Yes, by going through the first
3 few pages, that looks like it.

4 Q. And I understand you have a
5 hard copy of that in front of you?

6 A. Yes, I do, that's correct.

7 Q. And if you want to for today,
8 you can feel free to refer to the hard
9 copy in front of you whenever we are
10 discussing questions. You don't have to
11 go back to the electronic copy.

12 A. Perfect. I feel much more
13 comfortable with paper. It doesn't need
14 updating while I read it. It doesn't run
15 out of power or focus.

16 Q. Considering Exhibit 1, your
17 declaration, as you sit here today are
18 you aware of any inaccuracies in your
19 declaration?

20 A. No, I am not.

21 Q. Is there anything in your
22 declaration you would like to correct,
23 amend or change?

24 A. Not, not substantively. But if
25 I had the opportunity and time and, of

1 course, whichever group that I am working
2 with, similarly have the opportunity and
3 time, there are sections that I would
4 expand for greater completeness. But
5 there is nothing absent from it that
6 would change any of the arguments or any
7 of the conclusions.

8 As I say, usually there are
9 updates or additional examples that I
10 would include for completeness.

11 Q. Was anyone besides you involved
12 in the authorship of your declaration,
13 Exhibit 1?

14 A. No. I first wrote the bulk of
15 it, the main informational sections,
16 before the assessment of Dr. Brady's
17 report. I initially wrote that document
18 for Alabama's case.

19 So there was, you know, some
20 typo checking, formatting, ensuring that
21 I am not using an overly technical word
22 or accidentally tripping over a legal
23 language that involves a term of art. So
24 there was that kind of minor copy editing
25 with the lawyers in that case.

1 But nothing, again,
2 substantive.

3 Q. Since the document was
4 originally written for Alabama, have you
5 made any substantive changes from that
6 Alabama case to today?

7 A. Not substantive ones, no. I
8 removed some sentences in the bulk of the
9 document that I wrote that were specific
10 in responses to experts in that case.
11 Nothing else of substance, no.

12 Q. Aside from counsel in this
13 case, have you discussed the substance of
14 your declaration with anyone else?

15 A. Yes and no. It's hard -- yes
16 and no. I haven't discussed anything
17 specific about the declaration itself or
18 its use, purposes for my point of view,
19 purposes for the state defendants' points
20 of view. But, of course, the material
21 itself is central to the science that I
22 have been doing and the knowledge
23 accumulating and information that I have
24 been accumulating in this material for
25 literally decades.

1 So I very, very frequently am
2 asked questions about this type of
3 material, what the research says. I
4 often will send sections of it to the
5 media or anybody else asking when it's
6 relevant to answering whatever question
7 they had.

8 So as I say, it's a little bit
9 difficult to make a -- to make a clean
10 mark when in the back and forth there are
11 discussions with other people helped me
12 realize what is clear, not clear.
13 Natural questions that occur in other
14 people's heads. Their automatic
15 assumptions that would give me an idea of
16 how to phrase something, not phrase
17 something. Other material that people
18 would need in order to understand
19 properly and not misinterpret content of
20 the science; none of which was specific
21 to any case that I am working on, but is
22 part of my, as I say, general, general
23 functioning as a sex researcher and an
24 academic.

25 Q. So just to make sure I

1 understand. You haven't discussed the
2 substance of your declaration in the
3 context of this case with anyone besides
4 counsel for this case?

5 A. Yes, that is correct.

6 Q. Let's go ahead and now also go
7 to Exhibit Share and pull up what's been
8 marked as Exhibit 2.

9 (Exhibit 2, CV of Dr. Cantor,
10 was so marked for identification, as
11 of this date.)

12 A. So this is where I need to
13 refresh the screen?

14 Q. I should already have
15 Exhibit -- Exhibit 2 should already be in
16 that main folder.

17 A. Yes, I got it.

18 Q. You have Exhibit 2, which has
19 your name at the top of it and this
20 appears to be your CV; is that right?

21 A. Yes, by the first couple of
22 pages, that looks like it, yes.

23 Q. Is this a fair and accurate
24 copy of your CV?

25 A. As best as I can tell from the

1 first pages, yes.

2 Q. So this is 32 pages. Is this a
3 complete curriculum vitae for you?

4 A. Yes, it looks like it. I am
5 just looking at the list of expert
6 witness cases to make sure it's complete,
7 and, yes, I believe it is.

8 Q. Are there any changes,
9 corrections or amendments to your CV?

10 A. No. But again, the only
11 potential change would be if there is an
12 additional case that I hadn't yet added
13 to this copy when it was submitted.

14 Q. So your current role is the
15 director of the Toronto Sexuality Center;
16 is that right?

17 A. That is correct.

18 Q. Can you explain what your role
19 is as the director of the Toronto
20 Sexuality Center?

21 A. That's the corporate name to my
22 private practice.

23 Q. What is the focus of your
24 private practice?

25 A. Sex and couples therapy.

1 Q. What are the age of the
2 individuals that you see in your private
3 practice currently?

4 A. Currently, approximately ages
5 25 and up.

6 Q. Are you currently seeing anyone
7 under the age of 18?

8 A. Currently, no, I don't believe
9 I am.

10 Q. Are you currently seeing anyone
11 who identifies as transgender, gender
12 nonconforming or gender dysphoric?

13 MR. RAMER: Objection to the
14 form.

15 A. Gender nonconforming, yes,
16 depending on how one is using the term.

17 Until, I would say roughly the
18 social media age, gender nonconforming
19 meant gender nonconforming; either a
20 biological female who is tomboyish or a
21 biological male who is a bit effeminate.
22 Over the course of the social media age,
23 that's been -- that term has become more
24 loaded and some people use the term, if
25 not synonymously, but very close to mean

1 towards the border of meriting a
2 potential diagnosis of gender dysphoria.

3 So gender nonconforming, in
4 what the words literally mean, but as I
5 say because some people use that term to,
6 in a bit more loaded of a way, that is
7 one of those instances I would have to
8 ask exactly what do you mean by that
9 phrase in order to decide, the people
10 that I have in mind, does it happen to
11 fit them.

12 Q. I appreciate that explanation.

13 So to make sure I understand,
14 you're currently not seeing any patients
15 who identify as transgender, correct?

16 A. Again, I need a little bit of a
17 yes and no. But the question isn't --
18 the ambiguity in my head is not over
19 whether the person counts as transgender
20 or not. The ambiguity in my head is
21 whether I am currently seeing them or
22 not.

23 As is very common in sex and
24 couples therapy, there are people ranging
25 from weekly formal psychotherapy to

1 checking in every once in a while, to
2 they are fine and come back a couple of
3 months later because there is a
4 particular event or a particular
5 situation we were anticipating and they
6 may come back, but they are not a regular
7 weekly kind of client. But of the
8 regularly scheduled, either once a week
9 or once every other week, I am not
10 currently seeing somebody for whom a
11 social transition or medical transition
12 is currently under consideration or
13 underway.

14 Q. And also to be clear, of
15 that -- using that definition of
16 currently seeing someone, so someone who
17 is regularly scheduled with you, you're
18 not seeing anyone who identifies as
19 gender dysphoric; is that right?

20 A. Yes, that's correct.

21 Q. And using that definition of
22 someone who is regularly scheduled with
23 you, you believe you are seeing
24 individuals who identify as gender
25 nonconforming but in, how you phrase it,

1 a biological female who a tomboyish or a
2 biological male who is a bit effeminate?

3 MR. RAMER: Objection to the
4 form. Mischaracterizes testimony.

5 A. I'm not actually -- it's a bit
6 hard to say. But there is also an
7 imperfect match between people who, you
8 use the word "identify," for this
9 particular adjective I would say just
10 describe themselves as, there were people
11 who would describe themselves as
12 effeminate and people that aren't. That
13 doesn't mean that I or somebody else
14 would perceive them as effeminate or not.

15 There's people whose
16 presentation is completely unremarkable
17 but are insecure about their masculinity
18 and they were afraid that they appear
19 effeminate; and vice versa, there are
20 people aware, simply acknowledge that
21 there is not -- they are not as obviously
22 masculine or obviously feminine as
23 others. But it's not really part of
24 their -- they don't consider it a part of
25 their gender. It's just their mannerisms

1 and they would use it to describe
2 themselves exactly as anybody else would
3 describe themselves as introverted versus
4 extroverted.

5 Q. Over the course of your -- over
6 the course of your career, how long have
7 you maintained a clinical practice?

8 A. Well, my private practice,
9 outside of another institution, it's
10 about five years now.

11 I began this as I was -- I
12 began my current private practice a year
13 or two as I was preparing to leave my
14 hospital and faculty appointments.
15 Again, about five, six years ago.

16 Before that I was a clinical
17 researcher and still performing clinical
18 duties. Training clinical students.
19 Fully engaged in the clinical process,
20 but not as part of a private practice.
21 It was part of a public hospital and
22 being a faculty -- a member of the
23 faculty of medicine at the University of
24 Toronto.

25 Q. So I just want to understand

1 that a little bit better.

2 So while you were on faculty at
3 the University of Toronto, what
4 percentage of your duty time was spent
5 personally seeing patients?

6 A. Clinical scientist and clinical
7 research doesn't quite break down so
8 neatly. For example, when I am training
9 a student I would sometimes have face-to-
10 face contact with their client. It would
11 be somebody I am interviewing or somebody
12 I am assessing. But my student is in the
13 room and the student writes the report or
14 conducts part of the psychometric
15 assessments and so on.

16 And in other parts of the
17 training or with more advanced students
18 that reverses. The student then is
19 engaged in what it is that I am training
20 them in and I am watching and
21 supervising.

22 Next phase in a student's
23 training I am not in the room, but I am
24 going over the clinical reports and
25 checking, checking their materials and so

1 on.

2 So at what part that counts as
3 my function versus their function depends
4 on the context and the nature of the
5 question, even though I am ultimately
6 responsible and it's my signature on the
7 formal clinical reports despite that I am
8 not the one who had the face-to-face
9 contact with the patient.

10 One level more abstract is that
11 when I or we or my field is conducting
12 clinical research on the outcomes, I am
13 now accumulating large amounts of data
14 from large numbers of people where I am
15 the one who directs and conducts and
16 supervises and am ultimately responsible
17 for its content. Again, this is now very
18 many patients, but I am not the one who
19 conducted the face-to-face interview.

20 Similarly --

21 Q. So let's cabin the question
22 then to face-to-face interview. So
23 during your time at the University of
24 Toronto, what percentage of your time
25 were you the one involved in the

1 face-to-face interview with a patient in
2 the context of a clinical practice?

3 A. Early in my career, 30 to 40
4 percent and then decreasing as I became
5 more senior and more involved in those
6 supervisory and training materials and so
7 on.

8 So towards the end, 5 to 10
9 percent or towards the end of my time at
10 KMH and U of T, 5 to 10 percent.

11 Q. So towards the end of your time
12 was 5 to 10 percent of your time being
13 spent with the one doing the face-to-face
14 interviews. Approximately how many
15 patients does that account for that you
16 were involved in the face-to-face
17 interview for?

18 A. 50 to 100 per year, perhaps.

19 Q. Individual patients or
20 individual sessions?

21 A. Individual patients.

22 Q. Over the course of your career
23 have you ever provided -- strike that.

24 Over of the course of your
25 career have you ever worked with children

1 under the age of 16?

2 A. Only in an observational
3 capacity. I never had responsibility for
4 such a case, no.

5 Q. So you never had responsibility
6 for the case of a child under the age of
7 16?

8 A. That is correct.

9 Q. And approximately how many
10 individuals between the ages of 16 and 18
11 have you had the responsibility for in
12 the course of your clinical career?

13 A. Roughly two dozen perhaps.

14 Q. Roughly two dozen between the
15 ages of 16 and 18 over the course of your
16 career?

17 A. Yes, that's correct. As, of
18 course, the sex and couples therapist,
19 the issues don't become pertinent until
20 the person is essentially an adult.

21 Q. So of these roughly two dozen
22 patients between the ages of 16 and 18
23 that you have seen -- excuse me, start
24 that over.

25 Of the approximately two dozen

1 patients between the ages of 16 and 18
2 that you've had responsibility for over
3 the course of your career, how many of
4 those, if any, identified as transgender?

5 MR. RAMER: Objection to the
6 form.

7 A. Such a question requires some
8 unpacking. The emphasis and the phrase
9 in common use in the lay public about a
10 person identifying themselves and again
11 is a very, very modern, almost
12 exclusively post-social media construct.

13 Before the influence of social
14 media, people, parents, families, the
15 kids themselves, the adolescents wouldn't
16 use such a phrase and they would use a
17 much more personal, direct -- insightful
18 isn't the right word, but internal
19 description of their experiences rather
20 than implying a ubiquitous phrase in
21 social media which can mean any of many
22 different things that the person isn't
23 reflecting on their own experience, they
24 are using language that they see online.
25 So many of these people use or used to

1 use a wide range of phrases describing
2 their experiences.

3 Some of them -- for some of
4 those people they would clearly translate
5 to what today would often be said to be
6 identified as, so the whole reason that
7 they came to me or the clinic itself was
8 because they had questions. They didn't
9 know. They just knew that they were
10 confused. They didn't fit in with other
11 people. They weren't like other people.
12 Their experiences weren't like those --
13 those of their peers.

14 Today especially somebody who
15 comes in already having decided or
16 thinking that they have decided where
17 they are, where they are going, what is
18 best for them, they tend to use such a
19 strong term. But they wouldn't be the
20 persons who came to me. The people who
21 came to me were the ones for whom it was
22 either a question or unclear or they came
23 in for a different issue and they didn't
24 or didn't yet appreciate the role that
25 gender or public perception or social

1 perception of their gender was a
2 pertinent or relevant issue.

3 So as I say, it's because the
4 use of the term itself has evolved over
5 time, so has the people coming in asking
6 questions about themselves.

7 Q. Let me try this a different
8 way.

9 Of the approximately two dozen
10 patients between the ages of 16 and 18
11 that you have had responsibility for over
12 the course of your career, how many of
13 those, if any, were seen by you for
14 issues related to gender or gender
15 dysphoria?

16 MR. RAMER: Objection to the
17 form.

18 A. Again, it didn't, doesn't break
19 down quite that neatly. More typically,
20 as I said, their descriptions of their
21 experiences were that they were unsure
22 what their experiences meant. They
23 didn't know if they were trans. They
24 weren't sure if this meant they were gay
25 or lesbian, or they were experiencing

1 some other atypical sexual orientation or
2 sexual interest pattern that some
3 proportion of the time overlapped with
4 what we would call today gender identity,
5 but they just didn't know. They were
6 unsure themselves. And what they needed
7 was a thorough, competent assessment,
8 testing each of the different patterns.
9 Testing each of the increased information
10 and education about the very wide, very
11 diverse world of sexuality, beyond
12 gender.

13 Many of the people coming in in
14 the post-social media age automatically
15 or reflexively translate everything to
16 gender and believe that the only --
17 believe that there exists only a spectrum
18 for masculine to feminine, for male to
19 female, but don't see any of the other
20 dimensions representing still other
21 spectrums.

22 One of the most common and
23 still overlooked situations would be
24 somebody who is expressing, for example,
25 sexual masochism. People who are turned

1 on by people who for whom it's
2 legitimately said their sexual
3 orientation is about being humiliated or
4 beaten. That is their genuine sexual
5 orientation. To such a person they will
6 often experience humiliation at being
7 called, for example, effeminate, so they
8 find themselves sexually aroused by it.
9 They know it's meaningful. They
10 experience it as core to their being, but
11 it's not actually about gender itself.
12 It's being attributed to gender. But for
13 that person, they actually will become,
14 you know, happier and more fulfilled
15 being able to use the masochism and being
16 able to use the experiences of
17 humiliation within a, for example, kinky
18 setting. So they will sometimes engage
19 in gender atypical behaviors, but not
20 because transition would help them engage
21 in it, but because it provokes from other
22 people in, as I say, in kinky kinds of
23 settings, it gets them the kind of
24 behavior and the kinds of partners and
25 the kind of opportunities that they want.

1 But in very much of the lay
2 public today where the only consideration
3 is transition or not, masculine or not,
4 or somewhere in between, nobody is asking
5 questions. Nobody is entertaining other
6 possibilities outside of what's now in
7 the public discourse.

8 So as I say, it simply doesn't
9 break down to gender versus not gender.
10 These various situations overlap and they
11 have been unfortunately terribly
12 oversimplified by people whose only
13 experiences are to apply what's familiar
14 according to gay/lesbian and applying it
15 to transgender status where it just does
16 not fit accurately.

17 Q. Okay. Of the approximately two
18 dozen patients between the ages of 16 and
19 18 that you have had responsibility for
20 over the course of your career, how many
21 of those did you provide counseling for
22 specifically in relation to transgender
23 issues?

24 MR. RAMER: Objection to the
25 form.

1 A. Again, I think that requires
2 some unpacking. Can you repeat the
3 question?

4 Q. Sure. Of the approximately two
5 dozen patients between the ages of 16 and
6 18 that you have had responsibility for
7 over the course of your career, how many
8 of those patients did you provide
9 counseling for specifically in relation
10 to transgender issues?

11 MR. RAMER: Same objection.

12 A. Again, it's hard to tell
13 because whether the person's experience
14 was about transgender issues or something
15 resembling transgender issues was
16 ambiguous.

17 Q. Okay. How many of those
18 patients, of those patients that you have
19 treated -- strike that.

20 How many of the patients
21 between the ages of 16 and 18 that you
22 have had responsibility for over the
23 course of your career, how many of them
24 were transgender?

25 MR. RAMER: Objection to the

1 form.

2 A. Really I can only say that it's
3 ambiguous. All of my time as part of KMH
4 and U of T, and most of my time in
5 private practice, I am a specialized
6 specialist.

7 When a case is, I hesitate to
8 say run of the mill, when a case is
9 clear, they don't need me. I get the
10 cases where it's not clear or it's
11 complicated or there are many intervening
12 or concurrent factors that require
13 somebody with a broader expertise than
14 the relatively, again, I am hesitating to
15 use the phrase run of the mill, because
16 in a meaningful way none of these are run
17 of the mill, but when a case, at least
18 superficially appears clear, it wouldn't
19 get to me.

20 Cases come to me or people ask
21 me to consult on cases when it's very
22 unclear. There are several different
23 potential explanations and they need, as
24 I say, a specialized specialist.

25 If it's somebody who just needs

1 a basic assessment to be able to say, are
2 you competent to provide informed consent
3 in order to undergo whatever medicalized
4 procedure, I wouldn't see such cases.
5 Many people are qualified to conduct such
6 an assessment and they don't bother with
7 me, they don't bother needing to consult
8 with me.

9 Q. So Dr. Cantor, you testified a
10 lot before about your experience,
11 correct?

12 MR. RAMER: Objection to the
13 form.

14 A. I am not quite sure what a lot
15 means, but it does take a substantial
16 proportion of my time this year and last
17 year.

18 Q. So you provided testimony I
19 believe you said in deposition in at
20 least six other cases regarding
21 transgender issues?

22 A. Yes, that's correct.

23 Q. And do you recall most recently
24 sitting for a deposition in June of this
25 year in a case related to the State of

1 Indiana?

2 A. I, again, would have to check
3 my notes. Oddly, because my role in each
4 of these cases is the same, the basic
5 questions are the same, it's very easy
6 for me to lose -- they are essentially
7 interchangeable in my head. So I would,
8 again, would have to check my notes.

9 And I have learned to keep very
10 careful notes, about exactly which case
11 is which and in which one I provided in-
12 person testimony versus video testimony
13 versus which were the trials, which were
14 the depositions. That sounds
15 approximately correct. But again, I
16 would have to check my own notes to be
17 sure exactly which one was which.

18 Q. Sure.

19 MR. MAY: And Rob, if we can
20 please go ahead and mark tab 4 as
21 Exhibit 3, please.

22 (Exhibit 3, Transcript of
23 Dr. Cantor's deposition from K.C.
24 versus individual members of the
25 Medical Licensing Board of Indiana,

1 was so marked for identification, as
2 of this date.)

3 MR. BENIMOFF: Exhibit 3 has
4 been introduced.

5 A. I got it.

6 Q. You have Exhibit 3 open,
7 Dr. Cantor?

8 A. Yes, I do.

9 Q. This is a transcript of your
10 deposition from the case of K.C. versus
11 individual members of the Medical
12 Licensing Board of Indiana.

13 A. That's what it looks like, yes.

14 Q. Did you have a chance to review
15 this deposition testimony after you
16 provided it?

17 A. I had a chance to review it,
18 yes.

19 Q. And you didn't identify any
20 corrections for this transcript, right?

21 A. Again, I don't recall. I don't
22 remember anything outstanding that was
23 left uncorrected. I don't think I have
24 any loose threads on it. But as I say,
25 because there are several of them, I

1 can't remember which corrections I might
2 have sent to which case.

3 Q. And if you can go to page 16 of
4 the pdf, you will see there's four pages
5 of testimony per page.

6 A. Yes, do you want me on page 16
7 of the pdf or --

8 Q. 16 of the pdf and the page
9 that's labeled 59. And starting at line
10 21.

11 A. Hold on one second.

12 Q. Sure.

13 A. Yes, I am at 59.

14 Q. Starting at line 21 you were
15 asked:

16 "Question: As I understand
17 from previous testimony, the extent of
18 your clinical experience with transgender
19 adolescents has been providing counseling
20 to eight transgender patients between the
21 ages of 16 and 18 in your career; is that
22 right?"

23 And you responded at page 60
24 lines 1 through 2: "For being a formal
25 clinician for cases, that number sounds

1 about right, yes."

2 Did I read that correctly?

3 A. Yes, it would seem so.

4 Q. So it's fair to say you've
5 provided counseling to eight transgender
6 patients between the ages of 16 and 18 in
7 your career?

8 MR. RAMER: Objection to form.

9 A. No, that was at that time.

10 Q. That was at that time, two
11 months ago or three months ago?

12 A. Correct. As time goes on, I
13 am, as I say -- I am frequently asked to
14 consult, answer questions, you know, see
15 somebody for a session or two, and as my
16 participation in these various legal
17 cases increases, my name becomes that
18 much more known -- that much more known,
19 and so I become -- lightning rod is not
20 the right phrase. Because very many
21 clinicians are afraid to speak openly or
22 critically about what's going on, I am
23 one of the very few people for many cases
24 for whom people feel confident or
25 comfortable or feel that they will get a

1 thorough assessment and ask me particular
2 questions that other clinicians either
3 are unwilling to see, unwilling to
4 respond to, or the families of the kids
5 don't trust the responses that they are
6 getting. They feel like they are getting
7 reflexive, automatic or superficial
8 responses.

9 So as I say, as my
10 participation in these various cases
11 increases, I am more frequently called to
12 consult on additional such cases.

13 Q. So in the last three months,
14 since you gave this deposition in Indiana
15 in June of 2023, how many transgender
16 patients between the ages of 16 and 18
17 have you provided counseling to?

18 MR. RAMER: Objection to the
19 form.

20 A. Again, I'm sorry, I am trying
21 to work through each of the caveats in
22 that question. Could you say that again?

23 Q. Sure. In the last three months
24 how many transgender patients between the
25 ages of 16 and 18 have you provided

1 counseling to?

2 MR. RAMER: Same objection.

3 A. Again, about another six to
4 eight.

5 Q. In the last three months you've
6 seen another six to eight transgender
7 adolescents between the ages of 16 and
8 18?

9 MR. RAMER: Objection to the
10 form. Asked and answered.

11 A. Again, I would have to add the
12 same kinds of caveats. The cases that
13 come to me are the cases for which I am
14 asking to consult are the more
15 complicated, more ambiguous. It's not
16 quite so clear. It's not quite so clear.

17 To call them a transgender case
18 is to presume the answer. Well, the
19 whole problem with much of the -- what's
20 going on clinically is that the answer is
21 being presumed before actually seeing the
22 person.

23 So people are coming in asking
24 questions. The answer is ambiguous. And
25 I help point out, you know, give the

1 person issues to think about, the
2 alternative ways to interpret their
3 experience. And does that count as a
4 transgender case? Sometimes yes,
5 sometimes no.

6 It's not a -- you're asking me
7 ironically to dichotomize what's actually
8 a spectrum of answers.

9 Q. So I am just a little confused
10 because I thought earlier you told me
11 that you're currently seeing patients
12 ages 25 and up and that you're not seeing
13 anyone under the age of 18.

14 A. Not regularly, correct.

15 Q. So you're drawing a distinction
16 between one-off consultations versus
17 regular treatment of patients; is that
18 fair?

19 A. Well, that's, yes, how the
20 field works, is that there are regular
21 patients and regular patients, how many
22 am I currently seeing. Well, the ones I
23 am regularly currently seeing I have
24 regular appointments with, weekly
25 monthly, whatever it is. And then I am

1 also asked for assessments for
2 consultation, for input, for people for
3 whom they have questions and it's, you
4 know, a limited number of sessions to
5 help them work through those issues.
6 It's whatever, one, two, three sessions,
7 and then their questions are answered or
8 they have information to chew on. We
9 have no set appointment. But they may,
10 indeed, return again a couple of months
11 later asking more questions or having
12 resolved it, or something else comes up
13 for which, again, they are confused. I
14 can't say that it's a current patient of
15 mine, because we don't have regularly --
16 regularly set appointments, but the
17 number of people that I have seen
18 continues to accumulate.

19 Q. So in the last -- so in the
20 last three months, you have seen another
21 six to eight transgender patients between
22 the ages of 16 and 18?

23 MR. RAMER: Objection to the
24 form. Asked and answered.

25 A. Again, I can't automatically or

1 easily say who does and does not count as
2 a transgender patient. That assumes a
3 conclusion that the person is still
4 exploring. They don't know what's right
5 for them. They don't appreciate the
6 other alternatives. They have to test
7 and try them out for themselves, and
8 neither I nor when I see them, they, know
9 what the answer is going to be. They are
10 testing it out.

11 So who does and doesn't count
12 as transgender is not easily or
13 dichotomously decided. But I am, on a
14 very regular basis, asked questions by
15 people, their families, their clinicians,
16 about the possibilities for any
17 particular one. So to say this was a
18 transgender patient and that one wasn't,
19 any clinic is willing to do that. But
20 for the complicated cases where people
21 are asking questions and there are
22 several different possibilities, those
23 are the ones where they tend to call me
24 in for a little while.

25 Q. In the last three months how

1 many patients under the age of 18 have
2 you seen?

3 A. Again, these would be the same
4 group of six-ish to eight-ish. Again, I
5 would have to check my notes for the
6 exact cutoffs in numbers, but they would
7 be the same. They would be the same
8 people.

9 The only cases of that age
10 range that I am asked about are the ones
11 for whom there is some -- it's somewhere
12 in the mix, the person isn't trusting the
13 feedback or they don't think that they
14 would get honest or accurate feedback
15 from -- from their regular clinicians.

16 And it's the ongoing basic, you
17 know, regularly scheduled appointments
18 are the folks 25 and up with a relatively
19 well demarcated set of issues that they
20 wanted to discuss and address.

21 Q. And these six to eight patients
22 under the age of 18 that you've seen in
23 the last three months, have you
24 personally seen them or have these been
25 issues where another doctor has asked you

1 to consult without interacting with the
2 patient directly?

3 MR. RAMER: Objection to the
4 form.

5 A. Those would be people that I
6 had seen myself. And sometimes, again, a
7 mix.

8 It starts by a question or
9 consultation from a particular person.
10 Then I, myself, would see the patient,
11 have my own conversation with them. And
12 either depending on what the case needs,
13 you know, provide my feedback to the
14 person, him or herself, to their family
15 as appropriate or to their clinicians and
16 providers as appropriate.

17 Q. Okay. Just to make sure I
18 understand. So prior to June of this
19 year, you had seen over the course of
20 your career eight transgender patients
21 between the ages of 16 and 18 and then in
22 the last three months you've seen another
23 six to eight transgender patients between
24 the ages of 16 and 18?

25 MR. RAMER: Objection to the

1 form.

2 A. That is roughly correct.

3 Again, I would have to check my calendar
4 for more precise numbers, but that's
5 roughly it.

6 Q. Okay.

7 MR. MAY: We have been going
8 about an hour, so I think now may be a
9 good time to go ahead and take a
10 five-minute break.

11 THE VIDEOGRAPHER: Thank you,
12 counsel, this is the videographer, the
13 time is 11:07, this ends media file
14 one.

15 (Off the record.)

16 THE VIDEOGRAPHER: We are back
17 on the record. The time is 11:13,
18 this begins media file two.

19 BY MR. MAY:

20 Q. Dr. Cantor, with reference to
21 those six to eight patients under the age
22 of 18 that you have seen in the past
23 three months, have any of those patients
24 come to you believing them to be trans,
25 believing themselves to be trans and you

1 disagree with that assessment?

2 MR. RAMER: Objection to the
3 form.

4 A. I don't think any really.
5 Again, it's the more complicated, unsure,
6 could go in many different directions,
7 kinds of cases that come to me.

8 People who are convinced,
9 settled, unquestioning about their
10 situation or their self-labeling, I
11 accord their self-labeling, you know, I
12 don't know if I can call myself a public
13 figure, but I mean my scientific analysis
14 and background and so on are at this
15 point, you know, sometimes very
16 positively, sometimes very negatively,
17 depending on the writer, described. And
18 patients, people, clients, the public
19 very purposefully self-select who they
20 want to see and why.

21 If a person does not want to be
22 questioned, they are not going to come to
23 me because I have a -- because I am
24 perceived to be asking exactly those very
25 challenging questions.

1 If the family, the situation,
2 are seeking only affirmation, you know, I
3 am going to have a very long list of
4 questions and explorations ahead of that.
5 They won't come to me for that.

6 When it's the not so sure and
7 there are other factors involved, and
8 it's unclear and they specifically want
9 to avoid an automatic presumption of, oh,
10 you're asking questions about
11 transgender, you're a transgender kid,
12 da, da, da, all you need is to be able to
13 understand the terms of the document they
14 are signing. Like I say, they don't come
15 to me.

16 They come to me when there are
17 more complications to the case. So I
18 really don't get presented -- people who
19 feel like they're sure don't come to me
20 to begin with.

21 Q. Have you diagnosed any of these
22 six to eight individuals under the age of
23 18 with gender dysphoria?

24 A. I haven't needed to because of
25 the way the healthcare system, the health

1 insurance and mental health insurance
2 coverage works here in Canada, people
3 don't require a diagnosis in order to
4 obtain that coverage. And because the
5 people coming to me are not or at least
6 not yet on track for medicalized
7 transition, again, they don't need a
8 diagnosis.

9 So as I say, typically the
10 sessions are aimed at helping the person
11 ask questions, ask themselves questions.
12 Things to explore. The final diagnosis
13 wasn't -- they needed me to help ask
14 questions, not provide them an answer.

15 We would usually give a
16 diagnosis or I would give, in this
17 context, would give a diagnosis if the
18 diagnosis is needed for a specific
19 purpose.

20 In the U.S. very often that is,
21 as I say, for insurance purposes or if
22 the person is specifically on track to
23 being medicalized, then depending on
24 their immediate circumstances, they
25 require a formal diagnosis. But I don't

1 get cases where that's -- where that's
2 part of the clinical need.

3 A diagnosis -- assigning or not
4 assigning a diagnosis is not a synonym
5 for coming to a conclusion. It's not --
6 we will continue to have whatever
7 sessions we will have until you get a
8 decision, you get an official diagnosis
9 or rule out. That's just not how it
10 works.

11 In standard, routine, mental
12 health practice, as I say, over the
13 course of therapy, somebody has some
14 questions. To take a non-sexual example.
15 Somebody is unhappy. Whatever is going
16 on in their personal life or professional
17 life and they want feedback or discuss
18 through whatever the issue is and that's
19 what we do with the client. So whether
20 the person actually merits a diagnosis
21 of, for example, depression or not, well,
22 that's just not the issue. One needs
23 that diagnosis only when that diagnosis
24 and to put it on a person's formal
25 record, if it will be of use somehow to

1 whatever the person's situation is.

2 Again, in the U.S., sometimes
3 such a diagnosis is needed in order to
4 qualify for insurance in the U.S., but
5 the diagnosis doesn't change what's going
6 on in the therapy sessions themselves,
7 which is the check-in, the feedback, the
8 practicing whatever skills, life skills,
9 social skills that the person is coming
10 in asking for.

11 Q. So just to be clear, you did
12 not diagnose any of these six to eight
13 individuals that you seen in the last
14 three months with gender dysphoria,
15 correct?

16 MR. RAMER: Objection to the
17 form. Asked and answered.

18 A. I don't think there -- I can't
19 answer that in a yes or no without,
20 again, unpacking some of the -- the way
21 you phrased the question, had I
22 diagnosed. I guess there are no means --
23 can mean two different things and I mean
24 one of them and not the other.

25 To say I did not diagnose, in

1 that I did not actually engage in the
2 activity and record a diagnosis in the
3 person's formal file. But that shouldn't
4 be taken to mean that I withheld the
5 diagnosis or said that the person
6 qualifies for a different diagnosis or
7 disagreed with an already assigned
8 diagnosis.

9 It's that the person's
10 diagnosis or a diagnostic description of
11 the person's situation was not the
12 clinical question. It just wasn't
13 pertinent to the case.

14 Q. So you did not diagnose any of
15 these six to eight individuals that
16 you've seen in the last three months with
17 gender dysphoria, correct?

18 MR. RAMER: Objection to the
19 form. Asked and answered.

20 A. There is no accurate yes or no.
21 The question -- as a matter of fact, the
22 question is logically identical to did
23 you -- "Have you stopped beating your
24 mother"; neither a yes nor a no is an
25 accurate response. It was never the

1 question. The question was that the
2 person was unsure and needed help
3 figuring out whatever their situation
4 was -- whatever their situation was.
5 Psychoeducation, as we call it,
6 demonstrating the different
7 possibilities.

8 So I was never -- the only
9 accurate answer is that I have never been
10 asked whether a diagnosis is appropriate
11 to a person in the recent cases that
12 we're discussing.

13 Q. Of those recent cases, have you
14 ever concluded that they met the criteria
15 for gender dysphoria as defined in the
16 DSM?

17 A. None of these kids really were
18 at a point where I, one, where a person
19 could come to a conclusion. These were
20 ongoing exploration, seeking
21 alternatives, need to get other issues
22 resolved before anybody could say
23 anything about the person. So none of
24 them did I really have any kind of
25 conclusion in either direction.

1 For lack of a better phrase,
2 they were all works in progress.

3 Q. So you didn't reach a
4 conclusion for any of these six to eight
5 individuals that they met the criteria
6 for gender dysphoria as defined in the
7 DSM?

8 MR. RAMER: Objection to the
9 form. Asked and answered.

10 A. Again, that's another "Did you
11 stop beating your mother." It was never
12 an intent. It was never a question put
13 to me.

14 Well, that's not exactly true.
15 I think people hoped to have a nice,
16 clean answer yes or no. But part of the
17 clinical conversation is that these
18 questions don't have a clear cut yes or a
19 no. So to say did not come to a
20 conclusion, again, kind of has packed
21 into it, could not come to or would not
22 come to, as opposed to the kinds of
23 questions and complicated cases that
24 require what we call tertiary care aren't
25 conclusive. It's like saying, "Have you

1 finished exercising?" Well, no, that's a
2 lifelong, ongoing, it's not a kind of a
3 task that one finishes.

4 Q. Were any of these six to eight
5 individuals that you've seen in the last
6 three months already diagnosed with
7 gender dysphoria?

8 A. It's possible that a prior
9 clinician gave a diagnosis, but none of
10 the cases were along the lines, a person
11 came in with a diagnosis and the patient
12 or their family were challenging it or
13 asking questions or wanted somebody to
14 disagree with it, and so none of them
15 were those kinds of cases.

16 But given the background and
17 the questioning, there were people who
18 were indeed unsure or not convinced by
19 what was said by a prior clinician, but I
20 don't know for sure if the assessment
21 that the person received included
22 specific DSM or ICD code and so on. So
23 it's possible. But again, that wasn't
24 really the question put to me.

25 Q. You mentioned these patients

1 were coming to you seeking alternatives;
2 what do you mean by that?

3 A. I don't know if I said so much
4 they came in seeking alternatives so much
5 as the simple dichotomous black and white
6 answers that they were receiving or
7 responses they were receiving just didn't
8 seem to fit or help or feel right, so
9 they were looking for something else.
10 Because the, as I said, dichotomous
11 simple answer they had just wasn't --
12 wasn't working for them. The person
13 wasn't feeling any better. Wasn't making
14 any progress. It didn't change anything
15 for them.

16 So they knew they needed
17 something. Or at least they felt there
18 were issues being left unaddressed. So
19 by presenting, exploring, considering
20 other possibilities and other situations
21 that exist in the sexual world beyond
22 the, I can only say almost cookie cutter,
23 cookie cutter, all one size fits all --
24 what's the word I am looking for -- not
25 superficial.

1 These are situations where the
2 kids or their families could perceive
3 that there were complexities and
4 unanswered questions, but when they
5 receive a simplified dichotomous answer
6 that didn't answer all of their
7 questions, they knew there was stuff left
8 unexplored or unexplained and -- loose
9 ends that just didn't fit in. So the
10 persons wanted -- knew that something was
11 missing. And so by discussing with the
12 kid or their families the broader world
13 that exists, gave them extra food for
14 thought, things to explore, possibilities
15 to try on as they more genuinely explore
16 who they are rather than be given what's
17 almost a social media script that they
18 try to push onto themselves in order to
19 have a very simple kind of answer. But I
20 wouldn't say they exactly came in looking
21 for alternatives.

22 There wasn't a situation --
23 there wasn't a situation where somebody
24 came in saying that they, I don't want to
25 transition or do want to transition, or

1 the family does or doesn't, so they came
2 in -- they came in asking me what is
3 something else they could do.

4 The questions were much more
5 along the lines of the simple reflexive,
6 superficial answers just didn't -- they
7 didn't feel their primary clinician or
8 previous clinicians were getting them.
9 They were just getting fed a boilerplate.
10 That's the word I am looking for. They
11 were getting a boilerplate report, if you
12 answer yes to any of these you're
13 transgender and off to the races, as
14 opposed to, no, this person has a more
15 complicated, deeper nuance. There is
16 other stuff going on that needs to be
17 addressed, integrated, attempted,
18 experimented with, explored.

19 Q. What was the natal or
20 biological sex of these six to eight
21 individuals that you have seen in the
22 past three months?

23 A. Roughly half and half, bio male
24 and bio female.

25 Q. Have you ever diagnosed anyone

1 under the age of 18 with gender
2 dysphoria?

3 A. That's a bit complicated,
4 again, by the nature of the kind of, the
5 clinics, I am thinking now about KMH.

6 The clinics that I have been a
7 part of, in the Canadian healthcare
8 system, within the hospital system, and
9 within the clinic where I was, these were
10 teen-based assessments and teen-based
11 diagnoses. So in such cases, I would
12 write a report and recommend or not -- or
13 recommend the ruling out -- the ruling
14 out of diagnoses.

15 But again, the process used up
16 here, the formal diagnosis, the diagnosis
17 of record that's recorded by the hospital
18 has to be assigned by an M.D. Again,
19 that's just the nature of the -- of how
20 the health insurance system up here
21 works. So it kind of depends on how you
22 count it. I am the one who did the
23 assessment. But the person's name, I was
24 going to say on paper, really on the
25 computer is the M.D., who was the head of

1 the team even though the M.D. that was
2 the head of the team never saw the
3 patient.

4 Q. Have you ever recommended
5 anyone under the age of 18 be diagnosed
6 with gender dysphoria?

7 A. Yes.

8 Q. How many times?

9 A. Oh, goodness. Five or six.

10 Q. What were the ages of five or
11 six patients that you recommended a
12 diagnosis of gender dysphoria for?

13 A. Again, 16 to 18. My hesitation
14 is, again, in the context of the clinic
15 and how things worked in that clinic, is
16 that these were ongoing -- these were
17 ongoing cases.

18 And the typical situation is
19 the person would come in for their
20 initial assessment. They would very
21 often get either no diagnosis or a
22 provisional diagnosis. It was relatively
23 rare to get a diagnosis off the bat; not
24 because the symptoms weren't present, but
25 because, you know, a proper assessment

1 requires observing the person over time
2 and being able to document that the
3 symptoms were persistent and consistent,
4 and you can't tell if something is
5 persistent and consistent after a single
6 assessment.

7 The routine procedures were to
8 see the person once every several months
9 to update -- to update the record. To
10 add anything that wasn't -- that wasn't
11 there before.

12 So in some cases I was the
13 initial or one of the initial, it usually
14 was a two-clinician, two appointments
15 each with a different clinician for each
16 case. So in some cases I would be one of
17 the initial assessors.

18 And again, we would never give
19 a formal diagnosis. It would be, you
20 know, at the most stringent provisional
21 diagnosis. Then one of the follow-up
22 appointments or one of the repeat
23 appointments we now have whatever
24 documentation in order to be able to
25 demonstrate the consistency and

1 persistency. So then a provisional
2 diagnosis could either be assigned at one
3 of the subsequent appointments or a
4 provisional diagnosis could then be
5 advanced or a recommendation for it to be
6 advanced to a formal diagnosis.

7 So as I say, the system and the
8 assessment procedure when performed, you
9 know, properly, by "properly" I mean
10 according to the clinical evidence, is
11 not just come in, you get a blood test,
12 okay, you tested positive for gender
13 dysphoria, that's the diagnosis. Send
14 you home to the races. That's one of the
15 things that make psychiatry and mental
16 health diagnoses entirely unlike actual
17 medical diagnosis in which there is
18 physical evidence.

19 Q. Did any of these five or six
20 patients for whom you recommend a
21 diagnosis of gender dysphoria ultimately
22 receive hormone therapy?

23 A. Yes.

24 Q. How many?

25 A. I didn't see all of them -- I

1 didn't always see them long enough term
2 to be sure, but I think all of them.

3 Q. Did KMH support that provision
4 of hormone therapy to those five or six
5 individuals?

6 MR. RAMER: Objection to the
7 form.

8 A. Yes.

9 Q. Did you personally support the
10 provision of hormone therapy to those
11 five or six individuals?

12 MR. RAMER: Objection to the
13 form. Vague.

14 A. Depends on what you mean by
15 "support." It was entirely appropriate
16 to the person's mental health status and
17 well-being. But it's not, the mental
18 health assessment is not the only part of
19 the assessment. It also takes an
20 endocrinological and more purely medical
21 diagnosis.

22 So I supported the facet of it
23 that I am qualified and able to do. But
24 mine isn't the only equation in the mix
25 and of course the other clinicians and

1 M.D.s at KMH also have to contribute
2 their part to it.

3 Q. Were those individuals under
4 the age of 18 when they started hormone
5 therapy?

6 A. Generally not. I don't
7 remember for sure if there were
8 exceptions. There could have been at
9 that time. But as I say, they were --
10 they were exceptions.

11 Q. When you say at that time, what
12 was the time frame in which you
13 recommended diagnosis for these five to
14 six individuals under the age of 18 with
15 gender dysphoria?

16 A. The early 2000s.

17 Q. Do you remember when the last
18 time it was that you recommended a
19 diagnosis of someone under the age of 18
20 for gender dysphoria?

21 A. Would have been the same --
22 would have been the same period. As I
23 say, in the cases that I am being asked
24 about or the people that I am seeing more
25 recently, that's not the question. They

1 are coming to me with questions. And
2 they are not coming to me already having
3 decided on their way and just need to
4 pull the paperwork together in order to
5 accomplish it.

6 Q. And you never diagnosed or
7 recommended a diagnosis for anyone under
8 the age of 16 for gender dysphoria,
9 correct?

10 A. Or anything else, that's
11 correct. As an adult psychologist, I
12 tend to get, again, the cases for whom --
13 for whom adult-related issues seem to be
14 kicking in early. But, you know, I am an
15 adult psychologist.

16 Again, it's part of sex and
17 couples -- sex and couples therapy.

18 Q. You don't have a medical
19 degree, correct?

20 A. That is correct.

21 Q. And you're not an
22 endocrinologist?

23 A. That is correct.

24 Q. You've never prescribed
25 personally puberty blockers or puberty

1 suppressors?

2 A. That is correct.

3 Q. And you've never prescribed
4 hormones for hormone therapy for trans
5 individuals, correct?

6 MR. RAMER: Objection to form.

7 A. Or anybody else, that is
8 correct.

9 Q. And all of these patients that
10 we have been discussing today, these have
11 all been patients that you saw in Canada?

12 A. Yes, that is correct.

13 Q. And you have never seen a
14 patient in the United States, correct?

15 A. Correct. Again, my
16 hesitation -- I am trying to think if
17 there is an exception. I have never had
18 a face-to-face or video -- the cases in
19 the U.S. have been consultations with
20 their clinicians. But I haven't seen
21 a -- myself seen or directly or video
22 directly, had clinical contact with a
23 client in the U.S., with a client in this
24 family of issues in the U.S.

25 Q. If you can pull up Exhibit 2

1 again, which is your CV.

2 A. Got it.

3 Q. All right. And if you would go
4 to page 3 of your CV for me. The heading
5 is "Publications"?

6 A. Yes.

7 Q. So this first section of
8 publications, there is 65 entries; is
9 that right? I believe it continues on
10 through page 7.

11 A. That looks correct, yes.

12 Q. Are these all peer-reviewed
13 publications in this section?

14 A. I think eventually I combined
15 the two lists. I used to keep them
16 separate. And I added maybe six of
17 these-ish are book chapters. For
18 example, the first one listed, my chapter
19 in the Oxford Textbook of
20 Psychopathology. I would have to go
21 through them and look. But I think six
22 of them were outside of the -- outside of
23 journals, peer-reviewed journals.

24 Q. So fair to say these are
25 peer-reviewed articles or book chapters?

1 A. Yes, again, I would have to
2 look through to double-check. But, yes,
3 essentially.

4 Q. And it looks like those first
5 two entries relate to gender, gender
6 dysphoria, transgender issues; is that
7 fair?

8 A. Yes. Well, the Shirazi one is
9 also pertinent, but not directly but
10 indirect. Has obvious implications for
11 medical care of transgender people. But
12 it wasn't of transgender people.

13 Q. Another article that I saw that
14 referenced gender identity, transgender
15 issues in this list of publications here
16 is entry number 54.

17 MR. RAMER: Is there a question?

18 Q. Sorry, are there any other --
19 is that right?

20 MR. RAMER: Objection to form.

21 A. That one --

22 Q. You know what? That was a bad
23 question. So let me ask it over again
24 from the start.

25 Entry number 54 is an article

1 about gender identity, gender issues; is
2 that fair?

3 A. Yes, very explicitly.

4 Q. Aside from entries number 2,
5 possibly 3 and number 54, are there any
6 other peer-reviewed journal articles that
7 pertain to gender identity or gender
8 issues in this area?

9 A. Although a straightforward
10 question, it doesn't have a
11 straightforward answer.

12 The sex and gender issues are
13 strongly overlapping and again don't chop
14 apart quite so neatly. As I gave in
15 relative detail in my report, one of the
16 aspects -- late onset or adult onset
17 transgenderism is motivated primarily,
18 some would say exclusively, by a specific
19 paraphilia called autogynephilia,
20 A-U-T-O-G-Y-N-E-P-H-I-L-A. The
21 paraphilias, all of those highly atypical
22 sexual interest patterns, strongly
23 overlap. Somebody with one is very
24 likely to have another. The available
25 brain imaging evidence we have, again,

1 demonstrates that for the adult onset
2 cases, these are strongly overlapping.

3 So any information about any
4 one of the paraphilias is highly, if
5 indirectly, relevant to the other
6 paraphilias which are in turn highly
7 relevant to what we know about adult-
8 onset gender dysphoria. The child-onset
9 gender dysphorias are strongly
10 overlapping from neuroimaging on down to
11 homosexuality and sexual orientation.

12 So research about sexual
13 orientation is, again, strongly
14 overlapping with gender identity, and you
15 can't meaningfully study one without the
16 other.

17 In the, I can't say modern era,
18 let me again say onset of social media
19 age, gender dysphoria has been the topic
20 of conversation and the lay public, and
21 unfortunately, you know, many of the
22 people who think of themselves as experts
23 on the topic collapse all of gender
24 dysphoria together and start treating
25 gender dysphoric youth as merely young

1 versions of adult -- of people with
2 adult-onset gender dysphoria even though
3 these are, in every objective variable we
4 have, unrelated phenomena.

5 So as I say, all of my research
6 is at least indirectly relevant, even
7 though they are not specific studies that
8 went out, tried to recruit a set of
9 people who are -- who are gender
10 dysphoric and to look at them and to
11 examine them.

12 The best analogy that I have is
13 with headaches. People are coming in,
14 "Doctor, my head hurts." Well, they are
15 reporting the same symptom. But it's not
16 competent care to say, "Ah, you have
17 headache disorder, here is the headache
18 pill." The proper treatment is to find
19 out what's causing the headache. A
20 migraine is not the same as a head
21 injury, is not the same as a brain tumor,
22 is not the same as an aneurism and so on,
23 even though people are describing, if
24 you're only asking does your head hurt,
25 the answer is yes. Okay, brain tumor.

1 Let's send you into brain surgery.

2 That's not how it works.

3 So then if somebody is asked me
4 how many of your publications were about
5 aneurisms, when I am instead publishing
6 mostly about brain tumors, well, you
7 can't study aneurisms without including
8 how you ruled out, for example, the
9 aneurism. You can't do one of these
10 without accounting for the others
11 simultaneously.

12 So as I say, they are not in
13 the superficially obvious, the way most
14 of the lay public think of it, studies
15 about gender dysphoria and go out and
16 recruit a sample. But one cannot come to
17 any meaningful conclusion about gender
18 dysphoria without the other, as I say,
19 paraphilias and sexual orientation-
20 related phenomena because that's what
21 gender dysphoria, to the best of
22 science's ability to demonstrate so far,
23 says how it breaks down.

24 Very much of the mistaken
25 perception that's being discussed is

1 gender dysphoria is gender dysphoria and
2 you just have to individualize it for the
3 person. But they are collapsing gender
4 dysphoria to a single phenomenon where
5 instead it's the most extreme versions or
6 end points of more than one unrelated
7 phenomena.

8 Q. Okay. So of your 65
9 publications, aside from the three that
10 we discussed, 2, 3 and 54, did any of
11 these peer-reviewed publications have as
12 an outcome measure or a research endpoint
13 something related to gender identity?

14 MR. RAMER: Objection to the
15 form.

16 A. No, I don't think so.

17 Q. Okay. The next section of your
18 publications, I guess I am just a little
19 confused as to the difference between a
20 letter and a commentary versus an
21 editorial.

22 Can you explain to how you draw
23 that distinction?

24 A. They are just different
25 journals give them different titles.

1 It's just part of the editorial style of
2 the particular journal.

3 I listed each of them because
4 the different journals that they appeared
5 in use different terms.

6 Q. And those are not peer-reviewed
7 articles, correct?

8 A. Correct.

9 Q. If we can turn to page 10 of
10 your CV, which discusses your funding
11 history.

12 A. I'm there.

13 Q. The first study listed here
14 under funding history lists you as a
15 coinvestigator for a grant titled "Brain
16 Function and Connectomics Following Sex
17 Hormone in Adolescents Experience Gender
18 Dysphoria"?

19 A. That is correct.

20 Q. Had you authored any papers
21 related to this grant?

22 A. No, it was since that time that
23 I left my formal academic role.

24 Q. And then the fourth entry here
25 is another, is a study where you are also

1 identified as a coinvestigator, titled
2 "Effects of Sex Hormone Treatment on
3 Brain Development: A Magnetic Resonance
4 Imaging Study of Adolescents With Gender
5 Dysphoria." Do you see that?

6 A. Yes.

7 Q. Have you authored any papers as
8 a result of this grant?

9 A. No, same, that is when I was
10 leaving academic life.

11 So of course, I was
12 participating in the design of the study,
13 coming up with the research questions,
14 because I had a background in, you know,
15 studying the -- I was actually one of the
16 first sex researchers using neuroscience,
17 or neuroscientists, you know,
18 investigating sex research, depending on
19 your point of view. Had do with
20 properly -- these were all overlapping,
21 it was my prior experiences in
22 publications investigating a different
23 sexual atypicality, of course pedophilia,
24 which I think was the first one of that
25 scale. So, of course, you know, my

1 contributions, it gave me a very, very
2 unique and experienced contribution for
3 them to apply that same information to
4 questions of gender dysphoria.

5 And then I left KMH. So I
6 just, you know, accepted an indirect
7 advisory, friendly way, these have been
8 friends and colleagues now for many
9 years, but I didn't have a -- I didn't
10 require a formal academic role or
11 authorship on the publications anymore.

12 Q. Of your remaining grants, four
13 relate to pedophilia; is that correct?

14 A. That sounds right.

15 Q. And one is related to
16 asexuality; is that correct?

17 A. Correct.

18 Q. So Dr. Cantor, you were
19 commissioned to write a report for the
20 Florida Agency For Healthcare
21 Administration in 2022; is that right?

22 A. I would have to check the
23 details of it, but that sounds about
24 right.

25 Q. I noticed that does not appear

1 to show up on your CV. And I am happy to
2 be told that I missed it, but do you know
3 where that appears on your CV?

4 A. I don't think I put it on my
5 CV. It wasn't meant to be an academic
6 contribution. I never intended to
7 publish it and so on.

8 Q. What do you mean by it was not
9 intended to be an academic contribution?

10 A. They asked me to review the
11 relevant information to their case, which
12 I did, for which I was hired. But it
13 wasn't something that, for example, I was
14 going to use to promote to full
15 professor. It wasn't something that I
16 was planning to publish independently in
17 a peer-reviewed journal.

18 Q. That study has not been
19 peer-reviewed; is that fair?

20 A. It wasn't a study. It was a
21 summary of the existing research for the
22 purposes of, for Florida's -- for the
23 purposes of the board, medical board in
24 Florida, I think was the -- I was going
25 to say plaintiff. The client. The

1 corporate client I'll call them.

2 Q. So that summary of existing
3 research for Florida, that has not been
4 peer-reviewed, correct?

5 A. Correct.

6 Q. Are there any other summaries
7 or similar works that you have done like
8 the summary that you did for the State of
9 Florida that are not otherwise reflected
10 on your CV?

11 MR. RAMER: Objection to the
12 form.

13 A. Only minor ones. In many ways
14 each of the reports that I've written for
15 the various cases, you know, each one is
16 an updated or expanded version of the
17 prior ones.

18 Chunks of that I might -- oh.
19 I guess what I am thinking is no,
20 although I circulate pieces of it when
21 somebody, whether it's a personal
22 journal, anyone asks me for the
23 information, I will take chunks of it
24 when it's relevant to their question.
25 But I am not recalling offhand any novel

1 or independent -- independent works. Not
2 that I -- I guess what I am saying, not
3 that I recall or these kind of overlap.
4 There is quite possible there is one
5 someplace that I am not thinking of, but
6 nothing major. Nothing in some large
7 formal public.

8 MR. MAY: Rob, can you please
9 mark tab 3 as the next Exhibit, which
10 I believe is Exhibit 4.

11 (Exhibit 4, Transcript of Dr.
12 Cantor's testimony in Loe versus Texas
13 was so marked for identification, as
14 of this date.)

15 MR. BENIMOFF: Okay. It's been
16 marked, so please refresh.

17 Q. Dr. Cantor, let me know when
18 you have Exhibit 4 pulled up.

19 MR. MAY: Let's go off the
20 record and try to resolve the
21 technical issue.

22 THE VIDEOGRAPHER: This is the
23 videographer, the time is 12:02, we
24 are going off the record.

25 (Off the record.)

1 THE VIDEOGRAPHER: We are back
2 on the record. The time is 12:03,
3 this begins media file three.

4 BY MR. MAY:

5 Q. Dr. Cantor, you have Exhibit 4
6 open in front of you right now?

7 A. Yes.

8 Q. And you see this is a document
9 entitled "Reporter's record in a case
10 titled Lazaro Loe, bunch of individuals
11 versus the State of Texas, versus some
12 other individuals related to a Hearing
13 For Application For Temporary Injunction
14 and Plea to the Jurisdiction"?

15 A. Yes.

16 Q. Do you recall giving testimony
17 in the context of this case, Loe versus
18 Texas, in August of this year?

19 A. Yes, I do, again, with the
20 caveat that these cases are essentially
21 interchangeable in my head, but I
22 remember that I did one for Texas and
23 this kind of looks like it. But it's
24 easy for me to confuse one case for
25 another.

1 Q. And does this appear to be the
2 transcript of your testimony from that
3 hearing?

4 A. It appears to be by it's
5 content, yes.

6 Q. Were you truthful during your
7 testimony that you gave in the case of
8 Loe versus Texas?

9 A. Yes, I was.

10 Q. And did you do your best to
11 answer those questions honestly?

12 A. Yes, I did.

13 Q. And you did your best to answer
14 your questions honestly regardless of
15 whether they came from plaintiff's
16 counsel or defendant's counsel?

17 A. That is correct.

18 Q. You can go ahead and put that
19 aside for right now. I wanted to go to
20 your declaration, Exhibit 1. And look
21 at -- and if you can go to paragraph 16
22 of your declaration, which I believe is
23 on page 7?

24 A. Yes, I have it.

25 Q. So in -- sorry, I am having a

1 struggle on my end now.

2 In the second sentence from the
3 bottom of paragraph 16, the paragraph in
4 general -- strike that and let me start
5 that over.

6 You agree this paragraph is
7 discussing international approaches to
8 provision of gender-affirming medical
9 care to trans youth?

10 MR. RAMER: Objection to the
11 form.

12 A. Yes, although just the way you
13 use the word "international" in that
14 particular sentence, it's not as if any
15 one of these spans multiple nations. So
16 it's not international in that sense.
17 But it means not limited to the U.S.

18 Q. Sure. I agree with that
19 characterization as well.

20 So you see the second-to-last
21 sentence of paragraph 16 reads that
22 "These range from medical advisories to
23 outright bans on the medical transition
24 of minors."

25 Do you see that?

1 A. Yes.

2 Q. And the pronoun "these" there
3 is referring to the non-American
4 approaches that you go on to discuss in
5 your declaration; is that fair?

6 A. Yes.

7 Q. Which countries have outright
8 bans on the medical transitions of
9 minors?

10 A. Finland, Sweden, Norway and the
11 U.K. have essentially banned it except
12 for research purposes.

13 Q. Just to be clear, what do you
14 mean by the words "outright ban"?

15 A. That general practitioners
16 aren't permitted to engage in these
17 procedures. That if ever they are going
18 to be done, as I say, there are
19 exceptions, that the agreed-upon therapy,
20 given the current state, the agreed-upon
21 interventions, given the current state of
22 the science is to use psychotherapy and
23 mental health -- well, psychotherapeutic
24 interventions.

25 Q. Are there circumstances under

1 which someone under the age of 18 can
2 obtain medical transition in Finland,
3 Sweden, Norway and England?

4 A. Can obtain, again, that
5 requires kind of some unpacking.

6 The state of the science and
7 what, you know, each of those healthcare
8 systems have concluded is that, you know,
9 there does not exist -- to do this with
10 minors is extremely new, unknown and we
11 don't have the kind of evidence that
12 would support the risk-to-benefit ratio
13 for its use as a general part of medical
14 care.

15 But it continues to be possible
16 that if, for example, we got better at
17 diagnosing or identifying who would
18 versus would not benefit from early
19 interventions, it's possible that that
20 might change in the future.

21 So if somebody is participating
22 in a research study that includes this,
23 then such a person, you know, that way
24 could obtain it depending on -- could at
25 the moment -- I shouldn't say at the

1 moment. Could potentially obtain it.
2 But that's different -- but because these
3 are part of, for the most part, at the
4 moment, hypothetical research projects
5 that haven't yet been designed, funded,
6 substantiated and begun, we don't know
7 what the content of those research
8 projects are or what situations those --
9 the government policies are to permit,
10 permit whatever relevant research needs
11 to be done.

12 Research projects and the
13 participants in any research project, you
14 know, have to go through a set of
15 inclusion and exclusion criteria. Now,
16 those inclusion and exclusion criteria
17 change from study to study and project to
18 project, according to whatever the
19 research project is. So if a person who
20 thinks that they would benefit, you know,
21 cannot, as if they were undergoing some
22 other procedure, walk in, request, and
23 say you have this official diagnosis,
24 therefore you can now get the -- whatever
25 the -- whatever the intervention is.

1 These are not clinics where they are
2 saying this is the treatment for that
3 diagnosis, therefore if you walk in and
4 say these symptoms you will get that
5 treatment. Whatever goes on, whatever
6 treatment is available is whatever
7 treatment is under investigation by that
8 particular clinic, and whoever qualifies
9 for whatever inclusion and exclusion
10 criteria.

11 Although the government
12 policies, any government's policy changes
13 very slowly and, in theory, does its best
14 to respond to the content of the
15 research. The content of the research
16 itself is always advancing. If the --
17 whatever, five years from now the general
18 conclusion is we tested it, none of this
19 worked, no point of doing anymore
20 experiments, that's it. No more
21 research, no more experiments, and the
22 government policy doesn't change. But it
23 is no longer possible to obtain under any
24 circumstances that treatment because
25 there is no ongoing research and there is

1 no government law saying scientists must
2 investigate this.

3 If, you know, on the flip side,
4 the science starts revealing that, ah,
5 now we can identify people of this
6 profile have whatever probability of
7 benefiting or people from that profile
8 have whatever probability of benefiting,
9 then they can modify -- any institution
10 can modify the conditions under which the
11 next research project can -- can perform
12 their inclusion/exclusion criteria or say
13 that it's time to change the medical
14 policy, medical policy itself.

15 So to say whether a person can
16 get it. Well, a person can't get it in
17 the way that they can get routine or
18 standard -- routine or standard
19 interventions.

20 I guess a legitimate comparison
21 would be there exists various substances,
22 controlled substances. They are illegal
23 for generic commercial recreational
24 purposes. But -- oh, possession of
25 cocaine is illegal. But for certain, you

1 know, research purposes, you know,
2 certain scientists can legitimately and
3 legally obtain cocaine for whatever
4 research purpose -- whatever the research
5 purpose is. So cocaine is banned, but
6 there are exceptions for certain research
7 purposes. But that's very different from
8 saying a person can go obtain cocaine.
9 Well, no, that's not an accurate
10 description of the situation.

11 So as I say, the presence of
12 exceptions does not void the rule to
13 which it's an exception.

14 Q. So in these countries under
15 research protocols, individuals under the
16 age of 18 can obtain -- can obtain
17 medical transition?

18 MR. RAMER: Objection to the
19 form.

20 A. That phrase suggests a
21 generality that's not true. I don't know
22 how better to phrase it other than to
23 repeat that there can be exceptions. But
24 that there are exceptions to a ban
25 doesn't mean that there is not a ban.

1 Q. Can we turn to --

2 MR. RAMER: If, Philip, if this
3 is a stopping point, I think we have
4 been going about an hour. May be time
5 for a break.

6 MR. MAY: I am fine taking a
7 break now. So let's go off the
8 record.

9 THE VIDEOGRAPHER: Thank you.
10 The time is 12:16, we are going off
11 the record.

12 (Off the record.)

13 (Lunch recess: 12:16 p.m.)

14

15 Afternoon Session

16 1:00 p.m.

17 J A M E S M. C A N T O R, having been
18 previously duly sworn, was examined and
19 testified further as follows:

20 THE VIDEOGRAPHER: Good
21 afternoon. We are back on the record.
22 The time is 1 p.m., and this continues
23 media file 3.

24 EXAMINATION (Continued) BY MR. MAY:

25 Q. Dr. Cantor, if you could please

1 turn to Exhibit 1, which is your
2 declaration.

3 A. I have it.

4 Q. And please turn to paragraph
5 20.

6 A. I am there.

7 Q. Paragraph 20 in your
8 declaration is discussing the current
9 policies in England; is that correct?

10 A. Yes.

11 Q. You agree that England will
12 permit the use of the puberty blockers in
13 the context of a formal research
14 protocol?

15 A. Yes, that is the exception to
16 their ban.

17 Q. And you agree -- so you agree
18 that they will allow the use of puberty
19 blockers in the context of a formal
20 research protocol, correct?

21 MR. RAMER: Objection to the
22 form. Asked and answered.

23 A. Well, that's the nature of the
24 exception, but that's a blanket -- but
25 it's not a blanket permission. The

1 research protocols themselves come with
2 strings attached isn't exactly the right
3 phrase. But as I said, all of the
4 exceptions, the exceptions are limited to
5 those within research but that doesn't
6 mean that every research proposal or
7 anything that's called research,
8 therefore, is able to do anything it
9 wants. The approval of a research
10 project requires its own applications and
11 supervisions and comes with --

12 Q. And I appreciate that and that
13 wasn't my question. My question was
14 England will permit the use of puberty
15 blockers in the context of a formal
16 research protocol, correct?

17 MR. RAMER: I am going to object
18 to the form. Asked and answered. And
19 also ask that the witness be allowed
20 to finish his response.

21 A. The particular phrasing you use
22 suggests a greater latitude than the
23 policy. The policy is limited to
24 research proposals. But to just say
25 allows it in research proposals excludes

1 all of the other limitations,
2 responsibilities, supervision. It's not
3 -- one can't merely declare we have a
4 research project and, therefore, it's
5 permitted. It changes the -- like with
6 my prior analogy with cocaine, it's
7 banned. There can be, you know,
8 exceptions within research. But that
9 doesn't mean anybody can produce any kind
10 of a research project or something that
11 might pass as a research project and,
12 therefore, and therefore restart it. As
13 I say, we don't know the results of what
14 the research is going to be. If the
15 research shows that it doesn't actually
16 cause, produce benefits that outweigh the
17 risks, then nothing will get past a
18 research ethics board and the ban will
19 then be complete except for a technical
20 possibility that science is never done
21 and somebody might think of something,
22 something in the future. So it leaves
23 itself at that exception, but to talk
24 about that exception broadly across all
25 potential research projects doesn't

1 capture the situation.

2 Q. Sure. And Dr. Cantor, I am not
3 talking about every single possible
4 research protocol. I am just asking you
5 what I think is a pretty simple question.
6 You agree that in England it is
7 permissible under certain circumstances
8 for a person under the age of 18 to
9 obtain puberty blockers in the context of
10 a formal research protocol?

11 MR. RAMER: Objection to the
12 form. Asked and answered.

13 A. Again, the phrasing assumes a
14 certain patient or client initiation of
15 the situation as opposed to a
16 research-driven project. A researcher
17 has a project for which they will look
18 for a certain kind of patient who will
19 qualify for the research project. If a
20 person believes that they fit those
21 inclusion and exclusion criteria, they
22 can volunteer to join the research
23 project, which is unlike a patient coming
24 in and asking and then seeing if there is
25 a research project that matches what the

1 patient wants.

2 Q. Okay. Can you -- assume for
3 the purposes of my next question that
4 there is a research protocol in place in
5 England that has, that is looking to
6 study the impact of puberty blockers on
7 individuals under the age of 18.

8 In the context of such a
9 research protocol, you agree it is, that
10 an individual under the age of 18 would
11 be able to be prescribed puberty blockers
12 in the context of that protocol?

13 MR. RAMER: Objection to the
14 form.

15 A. The word that's missing before
16 I could say yes would be that it's
17 possible.

18 Q. Sure. And that's the point of
19 the hypothetical. You agree that in the
20 event there is a research protocol
21 looking to study the impact of puberty
22 blockers on individuals under the age of
23 18, an individual under the age of 18
24 would be able to be prescribed puberty
25 blockers in the context of that protocol

1 in England?

2 MR. RAMER: Objection to the
3 form. Asked and answered.

4 A. Again, I can't really sign onto
5 that without the word "possible."
6 Without that, again, it's broader than
7 how research happens. Especially with --
8 especially it would be perfectly
9 reasonable and perfectly legitimate --
10 such research happens a step at a time.
11 For example, they could start with
12 whatever age range or one sex and not the
13 other sex.

14 Q. Dr. Cantor, and I appreciate
15 all of that and your counsel will have
16 the opportunity to ask you questions to
17 clarify. But I am really asking you to
18 focus on my hypothetical question that I
19 posed to you.

20 And my hypothetical question
21 that I've posed to you is a research
22 protocol looking to study the impact of
23 puberty blockers on individuals under the
24 age of 18.

25 Is it possible for an

1 individual under the age of 18 to then be
2 prescribed puberty blockers in the
3 context of that research protocol in
4 England?

5 A. Is it possible, yes.

6 MR. RAMER: Objection to the
7 form. Asked and answered. And object
8 again to counsel cutting off the
9 witness's response.

10 Q. Does England criminalize
11 doctors for providing puberty blockers to
12 individuals under the age of 18?

13 MR. RAMER: Objection to the
14 form. Vague.

15 A. I don't recall their using
16 their criminal process. Of course, it's
17 very difficult to compare -- it's
18 essentially impossible to compare that
19 level of detail in the U.K. system and
20 the public healthcare system with the
21 U.S. lack of a medical system, you know,
22 and, of course, the legislatures and
23 decision-makers have a very different set
24 of tools available to them.

25 Q. So you don't recall whether or

1 not it is a crime for doctors to provide
2 puberty blockers to individuals under the
3 age of 18?

4 MR. RAMER: Objection to the
5 form. Asked and answered.

6 A. I don't recall the report
7 indicating that they use their criminal
8 system to do it. But I don't follow the
9 -- as I say, I don't follow the details
10 of their legal system. I follow the
11 science itself.

12 Q. If you can turn to paragraph 24
13 of your declaration, Exhibit 1?

14 A. I am there.

15 Q. Looking towards the part of the
16 paragraph that is on page 11 it reads
17 "They" meaning Finland "Restricted the
18 procedures to their centralized research
19 clinics."

20 Do you see that?

21 A. Yes.

22 Q. So you would agree that in
23 Finland, the provision of puberty
24 blockers or cross-sex hormone treatment
25 has been restricted to their centralized

1 research clinics?

2 A. Yes. As I said, different
3 countries have different mechanisms
4 available to them. And the way that they
5 instantiate the research exception is to
6 permit their research hospitals to do it
7 under the appropriate circumstances and
8 projects.

9 Q. Do you speak Finnish,
10 Dr. Cantor?

11 A. No, I use one or another
12 translational service or professional
13 translators, you know, if I need to. Of
14 course, sometimes I am in contact with a
15 particular Finnish clinician in the
16 system. We are close colleagues.

17 Q. Do you know how you obtained
18 any of the translations of any of the
19 Finnish documents that you relied on
20 here?

21 A. Much of the information is
22 available in English, anyway. For
23 example, the part relevant, the relevant
24 parts or the studies that they included
25 in the, in their systematic reviews and

1 the conclusions.

2 Now, of course, the articles
3 that were included in their systematic
4 reviews are written in English. And so,
5 the appendicis of the report that lists
6 all of the studies that were included and
7 all of the studies that were excluded,
8 the lists are in English and I am already
9 familiar with it, with the papers that
10 are in them.

11 The policy itself, I don't
12 remember if I -- no, I didn't submit it
13 with this particular report. But I, you
14 know, retained the documentation from the
15 official translator who translated the
16 Finnish version of their policy.

17 Q. You would agree that an
18 independent individual under the age of
19 18 can be prescribed puberty blockers or
20 cross-sex hormone therapy at a
21 centralized research clinic in Finland,
22 correct?

23 A. The same as with the U.K. It's
24 possible, you know, when and during a
25 particular research project if somebody

1 otherwise qualifies for it, it's
2 possible. But it's not a matter of, oh,
3 you just have to go to this hospital
4 versus that hospital. That's not how it
5 works. It's not merely a relocation.
6 It's their particular phrasing for the,
7 you can't do it unless, you know. And so
8 the phrase to give permission to the
9 researchers to be able to engage in
10 whatever the research is. But it's not
11 like there is a law requiring that there
12 actually be any research or in the future
13 they decide, oh, no, this is hopeless, no
14 more research projects are being done at
15 all, the exception still theoretically
16 exists but then there is to way to obtain
17 it. So as I say, it's an exception and
18 when the exception is used, it is. And
19 when it's not, it's not.

20 Q. So you would agree an
21 individual under the age of 18 can be
22 prescribed puberty blockers or cross-sex
23 hormone therapy at a centralized research
24 clinic in Finland in the context of a
25 research protocol?

1 MR. RAMER: Objection to the
2 form. Compound. Asked and answered.

3 A. Same as before, I really
4 couldn't sign onto that without being
5 explicit to say that it is possible.
6 Without that is to suggest a blanket
7 permission that doesn't exist.

8 Q. Does Finland make it a crime
9 for doctors to prescribe puberty blockers
10 or cross-sex hormone therapy?

11 MR. RAMER: Objection to the
12 form. Calls for a legal conclusion.

13 A. To the best of my knowledge,
14 it's a similar situation as the U.K.
15 It's also a public healthcare system
16 that, you know, didn't rely on its
17 criminal system in order to? In order to
18 create, instantiate, establish its rule.

19 Because it has a public
20 healthcare system, they were able, I
21 don't know if by fiat is the right
22 phrase, but more directly control, you
23 know, when and who and how such projects
24 are done. They don't need to use a
25 criminal system. They don't need to use

1 their criminal codes in order to
2 instantiate the rule.

3 Q. If we can turn to paragraph 28
4 of your declaration?

5 A. I am there.

6 Q. Paragraph 28 of your
7 declaration pertains to policies in
8 Sweden, correct?

9 A. Yes, it does.

10 Q. You would agree that the
11 Swedish Board of Health and Welfare has
12 recommended restraint when it comes to
13 hormone treatment?

14 A. They use that phrase, yes.

15 Q. And you reference a document
16 there, I am not going to try to pronounce
17 it because I am going to get it wrong, I
18 am going to call it the Swedish support
19 document from 2022.

20 A. Yes, sometimes I called it try
21 S, which is a story unto itself. But try
22 S or SSS, any of those work.

23 Q. I am totally fine with SSS.

24 MR. MAY: So why don't we go
25 ahead and mark as our next exhibit,

1 tab 17, and I believe that will be
2 Exhibit 5.

3 (Exhibit 5, Document entitled
4 "Care of Children and Adolescents With
5 General Dysphoria, Summary of National
6 Guidelines," December 2022, was so
7 marked for identification, as of this
8 date.)

9 MR. BENIMOFF: It's been marked
10 and also been renamed.

11 A. Got it.

12 Q. Dr. Cantor what's been marked
13 as Exhibit 5, this is the Swedish
14 document that's referenced in paragraph
15 28 of your declaration; is that fair?

16 A. No, I don't think it's the same
17 document. They released several at that
18 time including updates and they
19 overlapped. I don't know if these are
20 the exactly the same one.

21 MR. RAMER: Phil, the document
22 that's been marked, it has six pages,
23 right? Am I looking at the right
24 thing?

25 MR. MAY: Yes.

1 A. The title of this document
2 doesn't match the title in my reference
3 list.

4 Q. Okay. Looking at your
5 reference list, which is Page 141 of
6 Exhibit 1, your declaration, the two
7 Swedish documents located there, dated
8 February 2022 and then there is one from
9 February -- excuse me, just one from
10 2020, correct?

11 A. Correct.

12 Q. So the two from 2022 are both
13 from February; is that fair?

14 A. Yes.

15 Q. And this document that I marked
16 here as Exhibit 5, is a document from
17 December 2022, correct?

18 A. Yes, according to its face
19 page.

20 Q. And so this would be a more
21 recent document than a February 2020
22 document, is that a fair assessment?

23 A. I would have to go through it
24 to be sure, but that's certainly what it
25 looks like.

1 Q. So this is a Document entitled,
2 "Care of Children and Adolescents With
3 General Dysphoria, Summary of National
4 Guidelines," December of 2022 published
5 by Sweden's National Board of Health and
6 Welfare, correct?

7 A. That's how it reads, yes.

8 Q. All right. If you can turn to
9 page 3 of this document for me.

10 A. Yes.

11 Q. And you see there is a bold
12 heading that says "Caution in the Use of
13 Hormonal and Surgical Treatment"?

14 A. Yes.

15 Q. And then there is a bullet
16 point underneath that, correct?

17 A. Yes.

18 Q. This document reads, starting
19 with the sentence above that bullet
20 point, "The National Board of Health and
21 Welfare, therefore, gives the following
22 weak negative recommendation as guidance
23 to the healthcare system. Treatment with
24 GnRH analogs, gender-affirming hormones,
25 a mastectomy can be administered in

1 exceptional cases."

2 Do you see that?

3 A. Yes.

4 Q. Do you agree that in Sweden
5 that treatment with GnRH analogs or
6 puberty blockers can be administered to
7 individuals in exceptional cases?

8 A. Yes. And as I say and research
9 purposes is one of the exceptions. The
10 other exceptions that they discussed are
11 people who are already in treatment who
12 have -- not to cut them off from, as I
13 say, ongoing treatment.

14 Q. And Sweden also permits
15 treatment with gender-affirming hormones
16 to individuals under the age of 18 in
17 certain exceptional cases?

18 A. That's how their policies have
19 consistently read, yes.

20 Q. And I think we can put that
21 aside for now. I don't think I have any
22 other questions about that document at
23 this time.

24 Does Sweden criminalize doctors
25 for providing puberty blockers or

1 cross-sex hormone therapy to individuals
2 under the age of 18?

3 MR. RAMER: Objection to the
4 form. Calls for a legal conclusion.

5 A. The same as with the other
6 countries, I am not aware of their using
7 their criminal systems in order to
8 establish the policy because they have a
9 nationalized, public healthcare system,
10 they have much more direct control.

11 Q. And we can now turn back to
12 your declaration, paragraph 29.

13 A. I am there.

14 Q. And this discusses policies in
15 France; is that fair?

16 A. Yes.

17 Q. You would agree with me that in
18 France there is no actual restriction on
19 the prescription of puberty blockers or
20 cross-sex hormonal therapy to individuals
21 under the age of 18?

22 A. Yes, not a formal ban, but
23 exactly as it reads, a far more
24 cautionary kind of statement so as to
25 avoid excessive and unnecessary

1 overapplication of medical interventions.

2 Q. Does France make it a crime for
3 doctors to prescribe puberty blockers or
4 cross-sex hormone therapy to individuals
5 under the age of 18?

6 MR. RAMER: Objection to the
7 form. Calls for a legal conclusion.

8 A. I am not aware of their having
9 used a criminal system in order to
10 enforce their guideline, recommendation,
11 urging, no.

12 Q. All right. And then if we can
13 please look to paragraph 30 of your
14 declaration, Exhibit 1. This discusses
15 policies in the country of Norway,
16 correct?

17 A. Yes, that's correct.

18 Q. And actually I was curious on
19 this. I tried very diligently and could
20 not locate any English translation of
21 Ukom's summary report.

22 So could you just let me know
23 how, how you were able to obtain the
24 translation and on what version you
25 relied on in forming your opinions here?

1 A. I don't remember offhand. I
2 would have to check my notes whether it
3 was an official or unofficial
4 translation, but I am in pretty regular
5 contact with the researchers on this
6 issue all around the world and we discuss
7 these kind of issues relatively freely.

8 So the basic information has
9 always been pretty familiar to me. And
10 then it's just a matter of using even
11 unofficial translations just to confirm
12 which document was which. But because
13 the information, and again the papers
14 that they are citing in order to justify
15 it are, you know, well familiar and been
16 published in English in the first place.
17 It's not a, it's not a -- it's not at all
18 a mystery on what the policies were
19 based.

20 You know, I certainly would not
21 use an unofficial translation in order to
22 provide a nuanced declaration of a sense
23 in which, you know, the particular, a
24 particular rule is enforced. But the, as
25 I say, through conversations with the

1 people in the country, and so on, it's
2 not, the basic recommendation that this
3 is a long series of unknowns for which
4 psychotherapy is the best indicated
5 treatment is not -- I shouldn't say not
6 under debate, but that is their policy is
7 not controversial.

8 Q. Do you still have the
9 translation that you relied on in writing
10 these paragraphs of your declaration?

11 A. Oh, I have them in my files,
12 yes.

13 Q. Okay.

14 MR. MAY: Mr. Ramer, we would
15 just ask for, if we can get a copy of
16 that in order to -- yeah, we would ask
17 for a copy of that. Obviously not
18 right this minute.

19 MR. RAMER: Understood.

20 Q. Dr. Cantor, in Norway is it
21 possible for an individual under the age
22 of 18 to be prescribed puberty blockers
23 or cross-sex hormone therapy in the
24 context of research?

25 A. I believe they included the

1 same exception, yes.

2 Q. Across all of the countries
3 that we discussed and are discussed in
4 your declaration, which are England,
5 Finland, Sweden, France and Norway, you
6 would agree that in all of those
7 countries it is possible for an
8 individual under the age of 18 to obtain
9 puberty blockers or cross-sex hormone
10 therapy in the context of a research
11 protocol?

12 MR. RAMER: Objection to the
13 form.

14 A. Again, my hesitation is in the
15 way that you phrase it, that the patient
16 obtains it. That kind of a situation is
17 again patient-and-client led rather than
18 researcher led -- rather than researcher
19 led.

20 It's also, that phrasing also
21 suggests a stable basis as opposed to how
22 things work in research is that, you
23 know, once the research comes out and the
24 research decides, the research indicates
25 whatever, that psychotherapy is better,

1 all right, question answered, no more
2 research. Well, no more research, then
3 no availability at all. So the potential
4 exception is a potential exception for
5 now for particular research purposes.
6 And where it goes from there, depends on
7 the results of that, of that research.
8 So a more blanket yes or no, doesn't fit
9 the customized fluid situation.

10 So the potential is there for
11 the exception. But there is no rule
12 requiring that such research forevermore
13 be available.

14 Q. Okay. So let me try and
15 address, try another question.

16 Across all of the countries
17 that we've discussed and are discussed in
18 your declaration which are England,
19 Finland, Sweden, France and Norway, you
20 would agree that in all of those
21 countries at the present moment it is
22 possible for an individual under the age
23 of 18 to be prescribed puberty blockers
24 or cross-sex hormone therapy by a
25 researcher in the context of a research

1 protocol?

2 MR. RAMER: Objection to the
3 form. Asked and answered.

4 A. Sort of. The current situation
5 is more complicated than that, in that
6 the research protocols themselves have
7 not yet been designed. The laws and the
8 regulations are designed by a different
9 stream of regulation. So the regulators
10 have left that open, but it's not the
11 regulators who design and implement the
12 research. They are giving researchers
13 permission to do it. But the researchers
14 themselves have not, are not yet up to
15 that stage.

16 I don't remember if it was
17 Sweden or Finland, so they were explicit
18 in indicating, in indicating that when
19 they said exceptional cases, that was the
20 situation that the regulators there were
21 trying to address. They were aware that
22 there did not yet exist research
23 protocols, and that that would take some
24 time. So the exceptional cases were,
25 again, meant to be this in-between stage

1 until there is something available or for
2 situations in which somebody is already,
3 you know, undergoing a medicalized
4 transition, so as to not to cut them off.

5 So the addition of the word
6 "current," again, there is a complication
7 to the issue is that currently each of
8 these countries is in a middle ground,
9 transition. Forgive the pun, a
10 transitional state.

11 Q. You would agree that across all
12 of the countries that we discussed today
13 and that are discussed in your
14 declaration, England, Finland, Sweden,
15 France and Norway, to the best of your
16 knowledge, none of those countries make
17 it a crime for doctors to prescribe
18 puberty blockers or cross-sex hormone
19 therapies to individuals under the age of
20 18?

21 MR. RAMER: Objection to the
22 form. Asked and answered. Calls for
23 a legal conclusion.

24 A. Yes, I am not aware of them
25 using their criminal regulations or

1 needing to use their criminal regulations
2 to enforce it.

3 As I say, because the public
4 healthcare systems are nationalized and
5 the government has direct control over
6 it. They have a very different set of
7 tools available to them for regulating
8 healthcare.

9 Q. I want to switch gears just a
10 little bit. Well, not really. But
11 turning away from Europe for the moment.

12 Do you think it's appropriate
13 to criminalize the conduct of doctors in
14 their prescription of care -- excuse me,
15 strike that.

16 Do you think it's appropriate
17 to criminalize doctors in their provision
18 of care to individuals?

19 MR. RAMER: Objection to the
20 form.

21 A. I really don't have an opinion
22 either way. I am a scientist. I can
23 tell you what the science says. I can
24 tell you how confident we can be in any
25 given conclusion. What would give us

1 more information, whether research
2 projects were done properly or not and
3 what the best indicator of a conclusion
4 is. But how any society, democracy or
5 legislature implements what is indicated
6 or suggested by the science, but that is
7 no longer a scientific question.

8 Q. Have you ever treated an
9 individual located in the State of Idaho?

10 A. No, I have not.

11 Q. Have you ever spoken with any
12 mental health practitioners or other
13 healthcare practitioners in the State of
14 Idaho?

15 A. Not that I recall. But I can't
16 definitively rule it out either. I get
17 e-mailed questions or, you know, phone
18 calls all the time from all over the
19 place and sometimes somebody will just
20 tell me they are in the U.S. and the
21 particular state isn't relevant. So I
22 can't definitively say no, but I don't
23 recall any particular -- I don't recall
24 one.

25 Q. Are you aware of how doctors in

1 Idaho make the decisions to prescribe
2 puberty blockers or cross-sex hormone
3 therapies for individuals under the age
4 of 18?

5 MR. RAMER: Objection to the
6 form.

7 A. No, not independently of how
8 any other state does it or how
9 clinicians, in general, in the U.S. do it
10 or want to do it or are recommended to do
11 it, or what they say in the media. I
12 don't recall anything specific to Idaho.

13 Q. So you're not familiar with the
14 specific practices or procedures of any
15 doctor in the State of Idaho who provides
16 prescriptions for puberty blockers or
17 cross-sex hormone therapy to individuals
18 under the age of 18?

19 MR. RAMER: Objection to the
20 form. Asked and answered.

21 A. I think it's more accurate to
22 say I am not aware of the behavior or
23 procedures in Idaho being at all distinct
24 from other states.

25 Q. Fair to say you don't have any

1 knowledge either way whether or not the
2 procedures in Idaho were distinct or not
3 distinct?

4 MR. RAMER: Objection to the
5 form. Vague.

6 A. No, I don't think I could say
7 that either. I mean if there were any
8 kind of a substantive difference in
9 Idaho, it would be odd for me not to have
10 run across it. There isn't, for example,
11 an Idaho chapter of WPATH issuing
12 standards or procedures that are distinct
13 from the overall WPATH procedures or
14 guidelines, for example. But if there
15 were, you know, some -- something
16 different, then again it would be awfully
17 strange for me not to have, you know, run
18 into that or that never having been
19 discussed, amongst any of the other
20 colleagues that I am regularly discussing
21 this family of issues with.

22 Q. You would agree that not every
23 doctor applies WPATH and Endocrine
24 Society Guidelines in exactly the same
25 way, right?

1 A. That's pretty much an
2 unanswerable question. The nature of the
3 and one of the largest problems with the
4 WPATH standards is that they are not
5 standards at all. They permit any
6 clinician to use his and her own clinical
7 judgment to overrule any guideline,
8 suggestion, that are in the guidelines.

9 Two clinicians can be doing
10 completely different things and both
11 declare themselves to be following the
12 WPATH standards -- following the WPATH
13 standards.

14 As included in my report, the
15 two versions of the WPATH standards, 7
16 and 8, changed what they were. Version 6
17 and earlier, you know, specifically,
18 explicitly called themselves minimum
19 standards. Beginning with version 7 they
20 took out "minimum." Well, without
21 minimum, now clinical judgment means move
22 standards up or down. So they are not
23 meaningfully called standards at all,
24 despite the word appearing in their
25 title.

1 So it's not possible. It's not
2 possible for two people to say that -- I
3 should say that in the reverse. It's
4 always possible for two clinicians to be
5 doing very different things, but both
6 following the WPATH.

7 Q. And you're not aware of the
8 specific practices of anyone in the State
9 of Idaho who describes puberty blockers
10 or cross-sex hormone therapy, right?

11 A. I am not aware of anybody in
12 Idaho having documented any, no.

13 Q. Have you ever spoken to any
14 patients or former patients of any gender
15 clinic in Idaho?

16 A. I don't recall any of them
17 identifying themselves specific to Idaho.
18 But as I say, I often receive
19 communications from people who either
20 don't mention their physical location or
21 give, you know, a vague reference to, you
22 know, a rough area of the country, but
23 don't name their state. So I don't
24 recall one specific to Idaho. But I
25 can't say that there is, that I never had

1 such communication.

2 Q. Do you support the provision of
3 puberty blockers and cross-sex hormone
4 therapies to individuals under the age of
5 18 in the context of answering research
6 questions and research protocols?

7 MR. RAMER: Objection to the
8 form.

9 A. I have no scientific or
10 ideological opposition to it, no. All we
11 have is the best guess we have according
12 to the current very incomplete
13 information in a large pile of unknowns.

14 I am a scientist, I would take
15 as a basic premise that science needs to
16 be able to ask as broad a range of
17 questions in order to continuously
18 improve it.

19 So as I say, so as a scientist
20 I pretty reflexively disagree with just
21 about any limit on what a, on scientific
22 questioning.

23 Q. Have you reviewed HB 71, the
24 law in Idaho?

25 A. When I was initially, initially

1 started with this case, yes.

2 Q. Does HB 71 permit the provision
3 of puberty blockers or cross-sex hormone
4 therapy to individuals under the age of
5 18 in the context of a research protocol
6 -- let me strike it. Again, I will ask
7 it from the beginning.

8 Does HB 71 permit the provision
9 of puberty blockers or cross-sex hormone
10 therapy to individuals under the age of
11 18 in the context of a research protocol
12 or in the context of answering research
13 questions?

14 MR. RAMER: Objection to the
15 form. Calls for a legal conclusion.

16 A. I don't recall it including an
17 exception for research, no.

18 Q. Would you favor such an
19 exception that allows for research?

20 MR. RAMER: Objection to the
21 form. Asked and answered.

22 A. As I say, yes, as a scientist I
23 reflexively side with the ability of
24 freedom of inquiry for scientists in
25 order to be able to answer the unknowns.

1 Q. Outside of the research
2 context, do you agree that there are
3 certain exceptional circumstances where
4 an individual under the age of 18 should
5 be prescribed puberty blockers or
6 cross-sex hormone therapy?

7 MR. RAMER: Objection to the
8 form.

9 A. I hesitate to say should
10 because that would, again, require
11 information that we don't yet have. It
12 is indeed possible. That is among the
13 unknowns. That is among the unknowns.
14 We don't have the quality of research or
15 volume of research in order to make
16 blanket uniform all-or-none decisions,
17 which is why, you know, exceptions can
18 be, why an exception for science would be
19 useful in order, in order to identify or
20 develop or see if it's possible to
21 develop a way of identifying, you know,
22 who might be an exception.

23 But without such knowledge, you
24 know, without information helping us to
25 identify who might be an exception, the

1 regulatory process -- you know, the basic
2 procedure that any clinician needs to use
3 as a risk-to-benefit ratio in the context
4 of how, how confident we can be in a
5 given diagnosis.

6 So far we can't be confident at
7 all. And so it's a matter of, so any
8 decision-maker has to weigh the potential
9 risks against the potential benefits.

10 And even though we acknowledge that there
11 could be exceptions, there is no good way
12 to instantiate that exception, if we
13 can't identify who might be the exception
14 in the first place.

15 So it's possible. It requires
16 research to identify who it is. But
17 without that research being done, we
18 can't identify who that exception is. So
19 we're back to where we started. We can
20 identify the possibility that they can
21 exist. But if we can't identify who that
22 person is, there is no way to enact that.

23 Q. Outside of the research
24 context, do you agree that there are
25 certainly exceptional circumstances where

1 an individual under the age of 18 should
2 be permitted to be prescribed puberty
3 blockers or cross-sex hormone therapy?

4 MR. RAMER: Objection to the
5 form.

6 A. Outside of a research, I'm not
7 sure that question makes sense.

8 Again, the purpose of the
9 research is in order to figure out how to
10 identify such a person so that that can
11 be, that policy can be enacted outside of
12 research.

13 So even though we can
14 acknowledge that, you know, that's
15 theoretically possible, we can't do it
16 until the research is done and tells us
17 how to identify such a person.

18 Q. Thinking back to what we
19 discussed earlier today, I believe you
20 said it was the five to six patients that
21 you had recommended a diagnosis of gender
22 dysphoria form who had gone on to receive
23 hormone therapy.

24 Do you recall that conversation
25 we had?

1 A. Yes.

2 Q. For those individuals, did you
3 support the decision for them to be
4 prescribed cross-sex therapy?

5 MR. RAMER: Objection to the
6 form.

7 A. The way that -- I don't know
8 whether I should say we, that clinic or
9 both, engaged in those decisions, it was
10 never really a matter of support. Our
11 task and the appropriate clinical task is
12 to identify all of the other and exhaust
13 all of the other less risky potential
14 interventions that might, that could help
15 this person lead a happy, healthy life.
16 Because the medical interventions
17 necessarily pose greater risks to
18 otherwise healthy and functioning tissue,
19 it is necessarily the intervention of
20 last resort. But it is still ultimately
21 the patient's decision. For us to
22 support that the patient do it, for we,
23 us, the clinical teams, the clinicians to
24 say support in that context means to
25 encourage. And we don't do that. We

1 shouldn't be doing that.

2 We can say no when there is a
3 specific physical or mental health need
4 for which, you know, we have the duty to
5 prevent patients from hurting themselves.
6 But there is never, there should be never
7 a situation in which one supports it. We
8 give permission should the patient so
9 decide. But that, as I say, is different
10 from our supporting it.

11 Q. And these patients that we're
12 discussing, it's your recollection that
13 at least some of them were under the age
14 of 18 when they started hormone therapy,
15 correct?

16 A. I actually don't remember.
17 They were all in that cusp. They were
18 close to 18. In that era there were
19 changes here in Ontario to the
20 regulations involving age of consent and
21 involving whether the public healthcare
22 system would for anyone over 18 or under,
23 fund medicalized transition. And again,
24 not just for minors.

25 And I was one of the outspoken

1 advocates indicating publicly then that,
2 you know, the healthcare system in my
3 view should be funding such transition.
4 But I don't definitively remember in the
5 changes in those days when I was sitting
6 in on the clinic or where, again, over
7 the line they were patients of my own
8 where I was participating in the
9 assessment of the patient versus sitting
10 in on the team which was making group
11 decisions. But I, myself, had not seen
12 the patient.

13 So again, I don't remember if
14 they were purely after 18 or within a
15 year or two of 18. I want to say that I
16 would go back and check, but of course
17 since I left KMH, since I left KMH, I no
18 longer have access to the records.

19 Q. You mentioned that you --
20 sorry, you mentioned that you were an
21 advocate for the payment of medicalized
22 transition during that early 2000 period,
23 right?

24 A. Yes, that's correct.

25 Q. Why were you an outspoken

1 advocate in favor of that -- strike that.

2 Let me ask that question again.

3 Why were you an outspoken
4 advocate in favor of the public health
5 system funding medicalized transition in
6 the early 2000s?

7 MR. RAMER: Objection.

8 A. Again, just for the record, I
9 want to make it explicit that this was
10 for adults. Medicalized transition for
11 minors was not on the table. It was not
12 -- it was never part of the system. And
13 my support for it is exactly the same as
14 how any of my opinions for any of these
15 issues follow, is that that is what was
16 most consistent with the science. For
17 otherwise mentally healthy adults who
18 have, you know, tried, already tried the
19 other options available to them, they do
20 fine most of the time after medicalized
21 transition. They were doing fine in
22 Ontario. They were doing fine, the
23 patients who were coming through our
24 clinic and the provincial healthcare
25 system as part of, you know, a much, much

1 larger, more important set of budget
2 cuts, you know, eliminated this one even
3 though there was no scientific or medical
4 justification for it.

5 So as I said, I did what I
6 always do, is point out, you know, what
7 is consistent with the science and the
8 science was consistent with that is the
9 best intervention available, given the
10 criteria that were being used at the time
11 which were much, much higher than the
12 WPATH criteria.

13 Q. Is it still your view that
14 medical transition for adults should be
15 paid for by the Canadian healthcare
16 system?

17 MR. RAMER: Objection to form.

18 A. Again, there are a couple of
19 caveats mixed in -- there are a couple of
20 caveats to it.

21 For example, the otherwise
22 healthy and having met the criteria that,
23 you know, the clinic, a clinic, that
24 clinic was using at the time. But the
25 standards that are being discussed,

1 largely in the U.S. today, have removed,
2 largely removed, have largely removed the
3 protections that were in place. You
4 know, they eliminated the criteria that
5 were being used that demonstrated
6 successful transitions. So without the
7 gate-keeping process, that's not so
8 clear.

9 So as a base -- so the only --
10 ideology is not the phrase. The
11 principle that I am applying is that when
12 the science supports the transitional
13 process, then, yes, then, the only
14 consistent public policy would be to
15 enable it to happen.

16 But in the absence of the
17 gate-keeping process, which produced the
18 successful results, well, now we've lost
19 the justification for it having been
20 covered. You know, it's just because it
21 worked for some people.

22 Once you take out that
23 assessment process, well we don't have
24 evidence that this newer -- after the
25 gatekeeping process was removed and

1 replaced with an informed consent
2 procedure, which is a very, very low bar,
3 we don't have evidence that this, you
4 know, low bar is successfully
5 distinguishing between people who will
6 benefit and people who will make a
7 mistake.

8 So that's not -- so I can't
9 endorse -- once the procedure is changed
10 I can no longer endorse the new procedure
11 because it's not tested.

12 Q. What are these gatekeeping
13 processes that you're referring to that
14 you believe have been removed from the
15 process?

16 A. The major one is the use of
17 what they call and we still call the real
18 life experience. Before that it was
19 called the real life test. There was a
20 very specific set of stages. Again, an
21 adult would undergo, beginning with
22 coming out to their friends and family.
23 You know, announcing that this was the
24 plan. Cross-living for a full year, a
25 full calendar year in their new role,

1 including legal name change and the
2 change in the sex on their -- usually it
3 was a driver's license, but any
4 government-issued documentation would
5 work.

6 The person needed to be able to
7 document that they were successfully
8 functioning in their new social role for
9 that year.

10 The definition of success was,
11 you know, actively in full-time
12 employment or a full-time student or
13 full-time volunteer work or any
14 combination of those three that summed up
15 to full-time. So if they were, you know,
16 capable of living, as I say, documenting
17 specifically that they were engaged in
18 that new role successfully for a year,
19 then they were eligible for hormone
20 treatment.

21 The same story, they needed
22 that one year of real life experience or
23 real life test under the hormones, under
24 the hormones, continuing to be able to be
25 successful. Document that success

1 through whatever combination of volunteer
2 work, gainful employment or being
3 enrolled as a student. Then after that,
4 which is now the second year, they would
5 then be eligible for surgery.

6 But as I say, in the clinic
7 where I was, and it was one of the
8 clinics that demonstrated, you know,
9 under those circumstances that people who
10 completed it did quite well. Other
11 clinics would use time less than a year.
12 The WPATH standards have the time, I
13 think were three months. They were the
14 lowest standards across any clinic and
15 they were untested. That was further
16 watered down, and they also permitted a
17 person not to undergo real life
18 experience at all and instead to be in
19 psychotherapy over the course of that, of
20 that time.

21 And then the, you know, with
22 subsequent versions, and I detailed it in
23 my report, as they continued to lower the
24 standards, now clinicians are permitted
25 to, you know, remove any of the criteria.

1 And now it's just an informed consent
2 procedure which is pretty much the lowest
3 bar mental health has to offer. It's,
4 essentially do you have an IQ sufficient
5 to understand the form that you're
6 signing. And essentially, are you not
7 actively psychotic and hallucinating, the
8 bar for, you know, mental competence is
9 very, very low.

10 So now rather a person being
11 engaged in a substantial amount of time
12 finding out what their hoped for life
13 really will be like and making a
14 genuinely-informed decision, instead the
15 person is just guessing and undergoing
16 medical treatments based on nothing but a
17 hope. And in some cases, even just a
18 fantasy of what they think their life is
19 going to be.

20 And we don't have evidence to
21 suggest that that low bar, lack of a bar,
22 lack of gatekeeping, successfully warns
23 people that their actual life is not
24 going to be quite like what they
25 imagined. People are only finding out

1 when it's too late. They are finding out
2 the hard way.

3 MR. MAY: We have been going
4 about an hour, I think now is a good
5 time for a break.

6 MR. RAMER: Sounds good. How
7 long would you like?

8 MR. MAY: Let's go off the
9 record.

10 THE VIDEOGRAPHER: Thanks, I
11 will just get us off the record. The
12 time is 2:02. This ends media file 3.

13 (Off the record.)

14 THE VIDEOGRAPHER: We are back
15 on the record. The time is 2:11, this
16 begins media file 4.

17 BY MR. MAY:

18 Q. Dr. Cantor, you agree that with
19 appropriate gatekeeping and under
20 appropriate circumstances, as you
21 described, gender-affirming medical care
22 can be beneficial for adults, right?

23 MR. RAMER: Objection.

24 A. Yes.

25 Q. Can gender-affirming medical

1 care be beneficial for some 17-year-olds,
2 if provided appropriately, as you
3 described?

4 A. That's a perfectly reasonable
5 hypothesis. But because the research is
6 restricted to 18-year-olds and over, we
7 can really only say that with firm
8 scientific backing for 18-year-olds plus.

9 But exactly how much that
10 finding can be generalized, you know, to
11 people expanding the range, that's now an
12 empirical question. You know, it's
13 relatively difficult, it's usually
14 relatively difficult to separate one year
15 of age from another year of age, given
16 the normal curve of just human abilities.

17 So because the switch from on
18 average, yes, to a little bit of a gray,
19 not really sure, the unknowns are now
20 building, it's very, very difficult to
21 draw a definitive line.

22 So we go from yes usually to
23 less certain, less certain, less certain.
24 And there is no definitive way to turn
25 that gray into a sharp line.

1 Q. But it's possible that
2 gender-affirming medical care could be
3 beneficial for some 17-year-olds, if
4 provided with sufficient gatekeeping?

5 A. Possible in some under certain
6 circumstances, yes.

7 Q. Is it possible for
8 gender-affirming medical care to be
9 beneficial to some 16-year-olds if
10 provided with appropriate gatekeeping?

11 MR. RAMER: Objection to the
12 form.

13 A. Same answer, really. Some,
14 theoretically, possibly, under certain
15 circumstances with, again, the now
16 increasing amounts shifting from yes on
17 average to even more uncertain than with
18 17-year-olds.

19 And the more we loosen the
20 restrictions, the more unknowns that we
21 have and the greater difficulty we have
22 in assessing the risk-to-benefit ratio.
23 It's finding out, figuring out what the
24 best balance of those, of
25 risk-to-benefit. And making more of the

1 unknowns more known is exactly the kind
2 of research that we need to do.

3 Q. I want to turn now to the
4 Endocrine Society Guidelines.

5 MR. MAY: So Rob, if you can
6 please mark tab 7 as the next exhibit,
7 which I believe will be Exhibit 6.

8 (Exhibit 6, Endocrine Society
9 Guidelines, was so marked for
10 identification, as of this date.)

11 MR. BENIMOFF: Marked and
12 renamed as Exhibit 6.

13 Q. Dr. Cantor, do you see Exhibit
14 6 in your folder and have you
15 successfully opened it?

16 A. I see the 6 in the folder. I
17 haven't been able to open it. The thing
18 that worked last time was -- yep, rejoin
19 as viewer guest -- there is 6. Didn't
20 work this time. One more. Got it.

21 Q. Do you have Exhibit 6 opened?

22 A. Yes.

23 Q. Exhibit 6, these are the, what
24 are referred to as the Endocrine Society
25 Guidelines; do you agree?

1 A. Yes.

2 Q. And you reviewed these and
3 discussed these at length in your
4 declaration, correct?

5 A. Yes.

6 Q. You would agree that the,
7 although your criticisms of the
8 systematic reviews that were
9 commissioned, you would agree that the
10 Endocrine Society did commission two
11 systematic reviews in the development of
12 these clinical practice guidelines,
13 correct?

14 A. Well, it's not quite complete.
15 They had two systematic reviews, one for
16 puberty blockers. One for cross-sex
17 hormones. They reviewed safety. But not
18 the effectiveness of either one.

19 Q. You have some criticisms of the
20 systematic reviews, but you don't
21 disagree with the fact that there were
22 two systematic reviews commissioned in
23 the development of the Endocrine Society
24 Guidelines, right?

25 A. Yes and no. Again, my

1 hesitation is that the missing phrase is
2 that in order to make the, in order to
3 engage in the decisionmaking pertinent to
4 this case and the various regulations
5 around it, it's not just any systematic
6 review of anything you want.

7 The information that is needed
8 by the decision-makers is to assess the
9 risk-to-benefit ratio. That requires a
10 systematic review of safety and a
11 systematic review of effectiveness. So
12 they engaged in systematic reviews, but
13 not systematic reviews of effectiveness
14 and safety, which is what is needed for,
15 as I say, the pertinent task. So I
16 couldn't -- it's not just any systematic
17 review of anything. It's partial reviews
18 of half the equation that one needs, that
19 one needs in order to assess the
20 risk-to-benefit ratio.

21 Q. So you have criticisms of the
22 systematic reviews that were relied upon.
23 But just you don't disagree that the
24 Endocrine Society did commission two
25 systematic reviews in the development of

1 these clinical practice guidelines,
2 right?

3 MR. RAMER: Objection to the
4 form. Asked and answered.

5 A. The criticisms I have aren't
6 exactly of the systematic reviews
7 themselves. My criticisms really are
8 about the application and interpretation
9 of the results of the systematic reviews.
10 And again, given -- and given the
11 application is to enact a risk-to-benefit
12 ratio, they weren't systematic reviews of
13 all of the necessary material. But
14 that's not a criticism of the systematic
15 reviews. That's a criticism of the
16 question that was or a limited question
17 that was put to the systematic reviewers
18 and then people over-applying the
19 systematic reviews to pertain to material
20 that wasn't contained in the systematic
21 reviews. And the other part just being
22 the --

23 Q. I am just trying to make sure
24 we are on the same page. And I think
25 this is a pretty binary yes/no fact.

1 The Endocrine Society
2 commissioned two systematic reviews in
3 the development of their clinical
4 practice guidelines, correct?

5 MR. RAMER: Objection to the
6 form. Asked and answered.

7 A. Answering that in a yes or a no
8 insinuates a level of completeness and
9 utility that they don't have.

10 Q. And I am not asking for any
11 characterization of the reviews. Again,
12 I think this is a very simple binary
13 yes/no question. Did they, in the course
14 of developing the clinical practice
15 guidelines, you agree the Endocrine
16 Society commissioned two systematic
17 reviews?

18 MR. RAMER: Objection to the
19 form. Asked and answered. And again,
20 I object to counsel cutting off the
21 witness's response.

22 A. It's not a dichotomous
23 question. For example, if somebody asked
24 does surgery work? Well, the question
25 can be phrased in a dichotomous way.

1 But the answer to the question
2 is, well, it depends on the surgery and
3 it depends on the diagnosis that you're
4 trying to use it for.

5 So did they conduct systematic
6 reviews, well, did they conduct
7 systematic reviews of the material that
8 was needed in order to answer the
9 questions to develop the policy it was
10 based on, as I say --

11 Q. Let's try this a different way.
12 Look at page 1 of Exhibit 6, under the
13 subheading called "Evidence." Do you see
14 that?

15 MR. RAMER: Objection to the
16 form. And again, object to counsel
17 cutting off the witness's response.

18 Q. Can you give me the decimal
19 number of the part you're referring to?

20 A. It's the first page of Exhibit
21 6. So the very cover page. And what
22 would be generally like an abstract
23 section. Yup.

24 Q. And the heading is called
25 "Evidence."

1 Do you see that?

2 A. Yes.

3 Q. The last sentence of that
4 paragraph "The task force commissioned
5 two systematic reviews."

6 Do you see that statement?

7 A. Yes.

8 Q. Do you have any reason to
9 disagree with that statement?

10 A. Yes, it's incomplete.

11 Q. What is incomplete about the
12 statement that the task force
13 commissioned two systematic reviews?

14 A. What they reviewed.

15 Q. Do you see that sentence goes
16 on to say "And used the best available
17 evidence from other published systematic
18 reviews and individual studies"?

19 A. Yes.

20 Q. So you would agree -- you won't
21 agree. Let me strike that and let me try
22 that again.

23 The Endocrine Society, in
24 addition to the two systematic reviews
25 that were commissioned, also relied on

1 other published systematic reviews and
2 individual studies. "

3 Do you agree with that?

4 MR. RAMER: Objection to the
5 form.

6 A. I agree that they did indeed
7 include -- I have no reason to disagree
8 that they included other materials in the
9 formation of a policy.

10 Q. And those other materials
11 included other published systematic
12 reviews, right?

13 A. That's what they said, but it's
14 not exactly clear which ones there were,
15 especially given that, given that year.

16 Q. If we could please go ahead and
17 turn to --

18 A. Oh, I am sorry. And, of
19 course, missing is the age range. The
20 large, large majority of the information
21 that they reviewed pertained to adults.
22 Of both of those reviews the total number
23 of studies that pertained to minors was
24 one. It was exactly one study between
25 both of those reviews, one study that was

1 about minors.

2 So it's only by removing those
3 details that it starts sounding like that
4 there were two systematic reviews. Yeah,
5 one of which included zero studies about
6 minors.

7 So by taking out the reviews of
8 what removes that the entire process for
9 minors included exactly one study. Which
10 I name in my report and I think it's
11 Table number 1 of my report, compared to
12 the other systematic reviews, which list
13 exhaustively all of the studies that were
14 included in all of the systematic
15 reviews.

16 So just generically saying
17 reviews, a review of one study is not a
18 review. It's just a study.

19 Q. So if we can please turn to
20 page 10 of Exhibit 6, which according to
21 the internal pagination is page 3878.

22 A. Got it.

23 Q. Do you see there is a table on
24 that page called Table 5?

25 A. Yes, I do.

1 Q. And Table 5 describes the
2 criteria for gender-affirming hormone
3 therapy for adolescents, right?

4 A. That's their title for it, yes.

5 Q. And it's broken into two
6 sections where the Endocrine Society
7 first provides criteria that makes
8 adolescents eligible for GnRH agonist
9 treatment, right?

10 A. Yes. And as I say, one study
11 that they reviewed was about cross-sex
12 hormone treatment. The number of studies
13 that they included for the puberty
14 blockers was zero. This is based on zero
15 studies.

16 Q. And the bottom half of the
17 table is identified by the Endocrine
18 Society as criteria that make adolescents
19 available for subsequent sex hormone
20 treatment?

21 A. Correct, that was the part that
22 was based on one study.

23 Q. And when you say it's based on
24 one study, you're referring to those two
25 commissioned systematic reviews, right?

1 A. Right, the two of them put
2 together found for minors a total of one
3 study.

4 Q. And you're not considering any
5 of the other articles, references and
6 studies that are cited within the
7 contents of the Endocrine Society
8 Guidelines?

9 A. The purpose of a systematic
10 review is to apply consistent criteria
11 through all of them.

12 So the point of those not being
13 included in the systematic review is that
14 they would, you know, they didn't
15 qualify, you know, they didn't meet the
16 criteria for an even-handed
17 identification of the appropriate
18 research.

19 That isn't to say that one
20 should necessarily ignore them. But one,
21 of course, needs to acknowledge that
22 there is a reason that they weren't of
23 the methodological quality in order to,
24 you know, be included in the systematic
25 review to begin with.

1 Q. So if we look at the first half
2 of Table 5, the adolescents eligible for
3 GnRH agonist treatment?

4 A. Yes.

5 Q. You agree that the Endocrine
6 Society lays out as one of the criteria
7 that the adolescent has demonstrated a
8 long lasting and intense pattern of
9 gender nonconformity or gender dysphoria?

10 A. That's the text that they
11 wrote, yes.

12 Q. And another criteria is that
13 they require that the gender dysphoria
14 has worsened with the onset of puberty?

15 A. Yes, that's the text that they
16 included.

17 Q. And that any coexisting
18 psychological, medical or social problems
19 that could interfere with treatment, for
20 example, that may compromise treatment
21 adherence have been addressed such that
22 the adolescent's situation and
23 functioning are stable enough to start
24 treatment?

25 A. Yes, they included that test.

1 Q. And that the adolescent has
2 sufficient mental capacity to give
3 informed consent to this reversible
4 treatment?

5 A. That's their text, yes.

6 Q. Now, I will accept, and I know
7 that you have strong disagreement with
8 the inclusion of the parenthetical phrase
9 "reversible," correct?

10 A. I think the phrase is being
11 wildly misused and overinterpreted.

12 Q. You would agree that -- and
13 those four criteria all need to be
14 evaluated by a qualified mental health
15 professional, right?

16 A. I would add other criteria to
17 that.

18 Q. And there are other criteria --

19 A. I mean to the qualifications of
20 the mental health professional. An
21 unfortunate side effect of the
22 polarization that's going on is that it's
23 more than possible to engage in therapist
24 shopping.

25 If you find, you know, one

1 mental health person that says, says no
2 or you find a string of them that says
3 no, it's always possible to find another,
4 to find somebody who uses very low
5 stands, to find somebody with an ideology
6 bent, you know, in order to sign off on
7 whatever, on whatever it is the patient
8 wants. So in practice a qualified
9 becomes indistinguishable from a willing.

10 Q. Are you aware of the
11 qualifications of the various therapists
12 and mental health professionals in the
13 State of Idaho?

14 A. Only cursorily through the --
15 only cursorily in order to be able to
16 receive a license or registration in
17 general. But there does not exist a
18 documentation for qualifications specific
19 to being allowed to implement, implement
20 the WPATH or any other criteria.

21 Q. Do you consider yourself a
22 qualified mental health professional
23 under these criteria?

24 MR. RAMER: Objection to form.

25 A. I am not aware of their issuing

1 criteria for what's qualified. I am not
2 aware of WPATH or any of the other groups
3 having any assessment, regulatory or
4 supervisory powers at all. They merely
5 use the word "qualified" but there is
6 nothing in any of this that prevents
7 anybody from calling themselves
8 qualified. It's being used as a
9 throwaway term.

10 Q. Do you agree that the Endocrine
11 Society Guidelines say that coexisting
12 psychological, medical or social problems
13 that could interfere with treatment have
14 been -- must be addressed?

15 A. Again, they include that --

16 MR. RAMER: Sorry, objection to
17 the form. Sorry, I didn't want to cut
18 you off. Objection to the form, and
19 you can go ahead and answer.

20 A. They include that text, yes.
21 But it's, as I say, unenforced,
22 unchecked, unoperationalized in the
23 context of the endochronological
24 statement, in practice it's just saying
25 we are not responsible for this. We just

1 handle the endochronological part and the
2 mental health part, as long as you sign
3 your name to the paper and you're
4 responsible for it, you're responsible
5 for it. Not us. But they issue no
6 guidelines. They don't talk about how
7 they would assess or that they even
8 attempt to assess the qualifications of
9 the mental health professional who is
10 signing off on the medical transition.

11 Q. What qualifications would you
12 want the mental health professional to
13 have in order to make these
14 determinations?

15 MR. RAMER: Objection to form.

16 A. That's tough to say in the
17 current context. It's exactly because
18 these questions have become as polarized
19 and as controversial that they have that
20 we, the healthcare professions and we the
21 democratic societies require an objective
22 evidenced means of making these decisions
23 in order to be fair to people who
24 disagree. Disagree in a healthy way, I
25 mean.

1 Because that necessarily
2 includes an empirical evidence-based
3 means of deciding what the criteria for
4 the patients are, that pretty much
5 requires that the same empirically
6 demonstrated, tested criteria be applied
7 for the decision for which clinicians are
8 qualified to do that.

9 So if somebody asked me that
10 question 15 years ago, you know, I could
11 relatively fluently suggest the basic
12 parts of my field and the knowledge
13 that's in it in order to say this is the
14 kind of stuff a person needs to know in
15 order to come to an educated clinical
16 decision.

17 But because of the situation
18 that's bringing these questions forth
19 today, I would need to, and I think one
20 would need to say, how do you know that
21 those are effective. My best guess isn't
22 good enough anymore as it would have been
23 before these controversies emerged.

24 So I am still able and willing
25 to describe the areas of the field that a

1 person needs to be able, needs to be
2 fluent in in order to be able to assess
3 the multiple possibilities that, of what
4 might help a patient expressing gender
5 dysphoria. But there hasn't been a test
6 to demonstrate that, my hunch, my view,
7 my opinion, for what the qualifications
8 should be are, as I say, themselves
9 empirically validated.

10 The one exception to that is
11 the more general finding that has been
12 shown in research about healthcare
13 providers is that actual clinical
14 experience in this or other relevant
15 questions does not help. It does not
16 improve clinical decision-making and
17 level of clinical care. It increases the
18 confidence of the clinician. But it does
19 not improve actual clinical care, which
20 is exactly the opposite of how most lay
21 people think of it and including most of
22 the legal systems where people kind of
23 have this prejudice, hunch, myth. That
24 more experience at performing this kind
25 of care makes one better at this care.

1 The research does not support that.

2 Q. Are you a qualified mental
3 health professional who would be able to
4 make these determinations listed out here
5 -- sorry, let me strike that and start
6 over. I realize I am asking my question
7 slowly.

8 Are you a qualified mental
9 health professional who is able to make
10 the assessments laid out in, under number
11 1 of Table 5 of the Endocrine Society
12 Guidelines?

13 MR. RAMER: Objection to the
14 form.

15 A. Again, without an objective set
16 of what those criteria are it's hard to
17 be definitive. At the same token, it's
18 difficult to think of a set of criteria
19 that wouldn't approve me while still
20 being legitimate criteria at all.

21 I mean, there are people who
22 would want to disqualify me, accusing me
23 of whatever myth or stereotypes they have
24 about me. But for objective criteria,
25 again, it would be difficult to say which

1 ones I wouldn't -- what kind of criterion
2 I wouldn't meet. Again, I'm limiting my
3 own opinions to adults.

4 Q. You agree that the Endocrine
5 Society lays out in its criteria for
6 gender-affirming hormone therapy for
7 adolescents that a qualified mental
8 health professional has to confirm these
9 points under number 1 in Table 5, right?

10 MR. RAMER: Objection to form.

11 A. Yes. As I say, it's an
12 expression that that is essentially the
13 coverage they are giving themselves. If
14 it turns out the person's mental health
15 status doesn't improve this is the
16 opportunity for endochronologists to say,
17 that wasn't our job.

18 Q. The Endocrine Society as part
19 of that wants to ensure that -- strike
20 that.

21 The Endocrine Society
22 Guidelines lay out that a patient's
23 coexisting psychological, social or
24 mental problems that can interfere with
25 the treatment have been addressed, right?

1 MR. RAMER: Object to the form.

2 A. Well, again, it's the same
3 thing. They are saying if they have not
4 been addressed, that wasn't our job.
5 That's the fault of a clinician who sent
6 the patient and cleared the patient
7 before they came to our door.

8 Q. Unless a mental health
9 professional -- unless a qualified mental
10 health professional has confirmed that
11 the patient doesn't have coexisting
12 psychological, medical or social problems
13 that could interfere with treatment or
14 any such problems have been addressed,
15 then the Endocrine Society Guidelines say
16 that person is not eligible for GnRH
17 agonist treatment, right?

18 MR. RAMER: Objection to the
19 form.

20 A. Yes, that's what provides them
21 the coverage.

22 Q. And the Endocrine Society
23 Guidelines say that GnRH agonist
24 treatment should not be started before 10
25 or stage 2, right?

1 A. That's a throwaway kind of
2 requirement, because you can't block a
3 puberty that hasn't happened. So the
4 presence of that line is correct. But as
5 I say, it's a pretty vacuous claim.

6 Q. You can't administer puberty
7 blockers to pre-pubertal children, right?

8 MR. RAMER: Objection to the
9 form.

10 A. There is no point to it. So as
11 I say, it's a vacuous, it's a vacuous
12 claim. It shouldn't be interpreted to
13 indicate some sort of a conservatism on
14 their part. It's an empty rule. Don't
15 give medicine to a person who doesn't
16 need the medicine. Okay, fine. As I
17 say, it's an empty -- it's an empty rule.

18 Q. If a patient satisfied all of
19 the criteria laid out in the first half
20 of Table 5 under the heading of
21 "Adolescents Are Eligible for GnRH
22 Agonist Treatment If," if there were a
23 person under the age of 18 who satisfied
24 all of those criteria, should that person
25 be able to obtain puberty blockers?

1 MR. RAMER: Objection to the
2 form.

3 A. Well, to me able is a
4 conclusion of what's a risk-to-benefit
5 ratio. We have grossly insufficient
6 information about the risks, and
7 especially the benefits. The Endocrine
8 Society did not include in their
9 systematic reviews either the risks or
10 the benefits of puberty blocking
11 medication. So we simply do not know if
12 they are able. We simply cannot assess
13 the risk-to-benefit ratio. And they cite
14 no evidence suggesting that they have it.
15 It's an unanswerable question. We have
16 slightly more information now than when
17 they first wrote this.

18 I included in my report, in my
19 response to a Dr. Baker, I included a
20 table that had the exact year of this and
21 the list of all of the studies, you know,
22 by year, in order to, you know,
23 demonstrate that at the time of this, the
24 studies we had didn't exist. These
25 criteria, indeed I think expire this

1 year. And they, I assume, are planning
2 to update and reengage it.

3 The current set of the
4 Endocrine Society -- their policies
5 automatically give out, I think every
6 five years, I think. So this is as out
7 of date as their criteria.

8 I take that back. It's the AAP
9 that just announced a redoing of it. But
10 as I cite, the years on which this is
11 based on the lack of research on which
12 these statements about GnRHs are applied
13 are all still true. So they came up with
14 a policy, but it is not based on any
15 research at all.

16 Q. Do you think that GnRH agonist
17 treatment is appropriate under any
18 circumstances for purposes of treating
19 gender dysphoria?

20 MR. RAMER: Objection to form.

21 A. It can be, as we were
22 discussing before. It has to have the
23 caveats of it's possible, but mostly
24 unknown, which is the whole trouble. We
25 need to do the research in order to be

1 able to identify, assuming it's possible
2 at all, to identify which people for whom
3 it might be beneficial or at least give
4 us a favorable risk-to-benefit ratio. If
5 we can't identify which persons they are,
6 that it's possible, is the question.

7 Q. I think you mentioned this
8 earlier, if we can go back to your
9 declaration, Exhibit 1, and look at Table
10 1, which I believe occurs right after
11 paragraph 78. Or right before paragraph
12 78, I am sorry.

13 So the studies that you listed
14 in this table, under Endocrine Society,
15 the only one that you have listed is
16 Klink?

17 A. Yes, that is the one study that
18 their systematic review found.

19 Q. So to be clear, this table is
20 discussing what was included in
21 systematic reviews, right?

22 A. Correct.

23 Q. This table does not indicate
24 what studies were relied on by the
25 Endocrine Society in providing their

1 guidelines in addition to the systematic
2 review?

3 A. That's correct. That's the job
4 of the systematic reviews to apply that
5 criteria to everything going on. Things
6 that are excluded by a systematic review
7 are excluded for an explicit reason.

8 Now the part that needs to be
9 answered is that if this study didn't
10 qualify for your systematic review,
11 exactly why are you including it in your
12 policy at all. If it wasn't good enough
13 for the systematic review for the policy,
14 what makes it good enough for the policy.

15 Q. This table also doesn't include
16 other systematic reviews that were relied
17 upon by the Endocrine Society except for
18 the two that they commissioned, right?

19 A. The great majority, really,
20 except for this one study, everything
21 else in their systematic review is about
22 adults.

23 So the other systematic reviews
24 that they included were systematic
25 reviews about outcomes and risks for

1 adults, not adolescents.

2 Q. And you applied the same
3 criteria for what you included in the
4 column for the WPATH?

5 A. Yes.

6 Q. And so just to be clear on
7 that, because I thought that was a
8 terrible question, personally. So in the
9 column for WPATH, the articles listed
10 there, are just the articles that were
11 included in the systematic review
12 commissioned by WPATH, right?

13 A. Correct, that's the point of
14 the systematic review is to exclude
15 everything with the explicit criteria,
16 which says, these are the studies good
17 enough to, you know, be in.

18 If you say, oh, the studies
19 after setting your criteria, finding
20 that, oh, I don't like the studies that
21 meet my criteria, so let's include these
22 other studies that I wanted to include
23 all along. That's now gaming the system.
24 The entire purpose of the systematic
25 review is to disallow that kind of cherry

1 picking.

2 Once you add or read studies
3 that were excluded by a systematic
4 review, as I cite, that's spoiling the
5 whole point of trying to be objective and
6 avoid cherry picking. That's merely
7 claiming that you're avoiding cherry
8 picking and then throwing more cherries
9 into the basket after the fact.

10 Q. If we can turn to paragraph 143
11 of your declaration.

12 MR. RAMER: Sorry, Philip, did
13 you say 143?

14 MR. MAY: Yes.

15 MR. RAMER: Thank you.

16 Q. The first sentence of this
17 paragraph reads "The social media voices
18 today loudly advocate
19 'hormones-on-demand' while issuing
20 hyperbolic warnings that teens will
21 commit suicide unless this is not
22 granted."

23 Did I read that correctly?

24 A. Yes.

25 Q. What do you mean by the phrase

1 "hormones-on-demand" in quotation marks?

2 A. That there should not be an
3 assessment or gatekeeping process. That
4 obtaining, obtaining these medications is
5 itself a civil right rather than an
6 assessment of risk-to-benefit ratios.

7 Q. The Endocrine Society does not
8 endorse providing hormones-on-demand,
9 correct?

10 MR. RAMER: Objection to form.

11 A. They don't use that phrase.

12 Q. We just looked at the criteria
13 for the Endocrine Society for providing
14 hormones, and there are specific criteria
15 that should be met before
16 gender-affirming medical care is
17 provided, right?

18 MR. RAMER: Objection to the
19 form.

20 A. Yes and no. The language that
21 they use lacking any objective means of
22 assessment allows for absolutely anything
23 to happen with no comeuppance. There is
24 nothing to stop anybody from calling
25 anybody qualified.

1 So saying that it needs to be a
2 qualified person, but you give no way of
3 determining, assessing or supervising who
4 counts as qualified, well, that's not a
5 rule at all anymore.

6 Q. Are you aware of any doctor in
7 Idaho providing "hormones-on-demand"?

8 A. I can't imagine a licensed
9 healthcare provider making such a
10 statement publicly. As I say, it's
11 typically social media voices, people who
12 refer to themselves as activists
13 referring to engaging in such procedures
14 as a civil right, and so on, who are
15 expressing, without using the phrase, but
16 expressing what is indistinguishable from
17 operationally hormones-on-demand. But
18 such voices and advocates don't have a
19 license or insurance coverage to enable
20 it.

21 It's people with nothing to
22 lose and for whom it's very easy to say
23 out loud in an anonymous social media
24 account. It should be people deciding
25 for themselves, and that's that.

1 But the clinicians themselves
2 again -- there is one potential
3 exception, but not in, not in Idaho. As
4 I say, I am not aware of a licensed
5 clinician describing themselves with such
6 language.

7 Q. Are you aware of a licensed
8 clinician in Idaho whose practices
9 conforms as what you describe as
10 hormones-on-demand?

11 A. No, I never looked.

12 Q. And the sentence here refers
13 generally, to social media voices. There
14 is no citations for that sentence, right?

15 A. Correct. I didn't try to find
16 -- again, for example, specific quotes of
17 specific tweets or -- do we still call
18 them tweets -- posts on social media
19 where somebody said so.

20 Q. So you're relying on your
21 expert opinion for that, right?

22 A. I don't know really if it's an
23 actual -- I don't know if I would call it
24 my expert opinion. It's just, you know,
25 like more than once it's a pretty

1 ubiquitous -- it's pretty ubiquitous.

2 Q. All right. Let's go ahead and
3 shift gears just a little bit. In terms
4 of assessing research literature, you
5 believe that GRADE is the most widely
6 used methodology for assessment of, for
7 assessment of studies?

8 A. For clinical, clinical outcome
9 studies, yes.

10 Q. And you're familiar with the
11 literature underlying GRADE?

12 A. Yes, basically.

13 MR. MAY: Rob, we can go ahead
14 and mark tab 19 as the next exhibit,
15 which I believe will be 7.

16 (Exhibit 7, Article entitled
17 "GRADE Guidelines: 3. Rating the
18 Quality of Evidence by Balshem,
19 et al.", was so marked for
20 identification, as of this date.)

21 Q. What has been marked as Exhibit
22 7 is an article entitled "GRADE
23 Guidelines: 3. Rating the Quality of
24 Evidence by Balshem, et al." Do you see
25 that?

1 A. Yes.

2 Q. You're familiar with this
3 paper?

4 A. I can't say this specific
5 paper. At least I would have to check my
6 own notes to remember exactly which
7 reference, which version of this it came
8 from. But I know roughly the contents of
9 it.

10 Q. Why don't you turn with me to
11 page 2 of Exhibit 7 to the heading number
12 4.

13 A. I see it.

14 Q. You see the heading says "A
15 particular quality of evidence does not
16 necessarily imply a particular strength
17 of recommendation"?

18 A. That's correct.

19 Q. And in the first paragraph
20 underneath that section, the last two
21 sentences read, "Although higher quality
22 evidence is more likely to be associated
23 with strong recommendations than lower
24 quality evidence, a particular level of
25 quality does not imply a particular

1 strength of recommendation. Sometimes,
2 low, or very low quality evidence, can
3 lead to a strong recommendation."

4 Do you see that?

5 A. Yes.

6 Q. Do you disagree with that
7 statement?

8 A. That it can happen sometimes,
9 no, I don't disagree.

10 Q. You can go ahead and turn to
11 page 3 of Exhibit 7, section 5.

12 A. I am there.

13 Q. All right. And if we look at
14 the very last paragraph of that section
15 over in the right-hand column, the second
16 to last sentence. Quote, "Although the
17 processes for assessing quality are the
18 same, authors" --

19 A. Hang on. Hang on.

20 Q. Yes.

21 A. I am sorry, redirect me to that
22 sentence.

23 Q. It's about halfway through to
24 the spillover of the paragraph on the
25 right-hand column.

1 A. I got it. It's a couple of
2 lines above the 6. Got it.

3 Q. It reads "Although the
4 processes for assessing quality are the
5 same, authors of systematic reviews and
6 authors of guidelines will apply the
7 criteria differently."

8 Do you see that?

9 A. Yes.

10 Q. Do you agree that's an accurate
11 representation of how authors of
12 systematic reviews and authors of
13 guidelines can apply the GRADE criteria?

14 A. Again, removed from its
15 contexts, it would suggest that it's more
16 arbitrary as opposed to back in context,
17 recognizing that it's necessarily a fault
18 with the system and, therefore, something
19 which we need to do our best to mitigate
20 by having as objective as possible, you
21 know, the determinations of what, you
22 know, how quality is assessed.

23 Q. If you can go ahead and turn
24 with me now to page 6, excuse me, page 5
25 of Exhibit 7. The internal pagination is

1 page 405.

2 A. I am there.

3 Q. The heading 10, "Conclusion."

4 A. Yes.

5 Q. The first sentence the authors
6 note "In closing, we caution against a
7 mechanistic approach toward the
8 application of the criteria for rating
9 the quality of the evidence up or down."

10 Do you see that?

11 A. Yes, I do.

12 Q. Do you agree with that
13 statement?

14 A. Yes, essentially.

15 Q. The last sentence of that
16 paragraph goes on to say "Fundamentally,
17 the assessment of evidenced quality is a
18 subjective process and GRADE should not
19 be seen as obviating the need for or
20 minimizing the importance of judgment or
21 as suggesting that quality can be
22 objectively determined."

23 Do you disagree with that
24 statement?

25 A. No, not really.

1 Q. You say not really. What's the
2 really part?

3 A. Well, it's the missing part of
4 the obvious application of those specific
5 sentences to, you know, to the particular
6 conclusions relevant to this case.

7 What they were pointing out,
8 perfectly legitimately, is that sometimes
9 there is some wiggle room and some
10 exceptions.

11 Well, what's missing is, of
12 course, the rest of that argument. There
13 is absolutely no evidence whatsoever to
14 suggest that this is one of those
15 exceptions.

16 Nobody has listed any of the,
17 here is what the systemic reviews say and
18 here is the part where we think they
19 apply versus not. They simply ignore the
20 systematic reviews.

21 So that -- well, I suppose,
22 actually it's exactly the same as when
23 discussing that there are potential
24 theoretical exceptions among patients.

25 Okay.

1 There can be exceptions. But
2 if we don't have a means of justifying
3 which exception identifying those
4 exceptions, how do we know that, in that
5 example, a given particular patient is,
6 is an exception.

7 The identification that
8 exceptions can exist doesn't mean that
9 this patient is such an exception. For
10 this document, it indicates that there
11 are potential exceptions for when rating
12 particular studies or particular
13 literature.

14 Well, what's missing is any
15 evidence to suggest that the particular
16 studies that are being used in the
17 systematic review are such exceptions.
18 The insinuated argument is that if they
19 can never exist an exception, therefore,
20 this is one.

21 Well, no, wait a second.
22 Demonstrate or show evidence that the
23 studies that are being concluded, that
24 are being involved in the systematic
25 reviews of outcomes of a medicalized

1 transition are such exceptions. They are
2 not.

3 Also missing from the argument
4 is exactly as I listed in my table.
5 There have been multiple systematic
6 reviews of this literature. And they all
7 came to the identical conclusion. The
8 only groups coming to a different
9 conclusion are people who are the
10 managers of the clinics and are in a
11 financial conflict of interest over the
12 results.

13 So what exactly is the evidence
14 that, you know, it's that the
15 subjectivity here is on the part of
16 several public healthcare systems versus
17 the commercial system in the U.S.

18 So as I say, my really is the
19 insinuated argument of where that's going
20 to lead, because there can exist
21 exceptions, therefore the rule doesn't
22 apply to the present circumstance. No,
23 what we are missing is the evidence that
24 this is one of those exceptions. There
25 is no such evidence.

1 Q. Okay. So I want to -- you said
2 something towards the end there that I
3 want to follow-up on.

4 "The only groups coming to
5 different conclusions are people who are
6 managers of clinics and are in a
7 financial conflict of interest over the
8 results."

9 What's your basis for that
10 statement?

11 A. Primarily I'm referring to the
12 sets of experts whose reports I have been
13 evaluating and comparing to the
14 literature itself. Again, for this
15 particular case there is only Dr. Baker
16 himself. But in the back of my mind it's
17 the series of the same experts over and
18 over again that I have been encountering
19 in several different cases. I am
20 including them. And, of course, the
21 various professional societies which are,
22 they are in charge of defending guild
23 interest and defending guild interests,
24 period. Such as groups such as the
25 endochronological society, whose members

1 and funding come from the dues which are
2 people who perform these procedures.

3 So, as I say, they are not
4 being done by people or associations that
5 lack a conflict of interest. They are
6 coming from people and groups with a
7 conflict of interest.

8 Q. Okay. So let's focus on -- you
9 refer to Dr. Baker, but it's Dr. Brady?

10 A. I am sorry. Thank you very
11 much.

12 Q. Let's talk about Dr. Brady.
13 Dr. Brady is not the manager or director
14 of a clinic, right?

15 A. Correct. She said in her
16 report that 100 percent of her practice
17 was these patients. So, again, a
18 conflict of interest.

19 Q. She's not a manager or director
20 of a clinic, right?

21 A. That is correct. She's an
22 exception. As I say, in my head I am
23 thinking of them as a large group and the
24 important part is that they are in a
25 conflict of interest. I refer to them as

1 directors, because the majority of them
2 are. But that is correct, she is an
3 exception. She's in the same conflict of
4 interest, even though she's not the
5 director of the clinic.

6 Q. Dr. Brady is a psychiatrist,
7 right?

8 A. I don't remember if she said
9 psychiatrist or psychologist.

10 Q. And sorry, and thank you for
11 correcting me, she's a psychologist.
12 She's not an M.D. Dr. Brady does not
13 provide gender-affirming medical care,
14 right?

15 A. Correct. She doesn't provide
16 medical care. She conducts the mental
17 health assessments which then enable the
18 medical care.

19 Q. She does not herself provide
20 medical care, right?

21 MR. RAMER: Objection to the
22 form. Asked and answered.

23 Q. Let me strike that and ask it
24 differently. She herself does not
25 perform gender-affirming medical care,

1 right?

2 A. Again, my hesitation is really
3 just a quibble over words. The services
4 she provides are not directly hormonal or
5 surgical. But because these decisions
6 are being made on a team basis include,
7 and the team includes medical
8 interventions, that, again, that is part
9 of a hospital, you know, in a meaningful
10 way everything in the hospital counts as
11 medical. And there is many of the
12 activists, you know, start including,
13 refer to the entire process, including
14 the assessments as medically necessary.
15 But still require mental health
16 assessment, as I said, what counts as
17 medical, what counts as medical or not.
18 And if she does it versus a psychiatrist
19 doing it, it could be exactly the same
20 report, but one counts as coming from one
21 it's medical. And coming from the other,
22 it's not medical, even though it's the
23 identical service. As I say, it starts
24 becoming quibbling over what counts.

25 Q. Sure. My question was really

1 directed toward prescription of puberty
2 blockers and cross-sex hormone therapy.

3 A. Correct, she's a psychologist
4 and would not be directly prescribing the
5 hormones or performing the surgeries.

6 Q. And it's your belief that
7 psychotherapy should be the first line of
8 treatment, correct?

9 A. That is what the research is
10 most consistent with, yes.

11 Q. So shouldn't Dr. Brady be
12 advocating for more psychotherapy?

13 MR. RAMER: Objection.

14 Q. Under her conflict -- sorry.
15 According to your logic, shouldn't
16 Dr. Brady be advocating for more
17 psychotherapy and advocating against
18 gender-affirming medical care?

19 MR. RAMER: Objection to the
20 form.

21 A. I don't know about should be.
22 But -- I don't know what I could add to
23 that. I'm not sure if it should be. If
24 100 percent of her clinical time is
25 already accounted for, it's moot.

1 Q. You think a source of
2 compensation can have an undue influence
3 on a person's perspective?

4 A. It certainly can, yes.

5 Q. And I believe that you've
6 estimated that about 80 percent of your
7 current income comes from expert services
8 like this?

9 A. Last year and this year. I
10 have no control over it. This is really
11 up to the American legislatures, how
12 quickly they pass these regulations and
13 then how quickly they get sued. And
14 then, you know, for many of them I get a
15 phone call. I have no reason to think
16 that this is permanent. I can't help but
17 point out that I am a scientist. Nobody
18 becomes a scientist for the money. If
19 money were my motivator, then I would
20 have gone into, you know, clinical work
21 to begin with. But that, you know, I am
22 a scientist.

23 By pure coincidence, you know,
24 relatively late in my career, even though
25 I have always, my entire career, just

1 given away to whoever would ask, you
2 know, whatever information about my field
3 I could. This very bizarre,
4 unpredictable wave in society has just
5 changed how things work.

6 So I've, essentially, put my
7 private practice primarily, most of it,
8 on hold for as long as this lasts. And
9 then, you know, presumably I will switch
10 back when this is over, which could be
11 anytime, which could be anytime.

12 Q. Would being paid by an advocacy
13 group influence an opinion?

14 A. Again, it certainly can. But I
15 haven't said anything, you know, in any
16 of these cases that I haven't been saying
17 for many years. In fact, the thing that
18 brought me to the attention of these
19 groups was my fact-check of the AAP, now
20 five years ago, on my own time.
21 Perfectly free. Just because the
22 material, I could see what was going on.
23 I could see that it was dangerous. What
24 the public needed was the actual
25 information.

1 So just on my own time, because
2 I am interested in the material, I just
3 ran a fact-check. Well, at the time, it
4 was the first, really, peer-reviewed
5 publication on the subject, on the
6 subject matter.

7 So when the various cases
8 started coming forth, presumably, the
9 various legal representatives needed to
10 find an academic who knew the material,
11 and there weren't many. There continue
12 not to be many. I am one of the few,
13 because, exactly because I am already on
14 record. I have nothing to lose. I have
15 nothing to defend. I have nothing really
16 to gain. I just switch what it is that
17 my, my time is allocated to. And
18 presumably, whenever this round of cases
19 finishes, things will switch back.

20 Q. Dr. Brady could just as easily
21 change her practice in the same way,
22 right?

23 MR. RAMER: Objection to form.

24 A. I have no idea. I have no idea
25 what her other interests, expertise,

1 alternatives are.

2 Q. You have never practiced in the
3 U.S. medical care system, right?

4 A. I volunteered for parts of it.
5 I was a research assistant doing medical
6 research at Boston VA Hospital. And then
7 came to Canada.

8 MR. RAMER: If there is a good
9 breaking point coming up, we have been
10 going about an hour.

11 MR. MAY: I am coming up to one.

12 Q. Being compensated by a group
13 that advocates for the provision of
14 puberty blockers and cross-sex hormone
15 therapies could influence a person's
16 opinion, right?

17 A. Could, yes.

18 Q. And similarly being compensated
19 by a group that advocates against the
20 provision of puberty blockers and
21 cross-sex hormone therapy could also
22 influence an opinion, right?

23 A. It could.

24 MR. MAY: We can go ahead and
25 take a break.

1 THE VIDEOGRAPHER: Thank you.
2 This is the videographer. The time is
3 3:17, and this ends media file 4.

4 (Off the record)

5 THE VIDEOGRAPHER: We are back
6 on the record. The time is 3:25.
7 This begins media file 5.

8 MR. MAY: We can go ahead and
9 mark tab 25 as the next exhibit.
10 Maybe we should have done that during
11 the break. I believe that will be
12 Exhibit 8.

13 (Exhibit 8, Article entitled
14 "GRADE Guidelines 4, Rating the
15 Quality of Evidence, Study Limitations
16 (Risk of Bias)" by Guyatt, et al., was
17 so marked for identification, as of
18 this date.)

19 BY MR. MAY:

20 Q. Dr. Cantor, let me know when
21 you have that up.

22 A. Got it.

23 Q. Exhibit 8 is an article
24 entitled "GRADE Guidelines 4, Rating the
25 Quality of Evidence, Study Limitations

1 (Risk of Bias)" by Guyatt, et al.

2 Do you see that?

3 A. Yes, I do.

4 Q. Are you familiar with this
5 document?

6 A. Roughly.

7 Q. If you can turn with me to
8 Section 8 of this article, which is page
9 410 by the internal pagination.

10 A. I am there.

11 Q. The first paragraph, second
12 sentence reads that "First, empirical
13 evidence supporting the criteria is
14 limited. Attempts to show systematic
15 difference between studies that meet and
16 do not meet specific criteria have shown
17 inconsistent results. Second, the
18 relative weight one should put on the
19 criteria remains uncertain."

20 Do you see that?

21 A. Yes, I do.

22 Q. And this is in a section titled
23 "Limitations of GRADE's Approach of
24 Assessing Risk of Bias in Individual
25 Studies," right?

1 A. Yes, and again, acknowledging
2 their use of bias as not the synonym for
3 prejudice.

4 Q. Absolutely. This is bias in a
5 very specific context, right?

6 A. Yes, it's in the scientific
7 method version of bias meaning how close
8 it is to a pressure pushing in a single
9 direction.

10 Q. Absolutely. Do you agree with
11 GRADE's statements here in that first
12 paragraph?

13 A. For at that time. I would have
14 to go and look and see what's happened in
15 the decade since. I also think it's fair
16 to say that, again, with that sentence
17 taken out of the broader context,
18 something is missing, something gets
19 lost.

20 The sentence by itself, you
21 know, would suggest that, therefore, it
22 ought not be itself used where that's not
23 the alternative. What's missing is if
24 somebody can come up with a better
25 system, great, let's test them. The

1 alternative is not, therefore, do what
2 you want. This is, this is the best we
3 have until, you know, but we need to fine
4 point and tweak and change criteria but
5 nobody has found anything better yet.

6 Q. If we can turn to page 413 with
7 the internal pagination of Exhibit 8.

8 A. Yes.

9 Q. And in the bottom right-hand
10 column, the first full paragraph, it
11 starts with the sentence "The possibility
12 of discrepant judgments between
13 intelligent and well-informed review
14 authors is more than theoretical."

15 Do you see that?

16 A. Yes.

17 Q. Do you agree with that that
18 it's possible for discrepant judgments
19 between intelligent and well-informed
20 review authors?

21 A. Yes, that's the reason why
22 these assessments have to be done by
23 several people and for them to be able to
24 hammer out where there are disagreements.

25 Q. And the paragraph goes on to

1 discuss different studies of deep vein
2 thrombosis in airline passengers taking
3 long flights. And if you turn to page
4 414. At the top of the page, the end of
5 the spillover paragraph, it says that
6 "Even after direct contact and discussion
7 each group adhered to its own position,
8 and it's possible that either group is
9 correct."

10 Do you see that?

11 A. Yes.

12 Q. So possible for there to be
13 reasonable disagreement among review
14 authors even applying GRADE criteria,
15 right?

16 MR. RAMER: Object to the form.

17 A. Yes. It is indeed possible.

18 Q. Okay. You can put this aside
19 for now. I want to turn back to your
20 declaration, Exhibit 1 and go to
21 paragraph 108.

22 A. I am there.

23 Q. Here you're discussing the term
24 "gender identity" in this paragraph,
25 correct?

1 A. Mostly, really I am discussing
2 people's common, a popular definition of
3 gender identity using a non-scientific
4 one, and trying to attribute to it all
5 kinds of scientific attributes.

6 Q. You disagree with the idea that
7 gender identity could be defined as a
8 person's inner sense?

9 A. It can't be scientifically
10 defined as an inner sense.

11 Q. What do you mean by
12 scientifically defined?

13 A. Objective, verifiable and
14 falsifiable.

15 Q. And you say that it's
16 increasing popular to do this. Are you
17 saying this is a new phenomenon?

18 A. That what's a new phenomenon?

19 Q. Defining gender identity as a
20 person's inner sense?

21 A. Yes and no. It's use and
22 application for decision-making is pretty
23 new. It's been used before as just a
24 general description to kind of
25 characterize a phenomenon, generally at a

1 time earlier in mental health, where all
2 of mental health was really just a series
3 of metaphors and general descriptions.
4 But again, now, in the social media age
5 and when being used to justify medical
6 transition of minors, it's being given
7 the weight and consideration, not merely
8 of a general description, but as a
9 concrete objective criterion to justify
10 physical interventions.

11 Where, as I say, it was used,
12 it was originally just used as a general
13 metaphor. But it's no longer being
14 treated as a general metaphor. It's
15 being treated as a physical objective
16 unquestionable truth. That's what's new.

17 MR. MAY: If we can please mark
18 tab 31 as the next exhibit. I believe
19 that will be Exhibit 9.

20 (Exhibit 9, Article titled "The
21 Recalled Childhood Gender
22 Identity/Gender Role Questionnaire,
23 Psychometric Properties" by Zucker,
24 et al., was so marked for
25 identification, as of this date.)

1 MR. BENIMOFF: Exhibit 9 marked
2 and renamed.

3 A. Got it.

4 Q. If you can go actually to the
5 second page of Exhibit 9, which is the
6 first page of the real article.

7 A. So internal page 470?

8 Q. No, internal page 469. Just
9 the cover page of the pdf is the cover
10 page?

11 A. The cover page with the
12 abstract, yes?

13 Q. Yes. So this is an article
14 titled, "The Recalled Childhood Gender
15 Identity/Gender Role Questionnaire,
16 Psychometric Properties," by Zucker and
17 others including yourself that was
18 published in 2006, right?

19 A. Correct.

20 Q. Do you recall this article?

21 A. Really only vaguely. My
22 participation was for the statistics.

23 Q. If you go to the second page of
24 the article which on the internal
25 pagination page 470 --

1 A. Got it.

2 Q. -- you'll see here that it
3 says, the first, the very first full
4 sentence "Gender identity has been
5 defined as a person's basic sense of self
6 with regard to maleness and femaleness"
7 and then it cites articles from 1965 and
8 1968; do you see that?

9 A. That's right.

10 Q. Do you disagree with that
11 statement?

12 A. Again, it depends on the
13 context in which it's given. It's useful
14 as a general descriptor of what's going
15 on. And in back of those days that was
16 perfectly appropriate. But it's
17 inappropriate to use that as a literal
18 statement of a basic scientific truth
19 that would justify, you know, objective
20 and physical interventions which is how
21 it's being used now.

22 Q. I am not really understanding
23 what you mean by -- I am having trouble
24 understanding what you mean by a basic
25 scientific truth.

1 A. Objective, verifiable,
2 falsifiable.

3 Q. And isn't that the point of
4 your design of the questionnaire in this
5 article, in order to assess gender
6 identity?

7 MR. RAMER: Objection to the
8 form. And object, again, to not
9 allowing the witness to finish his
10 answer.

11 A. Yes, that was the purpose of
12 the questionnaire.

13 Q. And that's to make gender
14 identity verifiable and objective and
15 falsifiable?

16 A. Towards that direction, yes.
17 It wouldn't change the definition of
18 gender identity. It would be a measure
19 that would -- so that if two different
20 clinicians in two different clinics in
21 two different countries for that matter
22 administered the same questionnaire, we
23 would expect them to get the same set of
24 answers. Therefore, we would be able to
25 compare the outcomes of one clinic with

1 the outcomes of the other clinic, because
2 they are both using the same, the same
3 instrument.

4 But the instrument would not,
5 no instrument can provide us with a
6 definition of the construct that we're
7 trying to measure.

8 Q. So you can use a survey in
9 order to assess a person's gender
10 identity; is that fair?

11 MR. RAMER: Objection to the
12 form.

13 And, doctor, before you start to
14 answer. Allow me to be able to
15 interject the objections, thanks.

16 A. This isn't a survey.

17 Q. Apologies, a questionnaire.

18 MR. RAMER: Same objection.

19 A. And what was the question
20 again?

21 Q. Is it fair to say that you can
22 use a questionnaire in order to assess a
23 person's gender identity?

24 MR. RAMER: Objection to the
25 form.

1 A. That's what we call an
2 empirical question. We can only find out
3 if it's possible by trying to do it and
4 seeing if we're successful.

5 Q. The purpose of this 2006
6 article here was to design such a
7 questionnaire, right?

8 A. To contribute to the design of
9 such a questionnaire in order to address
10 some of the issues that are pertinent to
11 the creation of such questionnaires.

12 Q. Has such a questionnaire been
13 successfully designed?

14 MR. RAMER: Objection to the
15 form.

16 A. I can really only compare it to
17 my, to my prior analogy about asking does
18 surgery work. There are many different
19 kinds for many different purposes and
20 there are many different possible
21 answers. It works for this but not that.
22 It has high quality for this purpose, but
23 not for that purpose. It can pick up on
24 certain things, but not on other things.
25 It may have, you know, strengths and

1 weaknesses in different contexts.

2 Any one, any, pretty much any
3 one study is unlikely to unravel a
4 complicated set of questions ranging from
5 determining how valid a construct is all
6 the way through finding a valid way of
7 measuring that construct. So it's a
8 contribution to that literature. Well,
9 it's one paper contributing to that
10 literature. But it's very, very rare
11 for, you know, any one study to
12 single-handedly establish that kind of
13 validity.

14 Q. You said that it's ranging from
15 determining how valid a construct is all
16 the way through finding a valid way of
17 measuring that construct. Do you
18 disagree with gender identity as a
19 construct?

20 MR. RAMER: Objection to the
21 form.

22 A. That's kind of a circular
23 question. There are, for as long as
24 people use different -- people use the
25 phrase to mean different things in

1 different ways in different
2 circumstances, and they can vary in the
3 ways and circumstances in which it's
4 valid.

5 So it's the -- so the unpacking
6 is about is gender identity as being used
7 in a given circumstance valid, but
8 somebody else using it in another way in
9 another circumstance, I guess, there can
10 certainly be valid applications,
11 applications of it that are valid in one
12 circumstance, but not valid in another
13 circumstance.

14 The identification of whether a
15 construct is valid is -- my headphones
16 are giving out. Hold on, I am just
17 switching speakers. Can you still hear
18 me?

19 Q. Yes.

20 A. But can I still hear you? Say
21 something clever and devastating.

22 Q. I hope you can still hear us.

23 A. Try again.

24 Q. Can you hear us now, doctor?

25 A. Thank you. That was clever and

1 devastating, perfect.

2 So the research questions
3 about, for establishing whether a
4 construct is valid and for establishing
5 how to measure a construct, go hand and
6 hand. One begets the other. The better
7 our measures get, the more we can
8 validate a construct. The more valid a
9 construct is, the more directly we can
10 establish a way to measure it.

11 So as I say, each one study
12 kind of contributes to that cycle. But
13 there is nothing about it that really
14 allows us to say gender identity is
15 valid. That's part of that whole, part
16 of that research we find and often do
17 find it's valid in this way and this
18 circumstance but not valid in that way or
19 that circumstance. And it's from that
20 theories of research that we find out
21 what gender identity is.

22 But when the initial definition
23 is merely an inner sense, well, you can't
24 test an inner sense. It can't be used to
25 determine the validity of a construct

1 and, as I say, you can't measure it. So
2 that's what makes it not a valid
3 scientific definition, even though some
4 people find it an adequate descriptor
5 when somebody's, when the phrase was
6 first getting used, when somebody's main
7 purpose was really to differentiate it
8 from sexual orientation.

9 Q. So just looking back at this
10 article, this defines gender identity as
11 a person's basic sense of self.

12 Do you view a basic sense of
13 self to be different from an inner sense
14 of self?

15 A. Largely overlapping but not
16 identical. And the same issues apply.
17 Again, when we wrote this paper, you
18 know, these kinds of issues were not,
19 were not controversial. The main purpose
20 to defining gender identity was to
21 differentiate it from, from sexual
22 orientation. But it wasn't getting used,
23 you know, to make the kinds of dramatic
24 physical objective decisions to which
25 it's being applied now. In order to

1 justify, you know, objective physical
2 dramatic interventions we need equivalent
3 high level of research. A metaphor and
4 analogy doesn't cut it in the way that it
5 does in just getting a basic description.

6 Q. And while the goals in this
7 article was to develop or contribute to
8 the development of a questionnaire to
9 measure and assess gender identity as
10 defined as a basic sense of self, right?

11 A. I am hesitating on the "as
12 defined." Because to say as defined is
13 to add that, and we know that this is the
14 correct definition, and anything outside
15 of that definition we would exclude,
16 which is --

17 Q. I am just taking from what's in
18 the paper.

19 MR. RAMER: Objection to the
20 form. And objection, again, to
21 counsel interrupting the witness's
22 answer.

23 A. It's not just in the paper.
24 The paper is one piece of a larger
25 puzzle, together with all of its

1 references, the conversation going on
2 around it and absent the current
3 controversies around it. It was and
4 theoretically still is always possible
5 that during the development of such
6 questionnaires that we find that, oh, it
7 was the definition that we were using
8 that was preventing us from coming up
9 with whatever reliable or valid
10 questionnaire as opposed to this, each
11 one feeding the other kind of
12 information.

13 But we can't in that cycle of
14 measures and validity just say this is
15 the definition and now our choice is to
16 find something to measure that. No, no.
17 We are giving this our best guess given
18 what we have. We might have to tweak the
19 questionnaire or the instrument or we
20 might have to tweak what we are using as
21 the definition. Each of these feeds what
22 we know about the other.

23 Q. Does this paper, which has been
24 marked as Exhibit 9, does it advocate for
25 changing the definition of gender

1 identity, away from what's written in the
2 beginning of the paper as a person's
3 basic sense of self?

4 MR. RAMER: Objection to the
5 form.

6 A. No, not that I recall.

7 Q. And in the next paragraph it
8 starts with "Over the years various
9 assessment tools have been developed to
10 measure both gender identity and gender
11 role in children."

12 Do you see that?

13 A. Yes.

14 Q. Do you agree that gender
15 identity is measurable?

16 A. Again, that's the same
17 interrelated set of questions. There is
18 nothing in this questionnaire or in my
19 report that challenges the validity of
20 gender identity itself. It challenges
21 defining gender identity in a way that
22 cannot be tested at all.

23 Q. This paper, though, defines
24 gender identity as a person's basic sense
25 of self with regard to maleness and

1 femaleness, right?

2 MR. RAMER: Objection to the
3 form. Asked and answered.

4 A. No, not exactly. It
5 acknowledges and describes that, you
6 know, in the conversation, you know, in
7 the literature to which it was
8 contributing, that's the basic idea we
9 were aiming for.

10 But that's not how the phrase
11 is being used today which is to take that
12 basic description and to accept it as a
13 literal truth.

14 This paper was trying to find
15 ways to tap into it but that's different
16 from defining, concretizing, making
17 unquestionable, leaving out the
18 possibility that the definition was
19 wrong:

20 This is a decent definition of
21 gender identity, then we would be able
22 to, and now we have a series of questions
23 and the actual construct is the
24 correlation matrix we call it, is the
25 interrelatedness amongst each of the

1 variables that we have identified as
2 associated with each other.

3 But to use a phrase such as
4 inner sense and say, therefore, it cannot
5 be, a person reporting it can't be
6 questioned, that there can't be any
7 physical evidence for it that we must
8 take as literal truth, the person's
9 self-report.

10 No, that's not a scientific.
11 That is take a non-scientific or
12 pre-scientific construct and switching
13 from, in this paper, we would be taking
14 something that was untested, with the way
15 the phrase is being used now is to, as I
16 say, express something as untestable.

17 Q. Your paper does not conclude
18 that the definition laid out at the
19 beginning of the paper is incorrect; does
20 it?

21 A. Correct, in the context of the
22 paper we were not -- it required only a
23 general description of the phenomenon we
24 were going after. There was nothing in
25 the paper that was along the lines of

1 "because this is an inner sense,
2 therefore," and then assuming the
3 validity, the validity of it. It was
4 asking questions. If this is what it is,
5 then a person should give whatever series
6 of answers.

7 For example, with a
8 questionnaire, you know, once, after
9 developed, one can administer
10 questionnaires to groups of people which
11 would in turn allow us to say these
12 people are expressing this about their
13 gender identity and those people are
14 expressing that about their gender
15 identity.

16 But if one simply stops and
17 says that's a person's inner sense, well,
18 then it's no longer possible to disagree
19 with what somebody says their inner sense
20 is.

21 Q. So I just want to redirect you
22 back to my question, however. The paper
23 does not conclude that the definition of
24 gender identity that you laid out at the
25 beginning of the paper is incorrect,

1 right?

2 MR. RAMER: Objection to the
3 form. Asked and answered.

4 A. That was not the subject of the
5 paper and not an indication of any of the
6 results.

7 Q. If we can turn back to your
8 declaration, Exhibit 1.

9 A. Got it.

10 Q. And I want to go to paragraph
11 139, please.

12 A. Yes.

13 Q. So in this section of your
14 report you distinguish between
15 suicidality and suicide, correct?

16 A. Well, the research literature
17 on them does, and I am just summarizing
18 it.

19 Q. Sure. You agree that
20 suicidality is a serious issue, right?

21 A. Yes.

22 Q. And you agree that suicidality
23 is something that should be addressed --

24 A. Yes.

25 Q. -- in a patient presenting?

1 Sorry. You agree that suicidality is
2 something that should be addressed in a
3 patient that presents with indicators of
4 suicidality?

5 A. Yes, absolutely.

6 Q. You go on to discuss, if we
7 turn to paragraph 148, you discuss a
8 systematic review in paragraph 148 by
9 McNeil.

10 A. Yes.

11 MR. MAY: I want to go ahead and
12 pull that up. So if we can please go
13 ahead and mark tab 29 as the next
14 Exhibit, Exhibit 10.

15 (Exhibit 10, Article entitled
16 "Suicide in Trans Populations: A
17 Systematic Review of Prevalence and
18 Correlates," by McNeil, et al., was so
19 marked for identification, as of this
20 date.)

21 MR. BENIMOFF: Exhibit 10 marked
22 and renamed.

23 A. Got it.

24 Q. So Exhibit 10 is an article
25 entitled, "Suicide in Trans Populations:

1 A Systematic Review of Prevalence and
2 Correlates," by McNeil et al, right?

3 A. Yes.

4 Q. And this was published in 2017,
5 and it's the same article that you cite
6 in paragraph 148 of your declaration,
7 right?

8 A. Yes, it is.

9 Q. I want to go ahead and skip
10 forward to the discussion. And turn to
11 page 8 of the article which is 348 by the
12 internal pagination. And I apologize,
13 this isn't skipping ahead to the
14 discussion, this is still the results.

15 A. I am there.

16 Q. Do you see the heading for most
17 of this page is entitled "Trans-Related
18 Variables and Suicidality"?

19 A. Yes.

20 Q. And if you look to the bottom
21 of the left-hand column basically towards
22 almost the end of the column, McNeil
23 reports that "In contrast, however" --

24 A. I am sorry, I thought you were
25 reading from it, go ahead.

1 Q. I am reading from the article,
2 I apologize, if that's not clear. The
3 left-hand column, bottom paragraph, and
4 it's four or five lines from the bottom?

5 A. Yes.

6 Q. "In contrast, however, Bauer,
7 et al (2015), reported less suicidal
8 ideation for those undergoing a medical
9 transition compared to those who were
10 considering it."

11 Do you see that?

12 A. Yes, I do.

13 Q. And you don't disagree with
14 that assessment by McNeil of the Bauer
15 article?

16 A. I don't disagree with their
17 describing the result. But again taking
18 that out of context it's easy to
19 misinterpret what it means or its
20 indications, I should say.

21 Q. And if you go to the right-hand
22 column, staying on this same page, the
23 first full paragraph. And it starts with
24 "In terms of the specific medical
25 interventions that people might undergo,

1 Colton Meier, et al (2011), found a small
2 but nonsignificant decrease in lifetime
3 prevalence of suicide attempt among a
4 group of trans men who were taking
5 hormones compared to those who were not."

6 And then, "E.C. Wilson (2015),
7 found that hormones related to a
8 significantly lower rate of suicidal
9 ideation in trans women receiving them
10 compared to those who were not. Overall,
11 Bauer, et al 2015, reported that
12 receiving hormones was associated with
13 decreased suicidal ideation in a mixed
14 group compared with those who had not
15 started hormone therapy."

16 Did I read that correctly?

17 A. Yes, that's what those say.
18 But as I said, you know, when you kind of
19 remove it from its context, that's easily
20 misinterpreted to mean that there was a
21 causal association between the two where
22 they hadn't yet, none of those studies
23 had yet ruled out the more mundane, the
24 more parsimonious explanation.

25 As we were saying before the

1 successful transitioners are the ones
2 that get through the real life
3 experience, and so on, and are otherwise
4 mentally healthy.

5 When you take a sample of
6 people who have transitioned, you get a
7 sample of people who were screened for
8 mental health. When you compare them to
9 people who have not yet gone through that
10 screening, the people with lower mental
11 health are still in the sample.

12 So if you just compare one
13 group with the other, you get a group
14 from whom the mental health issues have
15 been removed, compared to a group of
16 people for whom the mental health issues
17 had not yet been removed.

18 So, of course, there is a
19 difference between the two, even though
20 there is absolutely no evidence that it
21 was the transition itself that caused the
22 change in the levels of mental health
23 between the two.

24 Q. All right. We can go ahead and
25 put McNeil aside. Can we turn to

1 paragraph 58 of your declaration, Exhibit
2 1.

3 A. I am there.

4 Q. So in paragraph 58 you say that
5 "People's self-reports do not represent
6 objective evidence"?

7 A. That's correct.

8 Q. Are there any circumstances
9 where subjective self-reporting could be
10 the basis for medical interventions?

11 A. Sorry, say that again.

12 Q. Is there any circumstance in
13 which subjective self-reporting could be
14 the basis for some medical interventions?

15 A. Sure. If it's a low risk
16 intervention.

17 Q. What else besides when it's a
18 low risk intervention can subjective
19 self-reporting be the basis for medical
20 intervention?

21 MR. RAMER: Objection to the
22 form.

23 A. I can't think of any.

24 Q. Are questionnaires evaluating
25 an individual's subjective self-reporting

1 or objective evidence?

2 A. It depends on the content of
3 the questionnaire and the method by which
4 one obtains the sample. A survey
5 typically consists of a series of face
6 valid we call it, just direct open-ended
7 questions, what you see is what you get.
8 The question being asked means the
9 question you're being asked. The person
10 taking the survey takes a poll of who is
11 going to vote for whom in whatever
12 election tomorrow. As I say it's a face
13 valid, obvious and easily manipulated
14 series of answers. And anyone that wants
15 to take the survey can take the survey,
16 which leads itself to all kinds of
17 problems, who has time for the survey or
18 not.

19 People who feel more strongly
20 about an issue can take it, and people
21 who don't care are people who don't care.
22 So when you get X percent think whatever
23 it is they think, it's difficult to come
24 to a conclusion, because anybody who
25 wants to take the survey can take the

1 survey.

2 Questionnaires in the field,
3 the sub-field or part of my field that
4 does these calls them psychometric
5 instruments, psychometric instruments,
6 where it's not so obvious what the answer
7 is and the investigator is looking for
8 patterns amongst the answers to the
9 question. And there really is no correct
10 answer, there is no correct answer at
11 all. And it's the way the questions
12 cluster unto themselves in order to
13 reveal an underlying pattern across them,
14 is what's of interest.

15 And such questionnaires need to
16 be what we call psychometrically valid.
17 They need to have been independently
18 determined to actually tap into whatever
19 construct it is that that questionnaire
20 is aiming at.

21 And a questionnaire would be
22 applied in a specific circumstance to a
23 particular kind of sample that was
24 ascertained by the researcher in a
25 specific way.

1 So they can look similar in
2 that it's a person answering questions,
3 but the kinds of questions and the way
4 the questions are administered and to
5 whom it's administered are independent --
6 are independent. Where the
7 questionnaire, the more formal and the
8 more scientifically valid method allows
9 us to come to more specific concrete
10 observations.

11 Q. So you mentioned that there
12 could be kind of a bias, you didn't use
13 the word "bias," but I am going to ask
14 you, is it appropriate to describe the
15 way that -- strike that question. Let me
16 start it over.

17 You mentioned the way that
18 anyone who wants to take a survey can
19 take a survey, can lead to all kinds of
20 problems. And is one of those problems
21 bias in the sample?

22 A. Yes, we would call that a
23 selection bias or ascertainment bias,
24 typically.

25 Q. And then beyond the scientific

1 term of bias, can the individuals who are
2 deciding to take the survey have a bias
3 one way or another towards their
4 perceived outcome of the survey?

5 MR. RAMER: Objection to the
6 form.

7 A. Possible, yes, certainly.

8 Q. And is that itself a different
9 kind of scientific bias?

10 A. Different from?

11 Q. Or is it a subset of selection
12 bias or ascertainment bias?

13 MR. RAMER: Objection to the
14 form.

15 A. That's a good question. That
16 wouldn't be the terms I would use to
17 describe that kind of a problem. Usually
18 we would describe that as a problem with,
19 with the validity of the survey. Usually
20 ascertainment and selection bias refers
21 to who is taking the survey rather than
22 the behavior of the people once they are
23 taking the survey.

24 Q. If a survey were exploring
25 topic X, and that survey were advertised

1 to people primarily pro-topic X, how
2 would that be described in terms of
3 scientific bias?

4 MR. RAMER: Objection to the
5 form.

6 A. Usually we would call that a
7 selection bias.

8 Q. Is that a problem if a survey
9 exploring topics X is advertised
10 primarily to people who are pro-topic X?

11 A. It depends on the content of
12 the survey and how it's being, how it's
13 being applied and interpreted.

14 There can theoretically exist
15 -- if one has a bias sample but you're
16 not asking questions -- but you're not
17 coming to conclusions that depend on that
18 bias, it's not going to make as much of a
19 difference.

20 For example, to make up a
21 generic example, if one used one's church
22 group to do a survey, well, if you ask
23 them about, you know, the nature of
24 religion, you're not going to -- it
25 wouldn't be valid from that to take that

1 percentage of Americans are this
2 religious. We have no reason to think
3 that, because they would be biased in
4 that specific way. But if we asked them
5 other kinds of questions -- if we asked
6 of the survey results or if we analyzed
7 the survey results for a conclusion that
8 people who get up early in the morning
9 tend to have whatever kinds of jobs, well
10 then the selection bias is less likely to
11 be relevant, it's less likely to be
12 relevant.

13 Even if we found that for
14 example, churchgoers were more likely to
15 wake up early in the morning. Fine. But
16 we would have much less of a reason to
17 suspect that that would change the
18 relationship between time of morning and
19 recreational interest, and so on.

20 So such surveys are not
21 automatically meaningless. But the
22 amount of validity we could have, depends
23 on how it's being analyzed, the questions
24 that are being asked of the survey.

25 Q. I believe you previously

1 testified to this statement, but you
2 agree that it's easier for advocates for
3 people with one or another political
4 persuasion to be able to effect a survey,
5 right?

6 MR. RAMER: Object to form.

7 A. In general, the transparency of
8 the questions allows for that, yes.

9 Q. And advertising a survey on a
10 particular website can mean that the
11 results would reflect that website's
12 bias, right?

13 A. Again, it depends on the
14 content of the survey and the questions
15 being asked. It can be perfectly
16 legitimate to advertise on a listserv of
17 people who have an experience with
18 whatever that experience is, because it's
19 people with that experience or what
20 you're trying to find out about.

21 A generic example if you want
22 to know people's experience on cooking,
23 you can run a survey on people who cook
24 whatever it is that they cook. Well,
25 that's perfectly fine, because that's the

1 thing that you're trying to measure.

2 But in a, again, in the context
3 of these particular questions, you know,
4 where there is a large controversy or a
5 polarized debate going on, then surveying
6 a group, you can't really say, you can't
7 from surveying one side of that group and
8 being able to conclude that whatever
9 percentage of the public think whatever
10 it is that you got from surveying from
11 that, from that one side. So it depends.

12 MR. MAY: Why don't we go ahead
13 and take a break now before I go ahead
14 and switch gears a bit.

15 THE VIDEOGRAPHER: Thank you,
16 the time is 4:15, we are going off the
17 record.

18 (Off the record.)

19 THE VIDEOGRAPHER: The time is
20 4:25, we are back on the record. This
21 begins media file 6.

22 BY MR. MAY:

23 Q. Dr. Cantor, in your declaration
24 you cite an article by Littman from 2018,
25 right?

1 A. Yes.

2 Q. And you're familiar with that
3 article?

4 A. Yes.

5 MR. MAY: So if we can go ahead
6 and pull up what's been marked as
7 Exhibit 11.

8 (Exhibit 11, Document titled
9 "Correction: Parent Reports of
10 Adolescents and Young Adults Perceived
11 to Show Signs of a Rapid Onset of
12 Gender Dysphoria", was so marked for
13 identification, as of this date.)

14 MR. BENIMOFF: Exhibit 11 is
15 marked and renamed.

16 A. Got it.

17 Q. All right. Exhibit 11 is a
18 document titled, "Correction: Parent
19 Reports of Adolescents and Young Adults
20 Perceived to Show Signs of a Rapid Onset
21 of Gender Dysphoria."

22 Do you see that?

23 A. Yes.

24 Q. And this is a correction of the
25 Littman article and a notice of the

1 republication of that article with the
2 corrections made, correct?

3 A. Yes. It's the editorial
4 standard in that journal to call that
5 corrections but one from that shouldn't
6 apply the usual phrase correction that
7 there was a mistake in error or something
8 false in the original version. It's just
9 that the editorial standard is that when
10 there is any change to an article it's
11 just called a correction.

12 Q. If we stick on the first page
13 of Exhibit 11, under the heading
14 "Emphasis That This is a Study of
15 Parental Observations Which Serves to
16 Develop Hypotheses."

17 The fourth line down, the
18 sentence reads "Rapid onset gender
19 dysphoria is not a formal mental health
20 diagnosis at this time."

21 Do you see that?

22 A. Yes, correct.

23 Q. You agree with that statement,
24 right?

25 A. Yes.

1 Q. And a few lines down the
2 sentence reads "Furthermore, the use of
3 the term 'rapid onset gender dysphoria'
4 should be used cautiously by clinicians
5 and parents to describe youth who appear
6 to fall into this category."

7 Do you see that?

8 A. I recall that that was a basic
9 idea in here. I am not seeing that
10 sentence. Where is it again?

11 Q. About halfway down the
12 paragraph.

13 A. And what was the first word of
14 the sentence?

15 Q. "Furthermore."

16 A. Yes, got it.

17 Q. So the statement "Furthermore,
18 the use of the term 'rapid onset gender
19 dysphoria' should be used cautiously by
20 clinicians and parents to describe youth
21 who here fall into that category."

22 Do you agree with that
23 statement?

24 A. Yes.

25 Q. All right. If we can turn to

1 page 3 of the correction notice, Exhibit
2 11?

3 A. Got it.

4 Q. There is a heading called
5 "Clarification of Study Designs, Methods
6 and Related Limitations."

7 A. Yes.

8 Q. The last sentence of that
9 entire section states that "For the
10 current study selection bias may have
11 resulted in findings that are more
12 positive or more negative than would be
13 found in a larger and less self-selected
14 population. Subsequent studies should
15 address these issues."

16 Do you agree with that?

17 A. Yes.

18 Q. You agree that selection bias
19 may have impacted Littman's findings?

20 MR. RAMER: Objection to form.

21 A. May have, yes. Again, my
22 hesitation really is about the lion's
23 share of that caution really applies to
24 how one is going to -- this is what I was
25 saying before, you know, about surveys in

1 general. It depends on exactly what it
2 is that one is going to conclude from
3 those results.

4 For example, one would not want
5 to use a survey like this to say, you
6 know, X-percentage find whatever,
7 characteristic or whatever somebody wants
8 to pull out of it. But if one says, oh,
9 my goodness there is a pattern of people
10 who show more of this also show more of
11 that. Oh, that's interesting because we
12 were expecting, whatever. Therefore, we
13 need to ask more questions.

14 So it is indeed, because
15 surveys are cheap and easy, you know,
16 it's very often the first line, the first
17 line of research. So again, with surveys
18 and everything else, one wants neither to
19 overinterpret nor underinterpret the
20 potential implications.

21 Q. The next heading in the
22 correction notice, Exhibit 11, is
23 "Updated Information About Recruitment."

24 Do you see that?

25 A. Yes, I do.

1 Q. And towards the bottom of page
2 3, there is a sentence that starts with
3 "This means that parents participating in
4 this research may have viewed the
5 recruitment information from one of at
6 least four sites with varied
7 perspectives. Specifically, three of the
8 sites that posted recruitment information
9 expressed cautious or negative views
10 about medical and surgical interventions
11 for gender dysphoric adolescents and
12 young adults and cautious or negative
13 views about categorizing gender dysphoric
14 youth as transgender."

15 Do you see that?

16 A. Yes, I do.

17 Q. Does that go along with the
18 selection bias that we were discussing a
19 little bit earlier?

20 A. Yes, essentially.

21 Q. Do you think it's a problem
22 that this study was advertised, in the
23 three out of four sites in which this
24 study was advertised had cautious or
25 negative views about medical and surgical

1 interventions for gender dysphoric
2 adolescents and young adults and cautious
3 or negative views about categorizing
4 gender dysphoric youth as transgender?

5 MR. RAMER: Objection to form.

6 Compound.

7 A. I would hesitate with the word
8 "problem." It's a problem, it's more or
9 less of a problem depending on what, you
10 know, one wants to derive from it. It
11 would be a huge problem if one is going
12 to, as I say, you know, claim that the
13 results are representative of the entire
14 population. That would be a problem.
15 That would be a large problem. But to
16 identify that, oh, this is not so rare,
17 there are a chunk of people saying this
18 not very obvious kind of thing. We
19 should follow that up. That is
20 perfectly -- that is perfectly
21 legitimate.

22 Also, missing, also missing and
23 what gets lost when this study is pulled
24 out from the other studies and when
25 individual sentences are pulled out from

1 this study. One -- how does the saying
2 go -- mistakes the forest for the trees.
3 This is one piece that's consistent with,
4 you know, several other different kinds
5 of findings, all of which are pointing in
6 a similar direction. No one of these
7 studies provides any kind of a firm
8 conclusion.

9 It's extremely rare outside of
10 physics for any one study to definitively
11 decide anything. It's the overall
12 pattern throughout many different
13 studies, looking at several different
14 things in several different ways and then
15 having a tendency, all pointing in one
16 direction and then somebody comes up with
17 an explanation that best explains the
18 entire set.

19 For this particular -- I
20 hesitate to say finding, but the most
21 relevant part of this finding was that
22 parents were reporting that the kids
23 started reporting feeling gender
24 dysphoria after a relatively profound
25 increase in uses of social media. Okay,

1 fine. If that were the only piece we
2 had, we really don't know what it means.

3 But, for example, in my report
4 I included, you know, several very large
5 representative epidemiological samples
6 which showed all at exactly the same
7 time, right around 2012, skyrocketing
8 rates of depression, suicidality, anxiety
9 disorders. And it corresponds exactly to
10 the large increases in gender dysphoria
11 and to social media culture having taken
12 on to youth.

13 So these are each completely
14 independent, unrelated sources of
15 information, all pointing in exactly the
16 same year. Year? Era? Within a year or
17 two of each other. As I said, you could
18 almost overlay each of these graphs on
19 top of each other.

20 So when put together, what we
21 see is no matter which way we look at it,
22 no matter who looks at it, both here and
23 in Europe, we keep finding the same
24 thing. Social media has revolutionized,
25 not in a positive -- I guess I don't

1 really want to assign it positive or
2 negative -- but in a dramatic way things
3 have, the social interaction and social
4 variables have drastically, drastically
5 changed for youth. All at the same time.
6 All coincident. Not coincidental, but I
7 mean all at the same time with the
8 introduction of social media.

9 So in the context of all of
10 these other findings the observation that
11 parents of gender dysphoric kids noticed
12 or say that they notice that the kids
13 started reporting gender dysphoria after
14 enormous amounts of use of social media.

15 As I was describing several
16 other findings, all of these are pieces
17 of the same puzzle and it's really
18 difficult to come up with a better
19 explanation to this pattern of findings.
20 And as I keep saying, it's a pattern of
21 findings. If one just considered one
22 finding at a time, in isolation from all
23 of the others, there is no such thing as
24 a perfect study. We will always be able
25 to find, you know, shortcomings of any

1 study. It's a human endeavor. But put
2 together, there is a very, very
3 consistent pattern. All associated with
4 the onset of social media. So that
5 presents, you know, a very, again, I
6 don't want to call it proof, but it
7 provides people could legitimately debate
8 over the word "compelling evidence," but
9 very strong evidence or evidence that
10 says that we need to take this
11 possibility extremely seriously, that
12 social media is driving all of this.

13 Nobody has presented, nobody
14 has presented any theory, hypothesis,
15 idea, explanation that explains nearly as
16 well such a wide range of these otherwise
17 completely independent observations.

18 Q. These are all correlative
19 conclusions not causative conclusions,
20 correct?

21 A. That's correct. There is no
22 real good way to test causality in this
23 one. But as I say, nobody has come up
24 with a better, with a better explanation.

25 Q. But you can't say that social

1 media exposure causes this presentation
2 of gender dysphoria in adolescents that
3 Littman reports on, right?

4 MR. RAMER: Objection to form.

5 A. Correct. We don't have a way
6 to measure the causality of this one.
7 The level of evidence for which we have
8 is, as I say, it's the going theory.
9 Nobody has a better one. No one has a
10 better one, period.

11 Q. The Littman study does not tell
12 you how common it is for adolescents to
13 experience gender dysphoria based on
14 exposure to social media, right?

15 A. Correct. It's not a
16 representative sample.

17 Q. The Littman study doesn't
18 actually survey adolescents, right?

19 A. It surveys their parents.

20 Q. And Littman himself agrees that
21 there may be aspects of the adolescent's
22 life that the parents do not have full
23 visibility into, correct?

24 MR. RAMER: Objection.

25 A. Yes, that is possible. Again,

1 not just in this study. That's the
2 nature of the study in youth, is that
3 it's very common, very common, almost
4 ubiquitous that the surveys are done of
5 the parents. We always try -- the field
6 tries to get as many different sources of
7 information as possible. One would, you
8 know, do a survey of parents, of
9 teachers, of their pediatricians, of the
10 youth themselves when they are old
11 enough. And it's appropriate to the
12 questions. The research, the findings
13 that are the most compelling are the ones
14 where, as I said before, where we keep
15 finding the same pattern no matter whom
16 we ask.

17 Q. You would agree that LGBT youth
18 often keep their sexual orientation
19 and/or gender identity from their parents
20 for some time, right?

21 MR. RAMER: Objection to the
22 form. Compound.

23 A. That was very clearly true
24 before the social media age. I am not
25 aware of analogous research repeating

1 that in a rigorous way of the post-social
2 media onset.

3 Q. What do you define as the onset
4 of the social media age?

5 A. 2011-ish, 2012-ish is when all
6 of these variables seemed to have
7 exploded.

8 Q. So if a person -- if an
9 adolescent -- let me strike that and
10 start over.

11 If an adolescent who is say
12 16-years-old in 2004?

13 A. So they were born in --

14 Q. '88.

15 A. Okay.

16 Q. You would expect that -- you
17 would not be surprised by a finding that
18 that individual hid their sexual
19 orientation or gender identity from their
20 parent, if it was not heterosexual or
21 cisgender?

22 MR. RAMER: Objection to the
23 form.

24 A. I don't think I would ever be
25 surprised if somebody told me that they

1 hid it, hid their sexual orientation from
2 their parents. But again in the social
3 media age and in the current environment,
4 there is not a lot of any report that I
5 would find surprising. It's exactly
6 because so many youth are so strongly
7 influenced by social media that -- I am
8 skipping a step.

9 In sex research, which I have
10 been at, you know, I want to make a joke
11 about it, since they invented sex, we
12 kind of take for granted that when you
13 ask a person about their sexualities,
14 their sex lives, their desires, their
15 erotic backgrounds, their masturbation
16 habits, and so on, we take for granted
17 that what they tell us may not be the
18 whole truth. It doesn't necessarily mean
19 they are lying, but it's hard to escape
20 the social pressures, the self-delusions
21 and stories that we tell ourselves that
22 what they are telling us, especially in a
23 first assessment meaning may not be the
24 whole story. That's always been true.
25 Especially when it comes to any kind of

1 atypical sexuality, including atypical
2 gender identities.

3 The methods that we have
4 objectively to tell us about people's
5 sexualities verify what we always took
6 for granted that the objective variables
7 do not always match what the person tells
8 us about their sexualities. That was all
9 before social media.

10 Social media itself has brought
11 with it a culture that has only further
12 increased, again, that has greatly
13 increased the social pressure, the desire
14 for people to tell the right answer, the
15 focus on how somebody looks or will
16 appear. And so I, we, an objective sex
17 researcher, is that much more in doubt
18 that a self-report is the whole story or
19 is accurate or can be taken at face
20 value.

21 So as I say, now, if somebody
22 tells me that they hid something from
23 their parents, didn't hide something from
24 their parents, there really is just about
25 nothing that somebody can say that will

1 surprise me but by the same token, I, and
2 I think anybody should take that much
3 more of a -- I am not even sure if I
4 should say critical or cynical -- that we
5 can't take for granted, especially from a
6 youth, especially from people, you know,
7 with their own social vulnerabilities and
8 mental health issues going on, that what
9 they are telling us is the literal truth
10 as opposed to how they want to be thought
11 of, how they want to think of themselves.

12 So we have both problems. We
13 have people who will, because of
14 perceived social stigma, hide information
15 from their parents, families, therapists,
16 doctors, friends, whoever. But by the
17 same token, other people who will
18 exaggerate situations in order to gain
19 from the sympathy of the people around
20 them. So in which cases is it being
21 overestimated and in which cases is it
22 being underestimated, we don't have an
23 objective way to check all of these
24 subjective reports.

25 Q. Dr. Cantor, do you recall what

1 my question was?

2 A. That's a good question. You
3 were asking something that followed from
4 the Littman study. That was it. Would
5 it be surprising if somebody said --
6 would I be surprised if somebody said
7 that they were hiding their sexual
8 orientation from their parents.

9 Q. In 2004. So I want to redirect
10 you back to my original question?

11 A. I apologize, I don't know if I
12 heard the 2004 part.

13 Q. If I can redirect you back to
14 my original question, you would not be
15 surprised by a finding that an individual
16 who was 16 in 2004, born in '88, hid
17 their sexual orientation or gender
18 identity from their parent, if that
19 person was not heterosexual or cisgender?

20 MR. RAMER: Objection to the
21 form. Asked and answered.

22 A. I wouldn't be surprised about
23 that.

24 Q. Is it fair to say that
25 teenagers and adolescents may conceal

1 their sexual orientation from their
2 parents?

3 A. Sure.

4 Q. And it's fair to say that still
5 holds true today as much as it did in
6 2004?

7 A. No, that's where I insert my
8 long answer is how much has changed
9 between then and now is that we can't so
10 easily generalize habits from then or
11 experiences from then to now.

12 Q. Do you think -- is it still a
13 likelihood that an adolescent will
14 conceal their sexual orientation from
15 their parent?

16 MR. RAMER: Objection to the
17 form.

18 A. That's a good question. I
19 don't think anybody knows. I am not
20 aware of that kind of a question, those
21 kinds of questions really being asked in
22 contemporary surveys. Different kinds of
23 questions have become, for lack of a
24 better word, fashionable.

25 Q. Would it surprise you if a

1 teenager or adolescent came to you and
2 told you that they were concealing their
3 sexual orientation from their parents?

4 MR. RAMER: Objection to the
5 form.

6 A. If a person said that today,
7 no, that would not be surprising.

8 Q. Would you be surprised if a
9 teenager or adolescent today told you
10 they were concealing their gender
11 identity from their parents if that
12 gender identity was not cisgender?

13 MR. RAMER: Objection to the
14 form.

15 A. Again, I wouldn't be surprised
16 if they said that. But I still would not
17 be sure that it's the whole story,
18 either.

19 Q. Okay. So in this hypothetical
20 a 17-year-old comes to you and says I've
21 been feeling like I may not, that my
22 gender identity may not align with my
23 biological sex. I haven't told anything
24 about this to my parents. But I am
25 feeling strongly that I may be

1 transgender. Do you have any reason to
2 suspect that this hypothetical individual
3 would be lying to you?

4 MR. RAMER: Objection to the
5 form.

6 A. Lying wouldn't be the right --
7 I would not readily use the word "lying."
8 Much more common and, therefore, my first
9 set of, you know, next pile of assessment
10 questions would be whether the person is
11 mistaken in labeling what it is that they
12 are experiencing.

13 If they, for example, use the
14 terms you did which are the terms
15 ubiquitously going around the, around
16 social media, I still don't know what
17 this person's actual experience is and
18 what it is that they are using those
19 terms to describe. So I would actually
20 skip all of the popular buzz words and
21 conclusions and jump right to exactly
22 what it is that you're feeling. How long
23 have you been feeling it. Under what
24 circumstances. And then I would start
25 presenting that some people say, some

1 people say, there are other people who
2 say, in order to broaden the other
3 possibilities in order to start getting
4 an idea of, you know, what the person's
5 actual experience is and then, you know,
6 what happens, what we know about other
7 people who describe those kinds of
8 experiences.

9 If I start out with I think I
10 am transgender, at this point those words
11 aren't meaningful anymore. They are just
12 kind of a generic stamp at this point
13 that people use for many different
14 purposes. But they are not lying. In
15 general, they are using the only
16 vocabulary that they have to describe it.
17 They are using terms that they see
18 everybody else using.

19 But my clinical or any standard
20 clinical assessment actually would be to
21 jump over that secondary vocabulary into,
22 all right, what's going underneath the
23 surface.

24 Q. Okay. So with that same
25 hypothetical patient. After you have

1 seen them for a couple of sessions or as
2 long as you need to make an appropriate
3 assessment, you come to the conclusion
4 that they meet the criteria for gender
5 dysphoria under the DSM.

6 Would you still believe them if
7 they said they had not told their parents
8 that they were, that they had feelings of
9 a gender identity, a gender identity that
10 did not align with their biological sex?

11 MR. RAMER: Objection to the
12 form.

13 A. Again, there are a couple of
14 things built into that question, one of
15 which is that the DSM-5 would actually
16 not be relevant to such a, such a case.
17 The DSM-5 criteria predate all of the
18 outcome studies on adolescent onset
19 gender dysphoria.

20 The research that was available
21 in 2013, there existed one outcome study
22 of kids who transitioned. We didn't have
23 the information. We didn't have the
24 information. We didn't get have this,
25 you know, explosive increase in

1 adolescent onset cases. So its validity
2 for diagnosing adolescents is zero. As I
3 say, the DSM doesn't cover adolescent
4 onset cases.

5 Now I am kind of working in the
6 assumption that this is an adolescent
7 onset case because they are today the
8 great, great majority of the adolescents
9 who are coming in. Before 2012-ish,
10 before the DSM-5, there were basically
11 none. We had the prepubescent kids
12 coming in and we had middle-aged adults
13 coming in. Barely anybody in between.
14 That's why we had the adult or late onset
15 cases or the childhood or early onset
16 cases.

17 So if somebody comes in at 17,
18 really, my initial questions are about
19 when did this start. Is this new. Is
20 this something that just began. You
21 know, is it adolescent onset or is this a
22 kid who was always ridiculed, bullied,
23 who is very clearly different from his or
24 her peers, really since childhood. Is it
25 a childhood onset case. And knowing the

1 difference between those, you know, keys
2 in, you know, very, very different parts
3 of the literature as relevant.

4 If it were an adolescent onset
5 kind of case, again, nope, nothing would
6 surprise me, including that they didn't
7 tell their parents.

8 If it were a childhood onset
9 case, the question becomes moot. Even if
10 they didn't say anything out loud to
11 their parents, their parents very likely
12 would have, you know, already figured
13 this out, even before the kid did. As I
14 say, the childhood onset cases stick out
15 for better or for worse.

16 To back up a step, therefore,
17 whether they meet DSM-5 criteria is not
18 really pertinent because the DSM-5
19 criteria aren't what was used in the
20 research that we have about the outcomes
21 for most of these, most of these youth.

22 Q. One of the things you mentioned
23 that even if they didn't say anything out
24 loud to their parents their parents very
25 likely would have already figured that

1 out?

2 A. For childhood onset cases, yes.

3 Q. You agree that's still
4 different than the child coming out to
5 their parents as having and revealing
6 that they recognize they have a different
7 gender identity than what aligns with
8 their sex from birth?

9 A. Yes.

10 MR. RAMER: Objection to the
11 form.

12 THE WITNESS: Sorry.

13 MR. RAMER: Objection to the
14 form.

15 Q. So that adolescent who had been
16 -- strike that.

17 That adolescent who had been
18 displaying signs of gender congruence,
19 gender dysphoria going back to childhood,
20 could still be themselves concealing
21 their gender identity from their parents?

22 MR. RAMER: Objection to the
23 form.

24 A. Yes, that again wouldn't, would
25 not surprise me.

1 Q. Turning our attention back to
2 the Littman paper, but not specifically
3 the correction. I want to turn to your
4 declaration in paragraph 136, your
5 declaration being Exhibit 1.

6 A. Yes.

7 Q. Paragraph 136 you discuss the
8 Littman paper, right --

9 A. Yes.

10 Q. -- among other articles, fair?

11 A. Yes.

12 Q. And you have a footnote 5 there
13 about the corrections to the Littman
14 article.

15 And you say that the relevant
16 results were unchanged between the
17 original article and the revised article,
18 right?

19 A. Yes.

20 Q. Are you familiar with both
21 versions of the Littman article, both the
22 original and the revised?

23 A. No.

24 Q. Were there any new hypotheses
25 or conclusions that Littman laid out in

1 the revised article that were not in the
2 original one?

3 A. Sort of. The range of
4 potential explanations was expanded. As
5 I say, the findings themselves were
6 unchanged.

7 MR. MAY: If we can go ahead and
8 mark tab 27 as the next exhibit, which
9 I believe will be Exhibit 12.

10 (Exhibit 12, Research article
11 titled "Parent Reports of Adolescents
12 and Young Adults Perceived to Show
13 Signs of a Rapid Onset of Gender
14 Dysphoria" by Littman, was so marked
15 for identification, as of this date.)

16 MR. BENIMOFF: Exhibit 12 marked
17 and renamed.

18 A. There it is.

19 Q. So Exhibit 12 is a research
20 article titled, "Parent Reports of
21 Adolescents and Young Adults Perceived to
22 Show Signs of a Rapid Onset of Gender
23 Dysphoria," by Littman.

24 A. Yes.

25 Q. That was the revised version of

1 the Littman article, right?

2 A. That's a good question. I
3 would have to compare both in my, in my
4 notes to double check. But I have no
5 reason not to take your word for it.

6 Q. I will represent to you that it
7 is the revised one.

8 A. Okay.

9 Q. If we can turn to page 34 of
10 Exhibit 12.

11 A. I am there.

12 Q. It's going to be the sections
13 spanning pages 34 and 35. Do you see
14 this hypothesis, "Two parental conflict
15 may provide alternative explanations for
16 selective findings"?

17 A. I see the section, yes.

18 Q. And I will represent to you
19 that this is new in the revised version
20 of the article.

21 A. Okay.

22 Q. Is this one of the range of
23 potential explanations that was expanded
24 that you referenced earlier?

25 MR. RAMER: Objection to the

1 form.

2 A. I can't say and I don't
3 remember saying exactly which of the
4 hypotheses were kind of alternative
5 explanations were there. But that,
6 again, is not pertinent, I don't want to
7 say that I even have a conclusion. It's
8 that the scientific term that we have is
9 the principle of parsimony.

10 For any correlation there are
11 necessarily several different
12 explanations. So when we look at any one
13 correlation, there is always any number
14 of possible ways to explain it.

15 What, as I was describing
16 before, the part that's, that makes this
17 strong evidence is that one of these
18 hypotheses, the association with social
19 media, is consistent with several others
20 of these findings entirely independent of
21 this, looking at entirely different
22 variables investigated by, as I say.

23 So if we line up the, oh, this
24 from this study goes together with that
25 study, with that study, with that study,

1 with that study. So that one hypothesis,
2 this is written by social media, explains
3 a wide range of very diverse findings.
4 That's what makes a compelling, strong,
5 important theory and the theory to beat.
6 When we isolate to one of the papers or
7 one set of correlations, yeah, no, we can
8 add as many alternative possibilities for
9 that one finding as we want.

10 But these others, parental
11 conflict might provide alternative
12 explanations. That doesn't explain the
13 coincidental timing of things exploding
14 for the entire generation for all of
15 these other variables, all happening at
16 exactly the same time.

17 Is it theoretically possible
18 that each of these things has its own
19 independent cause? Sure, that's
20 theoretically possible. But the
21 scientifically superior explanation is,
22 as I said, the principle of parsimony, is
23 that the more you can explain with one
24 theory, makes that the theory to beat.

25 And so the idea that this is

1 driven by social media explains not only
2 one of these hypotheses, but all of those
3 others. So, yeah, no, we can add as many
4 other hypotheses as we want, but the
5 principle of parsimony points us to one
6 of them.

7 Q. So redirecting you back to
8 Hypothesis 2 about parental conflict
9 might provide alternative explanations
10 for selected findings, Littman reports
11 that almost half of the -- if you go to
12 the second and third lines -- "almost
13 half of the AYAs" -- which I believe is
14 an abbreviation for adolescents and young
15 adults -- "withdrew from family, 28.5
16 percent refused to speak to a parent and
17 6.8 percent tried to run away."

18 Do you think it's still
19 reliable to rely on parental reports from
20 parents whose children refused to speak
21 with them.

22 MR. RAMER: Object to form.

23 A. If that were the only variable
24 available, then it would be hard to
25 choose amongst the potential

1 hypotheses -- well, explanations rather
2 than hypotheses.

3 Q. These are all hypotheses,
4 right?

5 A. These are evaluations of those
6 hypotheses. Again, I wouldn't have
7 called them hypotheses. I would have
8 reserved that term in the traditional
9 way.

10 The hypothesis is the idea that
11 you have, you know, before conducting the
12 study and the idea that you're trying to
13 either falsify or, you know, gather,
14 gather support for.

15 These are, you know,
16 hypothesized explanations for data that
17 were already gathered. I wouldn't use
18 the word "hypothesis" for that. But
19 again, that's within the journal's
20 editorial discretion.

21 Q. Let me take you back to Exhibit
22 11, which was the correction notice for
23 the Littman study.

24 A. I am there.

25 Q. Sticking with page 1, the first

1 bold heading that we looked at earlier is
2 this is an "Emphasis That This is a Study
3 of Parental Observations Which Serves to
4 Develop Hypotheses."

5 And she explains that the study
6 serves to develop hypotheses that rapid
7 onset gender dysphoria is a phenomenon,
8 and that social influences, parent-child
9 conflict and a maladaptive coping
10 mechanisms may be contributing factors
11 for some individuals, right?

12 A. Yes.

13 Q. The purpose of surveying the
14 data is to generate hypotheses; do you
15 agree with that?

16 MR. RAMER: Objection to form.

17 A. I would hesitate to narrow down
18 the purpose to a single one. Usually
19 that expression is used in order to, as a
20 reminder of how non-conclusive surveys
21 are when, you know, trying to investigate
22 or flesh out a theory and that it's
23 purpose is not to be conclusive, it can't
24 be conclusive. It's to help develop, oh,
25 look, these are associated. We should

1 look at that, look at that more.

2 Q. You can put this aside for
3 right now. Let's turn back to your
4 declaration, Exhibit 1. And if we can go
5 ahead and turn to paragraph 245.

6 A. I am there.

7 Q. Would you agree that desistance
8 is less likely to occur past the age of
9 12, right?

10 A. In childhood onset cases,
11 unfortunately a lot of people kind of use
12 that for anyone over 12, you know, and
13 including people for whom it only just
14 started when really that phrase only,
15 that conclusion only applies to people
16 for whom it was prepubertal onset and
17 persisting into adolescence, not just
18 anybody in adolescence.

19 Q. So for a child that presents
20 prepubertal with symptoms consistent with
21 gender dysphoria, once puberty, once
22 puberty has begun, and that child
23 continues to display signs of gender
24 dysphoria, you would agree that that
25 child is likely not to desist?

1 MR. RAMER: Objection to the
2 form.

3 A. Close. The part that's not
4 exactly accurate is to say once puberty
5 has started. There is no such sharp
6 line. It's not, you know, last month was
7 prepubertal. This week is, this month is
8 pubertal. Therefore, you know, this kid
9 is going to persist. As these studies
10 were coming out, it was generally over
11 the course of puberty and a sex drive
12 kicked in, the kids generally started
13 figuring out that they were gay or
14 lesbian, because they were experiencing
15 sex drive and their first crushes and
16 masturbatory fantasies, and so on. But
17 even though the studies were, you know,
18 just referring to puberty as the general
19 era, people with a motivation to, that
20 medicalized transition should begin as
21 quickly as possible, started just saying
22 the beginning of puberty where none of
23 these studies really said the beginning
24 of puberty.

25 But as I said and you almost

1 said, a kid with prepubertal, before
2 puberty, generally it's from the get-go
3 and continue after, after most of puberty
4 and into adolescence. Those are unlikely
5 at that point, it seems to desist for
6 that minority for who that happens. Most
7 of them desist, but not all of them.

8 Q. And for those who do not
9 desist, do you think that prescription of
10 puberty blockers can be appropriate for
11 some of those individuals?

12 MR. RAMER: Objection to the
13 form.

14 A. That's the open empirical
15 question for which we have, you know,
16 only mixed evidence. You know, so there
17 are some cases for which it appears to be
18 the case. But we can't figure out, we
19 haven't found a way to figure out for
20 which cases. And there are some, several
21 studies, and again I summarize them each
22 in my report, that it doesn't make a
23 difference to their mental health. Some
24 get better. Some don't. And it doesn't
25 seem to be strongly related to a

1 medicalized transition. So we can't say
2 it's impossible. But we can't say, you
3 know, for the cases for which it does
4 seem to be legitimate, we haven't yet
5 figured out how to predict which of those
6 it is, which leads us, of course, to the
7 policy question is, well, if we can't
8 identify which ones it is, and it is
9 interfering with the healthy development
10 of healthy functioning tissue, now we're
11 at the risk/benefit ratio. It's how much
12 risk to how much harm relative to how
13 good is the evidence to how much benefit.

14 And by and large we have,
15 exactly, as I elucidated in my report, we
16 don't have any evidence that it does any
17 good -- it does any better on average
18 than mental health treatment and
19 psychotherapy.

20 Q. If we can turn to paragraph 114
21 of your declaration, Exhibit 1.

22 A. I am there.

23 Q. I actually want to talk about
24 the heading above that, it says that 11
25 cohort studies follow children not

1 permitted social transition, all showing
2 the majority to desist feeling gender
3 dysphoric following follow-up after
4 puberty.

5 How do you define the phrase
6 "social transition," as you use it here?

7 A. That really wasn't pertinent to
8 the studies themselves because there was
9 no in-between or partial status in those
10 studies. The kids were still being
11 treated. Had the name. Used the gender
12 and pronouns of their biological sex.
13 These weren't cases where it was
14 ambiguous or there were certain
15 circumstances where they presented one
16 way, and in other social areas where they
17 presented another way.

18 The contrast is between these
19 11 studies and the Olson study where the
20 kids had already socially transitioned.
21 There might have been a handful of
22 exceptions, but they were nearly 100
23 percent of them. But again, it was not
24 particularly ambiguous that those kids
25 had socially transitioned. They had a

1 new name. New set of pronouns. And so
2 on. But there hasn't been any study
3 amongst the prepubertal onset cases where
4 anybody was looking at particular aspects
5 of social transition, amounts of social
6 transition, pockets of their lives in
7 which they did versus did not transition.

8 All we have are the results
9 from this now 12 studies and the one
10 which did have transition was a pretty
11 complete social transition. And the ones
12 that didn't transition, essentially,
13 didn't transition in any way before
14 puberty.

15 Q. So I am just trying to make
16 sure that we are all talking about the
17 same thing. I am trying to understand
18 what's your definition of social
19 transition?

20 MR. RAMER: Objection to the
21 form. Asked and answered.

22 A. I am not giving a definition of
23 social translation. I am describing what
24 happened in these studies.

25 Now, of course, I have no

1 trouble acknowledging that, as I said,
2 there are mixes and ambiguous
3 circumstances where a person can do this
4 in different ambiguous ways or in
5 different ways, in different pockets of
6 their life. But in describing this set
7 of studies, none of that ambiguity was,
8 was present.

9 Q. This is not a trick question.

10 A. I didn't know there was such a
11 thing.

12 Q. You may be thinking about it a
13 little too hard. I am just trying to
14 understand, to make sure we are all
15 discussing the same thing. What are you
16 describing as a social transition?

17 MR. RAMER: Objection to the
18 form. Asked and answered.

19 A. I am not describing anything.
20 I'm reciting and summarizing what the
21 studies contained.

22 Q. So what I am trying to
23 understand is using a different name than
24 the name given -- strike that question.

25 Is using a different name than

1 the name that was given to you by your
2 parents an aspect of social transition?

3 MR. RAMER: Objection to the
4 form.

5 A. It can be.

6 Q. Is using different pronouns
7 than aligned with biological sex a form
8 of social transition?

9 MR. RAMER: Objection to the
10 form.

11 A. Again, it can be. But just as
12 with, you know, several of the other
13 questions, no one of those is ah-ha
14 that's the line. It's the accumulation
15 of, you know, several of them and it
16 becomes more and more ambiguous, you
17 know, in between and then less and less
18 ambiguous at the other extreme. When
19 going from none of the options are being
20 used by the kid to every option available
21 to the kid is being used. And then in
22 between are the different pockets,
23 different circumstances, different ways
24 or the use of ambiguous pronouns or an
25 ambiguous name. And which of them

1 defines social transition? That's one of
2 the empirical questions which remains
3 uninvestigated.

4 So I don't have, I am not using
5 a definition, a definition of social
6 transition and these studies also, it
7 became moot because none of them had an
8 in-between status, they were all pretty
9 much all untransitioned or pretty much
10 all entirely transitioned. So I don't
11 need to generate a definition that I am
12 not using.

13 Q. So what are the various factors
14 that could be considered in whether or
15 not there has been a social transition?

16 MR. RAMER: Objection to the
17 form.

18 A. I am still back to that being
19 an empirical question. When most people
20 discuss it, they are generally referring
21 to some combination of changing names and
22 changing pronouns, but there are also
23 sometimes unspoken assumptions that go
24 along with it, such as how the kid thinks
25 of themselves: How they are being

1 treated by the different people that
2 they, that they interact with. Those are
3 legitimate associated ideas, but in order
4 to know which of those really counts is
5 one of our validity questions. We need
6 to be able to test which of those or the
7 combination of those or accumulation of
8 exactly which of those choices helps us
9 predict the trajectory that the kid is
10 on.

11 If we find that a certain
12 number of the choices or a certain
13 combination of the choices is more versus
14 less likely to lead to a successful
15 outcome or unsuccessful outcome in one
16 direction or the other direction, now we
17 have an objective way of knowing which
18 ones do and do not count. But we don't
19 have such research allowing us to
20 reliably predict that trajectory. So we
21 only have our, scientifically we only
22 have a best guess. But in communicating
23 with, you know, society, experts, policy
24 makers, other scientists, parents,
25 families and so on, again my usual

1 question is how do they want to use the
2 phrase. What do they mean by it, so I
3 can understand what they're saying.

4 Q. Right. Which is why I am
5 trying to understand what you're saying
6 when you wrote the words "social
7 transition."

8 A. I am using --

9 MR. RAMER: Objection, objection
10 to the form. Asked and answered.

11 A. I am using what those
12 scientists did, which didn't -- because
13 everything was so far from the line, they
14 didn't need and, therefore, I don't need
15 and can't offer more detailed definition
16 that could be applied to who was over and
17 under that line.

18 MR. RAMER: If you have a
19 breaking point coming up, we have been
20 going about an hour.

21 Q. If you go to paragraph 120 of
22 your declaration?

23 A. 120 you said?

24 Q. Yes.

25 A. I am there.

1 Q. And the heading says "One
2 Cohort Study Followed Children Who Were
3 Permitted Social Transition in Contrast
4 With Children Not Permitted to Transition
5 Socially, Most Persisted in Expressing
6 Gender Dysphoria."

7 Do you see that?

8 A. Yes.

9 Q. And in the next, the first
10 sentence of paragraph 120, you describe
11 Olson as discussing a cohort study of
12 children who had already made a complete
13 binary rather than intermediate social
14 transition, including a change of
15 pronouns.

16 A. Yes.

17 Q. Okay. What do you mean by a
18 complete binary social transition
19 including a change of pronouns?

20 A. I am repeating what, how Olson
21 described it. Again, change in hair.
22 Change in clothes. Change in pronouns.
23 Sometimes a change in name and they
24 weren't, as I said, I am just reflecting
25 what, what they said and because it was,

1 you know, complete and dramatic and
2 exactly the reverse of the other 11
3 studies, the questions or definitions
4 about do pronouns matter, well, because
5 one changed and nobody else did, it was
6 part of it, but pronouns weren't the only
7 thing that changed either.

8 So it doesn't the contrast in
9 those results doesn't tell us anything
10 about any one of the components of social
11 transition. All we have is the contrast
12 between people who used every option
13 available to them and the kids that
14 didn't use any such option.

15 Q. So is it fair to say that in
16 the context of your declaration, when you
17 refer to social transition, you're
18 referring to, you're adopting the
19 definition from Olson?

20 MR. RAMER: Objection to the
21 form.

22 A. I am not adopting anyone. I am
23 summarizing and reiterating the content
24 of those studies as given by those study
25 authors.

1 THE REPORTER: I need to take a
2 break.

3 THE VIDEOGRAPHER: This is the
4 videographer, the time is 5:27, we are
5 going off the record.

6 (Off the record)

7 THE VIDEOGRAPHER: We are back
8 on the record. The time is 5:37, this
9 begins media file 7.

10 BY MR. MAY:

11 Q. Let's turn to your declaration,
12 Exhibit 1, and go to paragraph 114, the
13 heading right above it.

14 So you said 11 cohort studies
15 followed children not permitted social
16 transition. So I want to understand the
17 verb there.

18 Is it that they were, is it the
19 children expressed an interest in doing
20 that and they were told they could not.
21 Is that what you mean by not permitted?

22 A. No. Again, these are studies
23 that go back, you know, some many
24 decades. They didn't report that level
25 of detail. They were just describing the

1 cases themselves.

2 So it was the only word that I
3 can think of that would accurately
4 capture all 11. But they weren't, as I
5 say, in the earlier studies they didn't
6 give enough detail, they didn't give
7 enough detail. And by the same token in
8 the 1970s, it wasn't the option that it
9 is today.

10 Q. Do you think it's fair to say
11 in those 11 studies, it's just that the
12 children have not socially transitioned
13 or did not socially transition as opposed
14 to the not permitted?

15 MR. RAMER: Objection to the
16 form.

17 A. I would have to go back and see
18 if there is an exception I am not
19 immediately recalling. But in the Zucker
20 samples, the youth that were in treatment
21 with him, the purpose of the therapy that
22 the kids were undergoing was to develop
23 comfort in their natural bodies. And his
24 philosophy was that allowing a social
25 transition would work exactly against

1 that.

2 So part of the process was in
3 order to help somebody become comfortable
4 in a situation where they are not
5 comfortable was exposure to that
6 situation. The same as trying to get
7 somebody uncomfortable with the fear of
8 heights. If you give them at every
9 opportunity permission to move into the
10 basement, and so on, you're not going to
11 be helping them get over their fear of
12 heights.

13 So part of the therapy that
14 Zucker was offering, again, required that
15 the person develop and, therefore, be in
16 the situation that they start therapy as
17 uncomfortable with. And that meant not,
18 not socially transitioning.

19 I use the word "permit," again,
20 kind of relatively generically but I
21 don't, I can't, especially without
22 checking each of the original studies
23 directly, to see what kind of --
24 enforcement isn't the right word, but
25 exactly how that situation was handled.

1 If a parent or family, you
2 know, didn't want to engage in that kind
3 of a therapy, then, you know, they
4 wouldn't be in therapy with Ken Zucker.
5 They would pick a different therapist or
6 clinic, you know, trying to do, trying to
7 do something else.

8 But my use of the term, as I
9 say, was as accurately as possible to
10 pick a word that covered, that covers all
11 11 studies.

12 Q. Which Ken Zucker study, is that
13 the one in Table 2 of your declaration,
14 that's the one, the last study listed
15 with the first author Singh?

16 A. And Drummond.

17 Q. And Drummond, okay.

18 For these 11 studies, was a
19 desire to be the opposite sex an
20 inclusion requirement?

21 MR. RAMER: Objection to the
22 form.

23 A. It varied over the course of
24 the studies. The DSM criteria changed.
25 Some of these used the 3. Others the 3R.

1 Others the 4. Other the 4R. And some of
2 them used a more generic description of
3 the kid, regardless of what the DSM
4 criteria at the time was. So it varied.

5 Q. Did all 11 of these studies
6 require the child to identify with a
7 transgender -- strike that.

8 Did all 11 of these studies
9 require the child to have a transgender
10 identity in order to be included in the
11 study?

12 MR. RAMER: Objection to the
13 form.

14 A. That question assumes a certain
15 definition and validity of what identity
16 means. And how that term is used and
17 what it means has changed over time and
18 in different situations.

19 But as I said, these used
20 several different DSMs over several
21 different decades in several different
22 countries. And every single one of them
23 came out with exactly the same result.

24 So to the extent that there
25 could be an exception -- then, of course,

1 there could always indeed be an
2 exception -- but the onus of proof then
3 belongs to whatever, whoever it is that
4 wants to say "But if you use this
5 definition, you will get something
6 different." Okay. That is always
7 possible. But there has never been any
8 such indication. It will eternally
9 remain possible, but nobody has ever
10 demonstrated any evidence that any one of
11 the symptoms or components that lead to a
12 diagnosis of gender dysphoria, that any
13 one of them is, makes a difference or how
14 much of a difference.

15 Q. So I appreciate that.
16 Redirecting back to my question.

17 For all 11 of these studies was
18 a transgender identity an inclusion
19 criteria?

20 MR. RAMER: Objection to form.
21 Asked and answered.

22 A. I don't know if I have another
23 way to express it. To answer that
24 question is to say that we have a
25 reliable way of knowing what the gender

1 identity is, and we don't. We have what
2 the kids say. We have what their
3 families say. How accurately does what
4 they say reflect their identity? We have
5 no idea. How valid is the concept of
6 identity in this context? We don't know
7 that either. So as I say, that level of
8 abstraction can't really be answered.
9 All we have is the various self-reports,
10 and then the observations of the
11 behaviors.

12 Q. Okay. Social transition is not
13 banned by the Idaho law HB 71, right?

14 A. That's my understanding.

15 MR. RAMER: Objection to the
16 form. Calls for a legal conclusion.

17 A. Sorry. That's my
18 understanding, yes.

19 Q. Social transition is not a
20 medical procedure, you would agree with
21 that?

22 MR. RAMER: Objection to the
23 form.

24 A. Again, we're falling into a
25 level of ambiguity where, you know, the

1 assumptions are the insinuations used by
2 the term, can't always be accepted at
3 face value.

4 Q. So let me try and maybe help
5 you definitionally then and rephrase the
6 question and ask a better question.
7 Social transition does not encompass --
8 strike that. Let me try one more time.

9 A prescription of
10 puberty-suppressing hormones is not an
11 aspect of social transition?

12 MR. RAMER: Objection to the
13 form.

14 A. Not directly, no.

15 Q. And cross-sex hormone therapy
16 is part of medical transition, not social
17 transition; you agree with that?

18 MR. RAMER: Objection to the
19 form.

20 A. Again, not in a simple, direct
21 way. But there are caveats to it that
22 are inescapable, that are pretty
23 inescapable.

24 The best analogy I have is that
25 going on a diet is not a medical

1 procedure, but having a really bad diet
2 has profound medical implications. So
3 these don't fall apart -- these aren't
4 completely independent either.

5 Q. Are you familiar with Daniel
6 Weiss?

7 A. I am not getting an image of a
8 particular person with that name, but I
9 have to acknowledge I am terrible with
10 names to begin with.

11 Q. I will represent to you that
12 Daniel Weiss is another one of the
13 experts that the state has submitted a
14 declaration from in this case. Do you
15 know him?

16 A. No, I don't think so.

17 Q. Have you read his declaration?

18 A. No, I haven't.

19 Q. Have you read his CV?

20 A. No, I haven't.

21 Q. Have you read his declaration
22 from any other cases?

23 A. No, not that I recall.

24 Q. I will also represent that the
25 state has submitted a declaration from a

1 doctor named William Malone; are you
2 familiar with this individual?

3 A. Yes, a bit.

4 Q. How are you familiar with
5 Dr. Malone?

6 A. Mostly over social, social
7 media and some of the essays that he's,
8 that he's written on the topic.

9 Q. Did you read his declaration
10 that he submitted in this case?

11 A. No, I haven't.

12 Q. Have you reviewed his CV?

13 A. I don't think so. If I did, I
14 don't really recall any of the details
15 from it.

16 Q. Do you think Dr. Malone is an
17 expert on the treatment of gender
18 dysphoria?

19 MR. RAMER: Objection to the
20 form. Calls for a legal conclusion.

21 A. He knows the material as
22 thoroughly really as a person can. Of
23 course, emphasizing on its medical
24 aspects.

25 Q. Do you think that Dr. Malone is

1 a credible expert with respect to gender
2 affirming medical care for minors?

3 MR. RAMER: Objection to the
4 form. Calls for a legal conclusion.

5 A. Yes, from my point of view,
6 that's, you know, a matter of having the
7 appropriate knowledge of the relevant
8 research, which he very much does.

9 Q. Have you ever spoken with
10 Dr. Malone?

11 A. We've been in group
12 conversations together. If we've ever
13 had a one-on-one conversation, I am not
14 remembering it.

15 Q. What were the contexts of the
16 group conversations that you had with
17 Dr. Malone?

18 A. There is a set of researchers
19 who want to conduct what is, essentially,
20 a systematic review of systematic reviews
21 evaluating how the various of the
22 systematic reviews of the safety and
23 effectiveness of the medicalized
24 transition of minors and how well each of
25 those reviews have stuck to the

1 appropriate protocol for the conduct of
2 systematic reviews.

3 Q. You mentioned earlier that the
4 certainty of the benefit of
5 puberty-suppressing and cross-sex hormone
6 therapy is less clear as the patient gets
7 younger and younger. Do you recall us
8 discussing that?

9 MR. RAMER: Objection to the
10 form. Mischaracterizes prior
11 testimony.

12 A. Sort of. I think really the,
13 what I was suggesting is that the farther
14 away we go from what's actually
15 established, you know, the less confident
16 that we can be that the information
17 generalizes to it. But at the same time,
18 not to make any kind of a, you know,
19 perfect, you know, line, once 18, all of
20 the sudden everything is going to be
21 different than the day before.

22 Q. Do you think that doctors,
23 families and patients are best positioned
24 in order to make a case-by-case
25 determinations for the medical treatment

1 for the patient?

2 MR. RAMER: Objection to the
3 form.

4 A. I don't think that's how the
5 lines are drawn. The quality of the
6 decision-making, as best as we can
7 measure, is how well it matches the
8 evidence we have. So different people,
9 you know, with different relationships
10 with the kid, you know, can be applying,
11 you know, different kinds of information.

12 If it's the parents who's
13 following the science, then the parents
14 are in the position. If the parent is
15 opposing the science, then the parent is
16 not in the best position and the same for
17 everybody else, you know, including the
18 kids themselves in their environment.

19 So it's not -- the people of
20 course factor in, but what actually will
21 be the best decision follows from how
22 well their input matches the science, not
23 really their relationship with the kid.

24 Q. If a patient -- if a parent --
25 strike that and let's start that over.

1 If a parent and an adolescent
2 go to their doctor and they say that we
3 have read all of the literature. We are
4 familiar with Dr. Cantor's views on
5 puberty suppression and cross-sex hormone
6 therapy. We are well-versed in the risks
7 and the benefits and the relative
8 information or lack thereof, knowing all
9 of this, we would like to proceed with
10 cross-sex hormone therapy.

11 Do you think it would be
12 appropriate for that individual to
13 receive cross-sex hormone therapy?

14 MR. RAMER: Objection to the
15 form.

16 A. I can't resist the gut
17 reaction. What 16-year-old can tell me
18 how the analyses are done, what a
19 systematic review is? What's known and
20 unknown is a profoundly complicated kind
21 of question. And I am having trouble,
22 you know, finding M.D.s and Ph.D.s
23 properly applying the basics of the
24 scientific methods.

25 Again, I would have to balk a

1 bit at the hypothetical to begin with.
2 If a person tells me that they know this
3 information, again, I have my usual
4 critical thinking. I am not going to
5 take at face value that their description
6 of their knowledge is true. I have
7 questions for them: What did you think
8 of this; what did you think of that; what
9 else did you try; how did you -- how did
10 you read what it is.

11 It's the kind of stuff that I
12 said and if you decide to go, you know,
13 go ahead with it anyway, all right. So
14 what was it that convinced you that I'm
15 -- it's not clear to me if they are
16 saying I am wrong or if they think they
17 are going to be one of the exceptions.

18 Again, my clinical nose
19 immediately is not to take it at face
20 value. Scratch beneath the surface. And
21 figure out how, how they got there.

22 And then after that, the
23 assessment would be pretty much as the
24 others, that they know this material.
25 All right. That's the primary component

1 of informed consent. Great. But the
2 rest of the clinical questions are still
3 the same. What other less risky stuff
4 have you tried already. You know, what
5 are the alternatives, and so on.

6 So although nothing in that
7 says, excludes them, it's not sufficient
8 either. The information we have, knowing
9 that we can't, we the professionals are
10 no good at predicting who would and would
11 not benefit from this, well, we can't do
12 it. Neither can the kids nor families.
13 We have no evidence suggesting, giving us
14 an idea of how accurate their predictions
15 are either.

16 And, of course, it's never, we
17 could never be too sure that what they
18 are saying is all we get. Are they just
19 saying whatever it is, if I am the
20 clinician or somebody else is the
21 clinician or are they just saying what
22 they think the clinician needs to hear in
23 order to sign off on the paper.

24 Q. So the same hypothetical. The
25 patient with the additional

1 characteristics of this patient has been
2 displaying gender dysphoric behavior
3 prepuberty. Has persisted through
4 puberty, and has been seeing a therapist
5 or a qualified mental health professional
6 since the age of five. Do you think that
7 that person should be categorically
8 excluded from being able to receive
9 cross-sex hormone therapy?

10 MR. RAMER: Objection to the
11 form.

12 A. As I say, we're no good at
13 predicting who will and won't benefit.
14 The flip side of that same coin is that
15 we can't categorically conclude in a
16 situation, you know, that matches the
17 cases of a couple of existing studies.

18 It is indeed possible that,
19 that this person would be an appropriate
20 candidate. But the nature of the
21 research doesn't allow us to make a
22 definitive conclusion. If they were in a
23 jurisdiction where that kind of research
24 was being done, that would be exactly the
25 place to send that person because they

1 would be one of the people from whom we
2 might be able to learn something -- that
3 we might be able to learn something.
4 But, of course, participating as part of
5 a clinical trial comes with a very
6 different set or comes with a much more
7 detailed, advanced deeper set of just
8 what the person is consenting to.

9 Now, they are consenting to a
10 situation that by definition acknowledges
11 how much of this is really just unknown,
12 and this is our best guess which is
13 different from the kind of informed
14 consent to say this is the established
15 practice. These are the pluses and
16 minuses. This is how much risk you're
17 taking on and you can either sign the
18 paper or not.

19 When it's a research protocol,
20 like I say, the documentation that goes
21 along with it and that even if it
22 doesn't, no matter what the results are,
23 society at large benefits from it,
24 because it's part of a data set that gets
25 analyzed and can help the next cycle or

1 generation of people going through it.

2 So as I say, because we can't
3 predict who would and would not benefit,
4 we can't categorically deny in the same
5 way that we can't automatically assume
6 success.

7 Q. So you would agree that that
8 individual should not be categorically
9 denied access for the possibility of
10 receiving cross-sex hormone therapy?

11 MR. RAMER: Objection to the
12 form. Compound.

13 A. I don't think I can say -- your
14 rephrasing is a bit broader than what I
15 think I am saying.

16 I am just acknowledging that
17 the current state of the science doesn't
18 allow us to do that. But we can't say it
19 more broadly or with a more permanent --
20 there is no ideological block to it. We
21 are just very limited still in our
22 ability to provide estimates of the
23 potential risks and potential benefits as
24 a part of, you know, a person coming to
25 their decision about it. Even WPATH

1 itself, as I have in my report, is just
2 long lists of unknowns.

3 Q. Turn back to your declaration.
4 If you can turn back to paragraph 215.

5 MR. RAMER: Was that 215?

6 MR. MAY: Yes.

7 MR. RAMER: Thank you.

8 A. I am there.

9 Q. In this paragraph you talk
10 about an elevated risk of Parkinsonism in
11 adult females.

12 A. Yes.

13 Q. Are you an expert in
14 Parkinsonism?

15 MR. RAMER: Objection to the
16 form. Calls for a legal conclusion.

17 A. Well, I am a neuroscientist
18 studying the role of sex in the brain and
19 as part of -- Parkinson's patients
20 resemble the control patients that we
21 used when I was at the Boston VA doing
22 research on the brain and memory. So I
23 am certainly very fluent in the relevant
24 information in assessing this kind of
25 research.

1 Q. And is this a study that you
2 cite in this paragraph of adult women
3 without gender dysphoria?

4 A. That's right.

5 Q. There is no children included
6 in this study?

7 A. That's correct.

8 Q. And there is no gender
9 dysphoric individuals included in this
10 study?

11 A. That's correct.

12 Q. There is no transgender people
13 included in this study?

14 MR. RAMER: Objection to the
15 form.

16 A. That's correct.

17 Q. You think this is a relevant
18 study to consider for risks for
19 transgender youth?

20 A. Yes, absolutely.

21 MR. MAY: Let's go ahead and
22 take a break for about -- let's go
23 ahead and take a break.

24 THE VIDEOGRAPHER: Thank you,
25 this is the videographer, the time is

1 6:06, we are going off the record.

2 (Off the record.)

3 THE VIDEOGRAPHER: The time is
4 6:16, we are back on the record
5 continuing media file 6.

6 BY MR. MAY:

7 Q. Dr. Cantor, we were discussing
8 earlier today the practices of some
9 different countries over in Europe; do
10 you recall those discussions we had?

11 A. Yes.

12 Q. And I want to turn your
13 attention specifically to Sweden. Would
14 you -- would you be comfortable -- strike
15 that.

16 Turning your attention,
17 specifically to Sweden, would you support
18 adopting Sweden's policies in Idaho?

19 MR. RAMER: Objection to the
20 form.

21 A. Essentially, yes. And I would
22 have to emphasize that a large chunk of
23 that is associated with Idaho. The
24 entire country of the U.S. needs a public
25 healthcare system like Sweden. And that

1 given that kind of a situation, you know,
2 where decisions then are made with, on an
3 appropriate basis. And like Sweden,
4 based on systematic reviews of the
5 relevant evidence.

6 Q. Would you support Idaho
7 adopting Sweden's policies towards the
8 treatment of transgender gender
9 dysphoric, gender nonconforming youth,
10 even absent a public healthcare system?

11 MR. RAMER: Objection to the
12 form. Compound. Vague. Calls for a
13 legal conclusion.

14 A. I'm not quite sure that those
15 can be separated. A major distinction
16 and what's making, what's associated with
17 the U.S. going in such a very different
18 direction than the other countries we
19 discussed is, again, it's unavoidable
20 that the basic difference is that in the
21 U.S. these decisions are being made by
22 professional guilds with a conflict of
23 interest whose decisions are reflecting
24 not the science, but the broader
25 principle of opposing a government

1 telling doctors what to do.

2 So when the science is, so when
3 the professional associations are saying,
4 oh come to our members because our
5 members are doing the right thing, we
6 know they are doing the right thing
7 because it's right for our members and
8 the decisions are being made by a group
9 with a conflict of interest. Where in a
10 public healthcare system, the government
11 is supposed to be directing and limiting
12 what it is that the medical profession
13 does.

14 At the moment the question
15 about, you know, the government telling
16 doctors what they may or may not do
17 happens to be about the medical treatment
18 and medicalized transition of minors, but
19 the U.S. is only in this position exactly
20 because the decisions are being made by
21 the providers rather than by a public
22 healthcare system which has the public
23 health as its primary concern.
24 Profession associations have as their
25 primary concern, the professionals.

1 As I say, at the moment the
2 question happens to be about medicalized
3 transition of minors, but that's just the
4 current situation. We're here, the U.S.
5 is here exactly because the decisions are
6 not being made by the appropriate people
7 on the appropriate basis, serving the
8 appropriate public interest.

9 Q. Would you support a system in
10 Idaho that allows for the prescription of
11 puberty-suppressing hormones and
12 cross-sex hormone therapy in the context
13 of formally-approved research studies?

14 MR. RAMER: Objection to the
15 form.

16 A. As a basic, as a basic
17 principle as we were saying before, yes,
18 again, as a scientist I do believe that
19 free scientific inquiry needs to be, a
20 society, a state, any group is better
21 off, you know, when scientists have a
22 freedom of inquiry.

23 If ever it is possible for us
24 to figure out or come up with a method of
25 accurately or reliably identifying who

1 would benefit from medicalized transition
2 versus who would be better off with a
3 different intervention, it's going to be
4 by increased research.

5 But in saying that, again, I
6 don't want to overstate it either. It
7 remains eternally possible that the, it
8 remains possible that the research may
9 show that it is very, very few people and
10 we're not able to identify such -- not
11 able to come up with a method to identify
12 these kids. And so even though there is
13 a, you know, theoretical exception made
14 for research, if there are no research
15 questions to be answered, then, again, it
16 becomes moot, it becomes not available.

17 Q. During the course of your
18 deposition today, did you speak with
19 anyone during any breaks or anything like
20 that?

21 A. No.

22 MR. MAY: Okay. Then I have no
23 further questions at this time. And I
24 will pass the witness.

25 MR. RAMER: And I have no

1 questions for the witness. And we
2 just ask to review and sign.

3 THE VIDEOGRAPHER: Thank you,
4 counsel. This is the videographer.
5 The time is 6:23, we are going off the
6 record. This ends media file 6 and
7 that concludes this deposition.

8 (Time noted: 6:23 p.m.)
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1 ACKNOWLEDGMENT OF DEPONENT

2

3 I have read the foregoing transcript

4 of my deposition and except for any

5 corrections or changes noted on the errata

6 sheet, I hereby subscribe to the transcript

7 as an accurate record of the statements made

8 by me.

9 -----

 JAMES M. CANTOR

10

11

12 SUBSCRIBED AND SWORN before

13 and to me this ____ day of _____,

14 2023.

15 -----

16 NOTARY PUBLIC

17

18 My Commission Expires:

19

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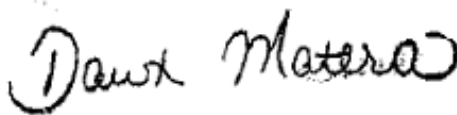
CERTIFICATION

I, DAWN MATERA, a Notary Public for
and within the State of New York, do hereby
certify:

That the witness whose testimony as
herein set forth, was duly sworn by me; and
that the within transcript is a true record of
the testimony given by said witness.

I further certify that I am not
related to any of the parties to this action
by blood or marriage, and that I am in no way
interested in the outcome of this matter.

IN WITNESS WHEREOF, I have hereunto
set my hand this 22nd day of September, 2023.



DAWN MATERA

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~oOo~

CASE NAME: Pam Poe v Raúl Labrador
DATE OF DEPOSITION: September 21, 2023
WITNESS'S NAME: JAMES M. CANTOR

[illegible]

Signature of Deponent

Subscribed and Sworn To
Before Me This _____ Day
of _____, 2023.

Notary Public
My Commission Expires

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Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

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Exhibit B

1
2 UNITED STATES DISTRICT COURT
3 FOR THE DISTRICT OF IDAHO
4 SOUTHERN DIVISION

-----x

5 PAM POE, by and through her
6 parents and next friends, Penny
7 and Peter Poe; PENNY POE, PETER
8 POE; JANE DOE, by and through her
9 parents and next friends, Joan and
10 John Doe, JOAN DOE; JOHN DOE,
11 Plaintiffs,
12 Case No.

v.

11 RAUL LABRADOR, in his official
12 capacity as Attorney General of
13 the State of Idaho; JAN M.
14 BENNETTS, in her official capacity
15 as County Prosecuting Attorney for
16 Ada, Idaho; and the INDIVIDUAL
17 MEMBERS OF THE IDAHO CODE
18 COMMISSION, in their official
19 capacities,
20 Defendants.

-----x

18 10:00 a.m.
19 September 22, 2023

20 VIRTUAL DEPOSITION of DR. DANIEL WEISS, an
21 Expert Witness in the above entitled matter,
22 pursuant to Notice, before Stephen J. Moore, a
23 Registered Professional Reporter, Certified
24 Realtime Reporter and Notary Public of the State
25 of New York.

DANIEL WEISS

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CODE COMMISSION, in their official
capacities

700 West Jefferson Street

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BY: RAFAEL DROZ, ESQ.

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DANIEL WEISS

EXAMINATION BY

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Exbt 5 Written testimony submitted
in Florida on October 24, 2022
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DANIEL WEISS

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DANIEL WEISS

THE VIDEOGRAPHER: Good morning, we are going on the record. The date today is September 22, 2023, the time is 10:02 a.m. Eastern time.

This is media unit 1 of the video recorded deposition of Dr. Daniel Weiss, taken in the matter of Poe, et al. versus Labrador, et al., filed in the U.S. District Court for the District of Idaho, Southern Division, case number 1:23-CV-00269.

My name is Christopher Hanlon, I'm a certified legal videographer. Our court reporter today is Steve Moore.

At this time I would ask participating attorneys to please state your appearances for the record.

All other attorneys will be noted on the stenographic record.

Attorney Korberg?

1 DANIEL WEISS

2 ATTORNEY KORBERG: Good
3 morning. My name is Alexia Korberg.
4 I am with the law office of Paul
5 Weiss Rifkind Wharton & Garrison,
6 and I am going to be taking today
7 and representing the Plaintiffs in
8 this case, Pam Poe, Penny Poe, Peter
9 Poe, Jane Doe, Joan Doe and John
10 Doe.

11 ATTORNEY DROZ: Good morning.
12 This is Rafael Droz. I am an
13 attorney for the Idaho Attorney
14 General, and I am a Deputy Attorney
15 General, and I am representing
16 Dr. Weiss in the deposition.

17 THE VIDEOGRAPHER: Thank you,
18 counsel.

19 At this time I would ask our
20 court reporter, Mr. Moore, to please
21 administer the oath and we can
22 proceed.

23
24 D A N I E L W E I S S, called as a
25 witness, having been first duly sworn by

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DANIEL WEISS

the Notary Public, was examined and
testified as follows:

EXAMINATION BY
ATTORNEY KORBERG:

Q Good morning, Dr. Weiss. How
are you?

A Good morning.

Q We haven't met before, but my
name is Alexia Korberg and I represent the
Plaintiffs in this case.

Do you understand that I'm
going to ask you questions today for use in
a legal case?

A Yes.

Q And do you understand that in
certain circumstances your testimony can be
used in court?

A Yes.

Q And do you understand that
you are under oath sworn to testify
truthfully, right?

A Yes.

1 DANIEL WEISS

2 Q Are you aware of any reason
3 today that you cannot testify truthfully or
4 accurately?

5 A No.

6 Q If you want to take a break
7 at any point, please just let us know and we
8 can do that.

9 So, I understand you've been
10 deposed before, so I'm really only going to
11 briefly review how this works.

12 But if you don't understand a
13 question, I'm going to ask that you ask me
14 for clarification.

15 Can we agree that if you do
16 answer a question I pose to you it means you
17 understood the question?

18 A Yes.

19 Q Great.

20 And are you aware that you
21 are not allowed to speak to counsel either
22 during the deposition or during the breaks
23 about the substance of the case or your
24 testimony?

25 A Yes.

1 DANIEL WEISS

2 Q So, do you agree that you're
3 not going to have any e-mail, texting or
4 messaging functions available to you today?

5 A During the deposition?

6 Q Exactly, during the
7 deposition.

8 A Yes.

9 Q Can we agree that if you do
10 communicate with counsel during the breaks
11 about the substance of your testimony that
12 you will alert me to the fact that you have
13 done so?

14 A Yes.

15 ATTORNEY DROZ: Objection. I
16 don't know if that's the rule or
17 not, but I just want to put it out
18 there that I can talk with Dr. Weiss
19 if necessary and we can take it from
20 there.

21 But I don't think we have to
22 disclose any substance of any
23 conversation.

24 ATTORNEY KORBERG: I would
25 disagree with that, but we can cross

1 DANIEL WEISS

2 that bridge if we do.

3 ATTORNEY DROZ: Yes.

4 Q Is there anyone in the room
5 with you today, Dr. Weiss?

6 A No.

7 Q Are there any papers or notes
8 in the room with you?

9 A Only my declaration.

10 Q Great.

11 A On my desk. There is
12 probably something behind me, but --

13 Q Does your declaration have
14 any notes on it, or is it a clean copy?

15 A No notes on it and it does
16 not -- I do not have my CV, by the way, on
17 my desk.

18 Q Okay.

19 So, Dr. Weiss, you're here
20 today to testify as an expert witness,
21 right?

22 A Yes.

23 Q On whose behalf are you
24 appearing as an expert?

25 A For the State of Idaho,

1 DANIEL WEISS

2 Attorney General's Office.

3 Q And who is paying your fees
4 in the matter?

5 A Idaho.

6 Q Have you ever personally
7 spoken with any of the Plaintiffs in this
8 matter, either the minors or their parents?

9 A No.

10 Q Have you ever personally
11 spoken with Plaintiffs' physicians?

12 A No.

13 Q Have you ever personally
14 spoken with anyone who has firsthand
15 knowledge of Plaintiffs?

16 A No.

17 ATTORNEY DROZ: Objection.

18 What is firsthand knowledge?

19 Q Dr. Weiss, have you ever
20 spoken to anyone who has told you anything
21 about the Plaintiffs other than that which
22 is in the Complaint?

23 A No.

24 Q When did Defendants first
25 contact you about the case?

1 DANIEL WEISS

2 A I don't remember.

3 Q Do you know, do you recall
4 roughly when?

5 A Perhaps a few months ago, but
6 I do not remember.

7 Q When you were first contacted
8 about the case, perhaps?

9 A Two months ago or something
10 or sometime thereabouts.

11 Q What did Defendants ask you
12 to opine on?

13 ATTORNEY DROZ: Objection to
14 the extent it calls for
15 attorney-client privileged
16 information.

17 You can answer, Doctor, to
18 the extent it doesn't reveal any
19 conversations.

20 A On the matter related to the
21 Plaintiffs' response to the Idaho law.

22 Q When you say you were asked
23 to opine on the matter related to the
24 Plaintiffs' response to the Idaho law, do
25 you mean you were asked to opine on

1 DANIEL WEISS

2 Plaintiffs' Complaint in the matter, or some
3 other document?

4 A The Plaintiffs' Complaint.

5 Q Prior to being contacted by
6 Defendants in this case, had you read
7 Plaintiffs' Complaint in this matter?

8 A No.

9 Q And were you asked to
10 generally give an opinion on Plaintiffs'
11 Complaint in the matter, or were you asked
12 to offer some more specific opinion?

13 ATTORNEY DROZ: Objection,
14 just calls -- it's confusing.

15 A I don't understand the
16 question.

17 Q Sure.

18 So you said you were asked
19 that the opinion you were asked to provide
20 in the matter was a response to Plaintiffs'
21 Complaint, right?

22 A Yes.

23 Q So, I'm asking were you asked
24 to respond to the Complaint generally or
25 were you asked to provide some more specific

1 DANIEL WEISS

2 opinion or response?

3 ATTORNEY DROZ: I'm going to
4 object just to the extent it calls
5 for confidential communications,
6 privileged, expert witness
7 privileged communications.

8 I mean, it's pretty clear
9 what's going on here.

10 Q You can answer, Dr. Weiss.

11 A So, I was asked to opine on
12 the -- on bans on hormonal interventions on
13 minors, and to the extent I was provided
14 information on the minors in this case, to
15 also comment on that.

16 Q When did you first perform
17 work in relation to this case?

18 A It would have been shortly
19 after I agreed to assist in the matter.

20 Q Roughly how many hours of
21 work have you personally put into the
22 matter?

23 A I don't remember.

24 Q Roughly, ballpark?

25 A Maybe 20 hours.

1 DANIEL WEISS

2 Q In relation it to this case
3 have you performed any work not directly
4 related to either preparing your declaration
5 or preparing for today's deposition?

6 A I don't understand.

7 Q Sure.

8 So you said you performed
9 roughly 20 hours of work in this case,
10 right?

11 A Yes.

12 Q And the work you performed
13 included preparing your declaration in this
14 matter, right?

15 A Yes.

16 Q And presumably the work you
17 performed included preparing for today's
18 deposition, right?

19 A Yes.

20 Q Outside of those two things
21 has any of the work that you have performed
22 in this matter --

23 ATTORNEY KORBERG: Withdrawn.

24 Q Have you done any work in
25 this matter that is unrelated to either the

1 DANIEL WEISS

2 preparation of your declaration or your
3 preparation for the deposition today?

4 A No.

5 Q So, you understand this
6 matter relates to an Idaho law, right, HB
7 71?

8 A Yes.

9 Q Have you taken a public
10 position on HB 71 either before or after its
11 passage?

12 A I do not recall having done
13 so, no.

14 Q Has anyone asked you to take
15 a public position on HB 71 at any point?

16 A Not that I recall.

17 Q From between the time that HB
18 71 was being conceived of, drafted and then
19 ultimately passed, did you speak to anyone
20 about it, other than the attorneys in this
21 case?

22 A So, I have taken -- I have
23 provided statements for many states related
24 to bans on hormonal interventions in minors
25 with gender dysphoria, and I may have

1 DANIEL WEISS

2 provided such a statement for Idaho, but I
3 don't recall.

4 Q Did anyone in the Idaho
5 legislature or otherwise consult with you on
6 the drafting of HB 71?

7 A No.

8 Q Have you expressed concerns
9 to anyone about any element of HB 71?

10 ATTORNEY DROZ: Objection.

11 Just concerns?

12 A I would have spoken to
13 counsel about it, so.

14 Q Sure. So other than counsel
15 in this case, have you expressed to anyone
16 any concerns, critiques, questions about the
17 provisions of HB 71?

18 A No.

19 Q Have you expressed concerns
20 to anyone --

21 ATTORNEY KORBERG: Withdrawn.

22 Q What did you do to prepare
23 specifically for your deposition today?

24 A I had a meeting with counsel
25 beforehand, but not today, and read through

1 DANIEL WEISS

2 my declaration.

3 Q And how many hours did you
4 meet with counsel?

5 A Less than an hour, 45
6 minutes, maybe.

7 Q Was anyone other than counsel
8 for the State of Idaho present for that
9 meeting?

10 A No.

11 Q Did you speak with either
12 Dr. Cantor or Dr. Malone in preparation for
13 today?

14 A No.

15 Q Prior to your retention in
16 this case had you ever spoken to Dr. Cantor
17 or Dr. Malone before?

18 A Yes, I have spoken to
19 Dr. Malone once about -- well, I will stop
20 there. Yes, one time.

21 Q Tell me the circumstances in
22 which you were introduced to Dr. Malone.

23 A Dr. Malone had written a
24 commentary about hormonal interventions in
25 minors with gender dysphoria, and I sent him

1 DANIEL WEISS

2 an e-mail praising him on the lucidity and
3 the soundness of his points.

4 He then responded to me and
5 we chatted on the phone.

6 Q When was this?

7 A About two years ago.

8 Q Have you been in touch with
9 Dr. Malone since that time?

10 A No.

11 Q Other than counsel for the
12 State of Idaho, have you spoken to anyone
13 about your deposition today?

14 A I spoke with -- I spoke with,
15 let's see John Reimer.

16 Q And who is John Reimer?

17 ATTORNEY DROZ: John Reimer
18 is an Attorney for Idaho, so --

19 THE WITNESS: Okay.

20 Q So, other than Mr. Reimer and
21 other counsel for the State of Idaho, did
22 you speak to anyone about your deposition
23 today?

24 A No.

25 ATTORNEY KORBERG: Can we

1 DANIEL WEISS

2 please pull up tab 1, which I
3 believe has already been marked as
4 Exhibit 1.

5 (The above described document was
6 marked Exhibit 1 for identification as of
7 this date.)

8 THE CONCIERGE: Shall I be
9 sharing it on screen, counsel?

10 ATTORNEY KORBERG: Sure.

11 THE VIDEOGRAPHER: I have a
12 question about that, counsel, this
13 is the videographer.

14 If he is sharing on screen,
15 would you like that included in the
16 video on a split screen or the
17 witness only?

18 ATTORNEY KORBERG: I don't
19 think we need to show it.

20 THE CONCIERGE: Do you need a
21 second, Chris, before I share it?

22 THE VIDEOGRAPHER: No, we are
23 good.

24 Q Do you agree that this is the
25 declaration that you submitted in this case?

1 DANIEL WEISS

2 A Yes.

3 Q And to the best of your
4 knowledge is -- does this, does Exhibit 1
5 reflect the full and complete declaration
6 you submitted in this case?

7 A Yes.

8 Q And are the opinions that you
9 espouse in your declaration your own?

10 A Yes.

11 Q Did you have assistance
12 drafting this declaration?

13 A No.

14 Q So nobody helped you draft
15 this declaration, is that correct?

16 A The contents are solely my
17 own. I did show it to my wife for
18 formatting only.

19 Q Understood.

20 Does your declaration
21 represent a complete statement of the
22 opinions that you are offering in this case?

23 ATTORNEY DROZ: Objection.

24 A I might offer additional
25 opinions during this deposition, but I agree

1 DANIEL WEISS

2 with all the opinions expressed -- I
3 continue to agree with the opinions
4 expressed in this declaration.

5 Q Okay, so let's take that in
6 parts.

7 So first, there is nothing
8 you would like to correct or amend in your
9 declaration, right?

10 A Correct.

11 Q And as you sit here today, at
12 this moment, the opinions expressed in this
13 declaration are all those you intend to
14 offer, but it is possible that over the
15 course of this deposition you might offer
16 additional opinions, is that right?

17 A Yes, that's correct.

18 Q All right. Can we turn to
19 page 50 of Exhibit 1.

20 It says, references at the
21 top are these the materials you relied on in
22 reaching your opinions expressed in your
23 report?

24 A Yes, and my experience in
25 rationality.

1 DANIEL WEISS

2 Q Did you personally read each
3 of the references listed --

4 A Yes.

5 Q -- here?

6 A Yes.

7 Q And you think each of the
8 representations you listed here is reliable?

9 A What do you mean by reliable?

10 Q Well, am I correct that you
11 formed the opinions expressed in your report
12 in reliance on among other things these --
13 the references that you list here?

14 A I think we need to define the
15 word reliance. I used -- critical analysis,
16 my experience, my ability to analyze studies
17 and all of that in careful review of each of
18 the references.

19 Q Understood.

20 But you believe in the
21 accuracy, the methodology, et cetera, of the
22 references that you list here on page 50 of
23 your report, is that correct?

24 A I don't think it's a matter
25 of belief.

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DANIEL WEISS

ATTORNEY DROZ: Objection.

There is numerous references. I'm not sure if you want to go through each one. I suppose we could do that.

But you can answer, Doctor.

A Certainly. So I don't think it's a matter of belief. This is not -- we are not talking about belief, we are talking about analysis, thinking, evaluation, careful evaluation of each of the references, and I think the declaration speaks for itself.

When I refer to a reference, I might comment on appropriate or inappropriate, flaw or quality type methodology.

So I might refer to something, and it doesn't mean I agree to everything that that reference says.

Q Do you have any concerns about the accuracy of any reference that you list here beginning on page 50 of your report?

1 DANIEL WEISS

2 A I think the word accuracy in
3 this context is unclear.

4 Q Is there any reference that
5 you listed in your report that you think is
6 unreliable in some way?

7 ATTORNEY DROZ: Objection, in
8 terms of reliability.

9 A I think the word reliable is
10 not -- it's not an absolute term, so --
11 medicine and science is not always
12 clear-cut.

13 So I think you need to be
14 more specific, and we can look at a
15 particular reference and then you can tell
16 me about it and we can analyze it.

17 Q Are there any references --
18 what does it mean to you, why did you list
19 these particular references in your report?

20 A I think the declaration
21 speaks for itself. Let's go to a particular
22 reference and I'll tell you why I listed it.

23 Q As a whole, what does it mean
24 for you to list a reference?

25 What does a reference mean in

1 DANIEL WEISS

2 this context? What role did it play in the
3 formation of your opinions?

4 A So, in the declaration I
5 would list a reference because it
6 solidifies, clarifies or supports a
7 statement I make.

8 Q And is there any reference
9 about which you have a concern about the
10 methodology employed in that reference?

11 ATTORNEY DROZ: Objection,
12 any particular reference, or what
13 are we talking about?

14 ATTORNEY KORBERG: No, I am
15 directing him to all the references,
16 and these speaking objections are
17 really, they are inappropriate, you
18 are directing the witness, and I
19 would ask you to stop.

20 ATTORNEY DROZ: I am just
21 trying to -- I don't want to say I'm
22 trying to help you, but I am just
23 trying to move it along in terms of
24 what we are talking about here.

25 ATTORNEY KORBERG: I hear

1 DANIEL WEISS

2 you. I don't need any help, please
3 just stick to the standard forms of
4 objection.

5 ATTORNEY DROZ: Objection,
6 vague.

7 A I have no problem with the
8 question. I think that we still have to
9 drill down and look at particular
10 references.

11 I might have cited a
12 reference, for example, by Dr. Turbin, who
13 is basically a statistician who finished his
14 psychiatry training like a year or two ago.

15 He's very well known in the
16 field of gender dysphoria. I might have
17 cited one of -- cited one of his papers
18 here, I don't recall, among all my
19 references, that are about 160 references.
20 If I cited his paper, it likely has very
21 flawed methodology.

22 And so that would be an
23 example of, yes, a reference I would have
24 concerns about.

25 But we can look through each

1 DANIEL WEISS

2 reference.

3 Q So, it's your belief that
4 some of these references that you list in
5 your report you do think have very flawed
6 methodology, is that correct?

7 A I said there may be one or
8 two. We would have to look through each.

9 I have to look at them and
10 tell you that one has a particular problem.
11 That one doesn't.

12 And I will mention that so
13 the declaration again it speaks for itself.

14 It will refer to a reference
15 and say, for example, the Dutch protocol, I
16 referred -- that's in there -- that
17 subsequent study, the late study after
18 surgical reassignment, had very flawed
19 methodology, and I discuss that in the
20 declaration.

21 Most of the other references,
22 however, I think are sound, but we have to
23 look at each individual one.

24 Q Okay.

25 So, some of the references

1 DANIEL WEISS

2 have methodological and other flaws that you
3 identified in the declaration, right?

4 A Yes, and some of them may
5 have other flaws that I might not have
6 identified.

7 Q Okay, so some of the
8 references, none of which you can identify
9 specifically as you sit here today, but you
10 relied upon in forming your report, may be
11 flawed, methodologically or otherwise,
12 right?

13 A No; I don't think that's
14 accurate.

15 If we look through the
16 references today, sitting, and we go through
17 each one, I may tell you of flaws in them.

18 But right now, without going
19 through each individual one, I can't by
20 memory, tell you which ones are flawed.

21 We can look at each one, we
22 can go through all 163 or so of them, if you
23 would like.

24 Q So I understand that you
25 can't by memory identify now which ones are

1 DANIEL WEISS

2 flawed in ways that you haven't already
3 outlined in your report.

4 But it is your testimony that
5 there is some number of references that you
6 rely upon in your report and list here that
7 are flawed in some way, whether
8 methodological or otherwise, that you do not
9 identify as flawed in your report, right?

10 A No.

11 ATTORNEY DROZ: Objection to
12 form.

13 A I would not agree with that.

14 You're using the word relied
15 upon in a very misleading way. I may have
16 mentioned it, I may have referred to it, but
17 I would not have relied upon a report that
18 was significantly flawed.

19 So, by using the word rely,
20 it sounds like I'm basing my statement or
21 declaration upon flawed references, and I'm
22 not.

23 I might have referred to a
24 reference that was flawed, but I'm not
25 basing an opinion or conclusion based upon a

1 DANIEL WEISS

2 flawed reference.

3 Q In reading your report, how
4 am I supposed to know which references you
5 are relying upon and which references you
6 are referring to for some other reason?

7 A The declaration is fairly
8 clear in that, is very clear in that regard.

9 Q For every reference it is
10 your -- it is your testimony that your
11 declaration is clear as to whether you are
12 relying on that reference or not?

13 ATTORNEY DROZ: Objection to
14 form, vague.

15 A I don't know what you mean by
16 relied upon. I don't use that terminology
17 when describing a scientific or medical
18 conclusion.

19 I may consider a study, a
20 paper, but to rely upon implies that it's a
21 foundation for a decision.

22 There is no single reference
23 here that provides a sole foundation for my
24 decision.

25 It's the overall scientific

1 DANIEL WEISS

2 literature, my clinical experience, my
3 ability to evaluate that literature, and
4 rationality or common sense.

5 Q We will return to that.

6 ATTORNEY KORBERG: Let's pull
7 up what I understand has already
8 been marked as Exhibit 2.

9 (The above described document was
10 marked Exhibit 2 for identification as of
11 this date.)

12 Q Would you agree with me that
13 this is your CV that you submitted in this
14 matter?

15 A Looks like it, yes.

16 Q And is the CV that you
17 submitted in this matter currently accurate?

18 A I'm not sure when it was
19 submitted, but it should be accurate, yes.

20 Q Do you have anything that you
21 would like to add or amend to your CV?

22 A Not that I can think of, no.

23 Q Starting at page 92 of your
24 CV, you list legal experience, then three
25 cases.

1 DANIEL WEISS

2 Do the cases that follow
3 reflect all of your legal experience?

4 A Can we go to page 92, and
5 let's look at 93. Back to 92.

6 Yes, that's all.

7 Q Did you submit a declaration
8 in Van Garderen v. Montana, a challenge to a
9 Montana law banning gender affirming care
10 for transgender adolescents?

11 A Yes.

12 Q Why wasn't that case included
13 on your CV?

14 A It came after the submission
15 of the CV.

16 ATTORNEY KORBERG: Can we
17 please mark tab 4 as Exhibit 3,
18 which is your declaration in that
19 Montana case.

20 (The above described document was
21 marked Exhibit 3 for identification as of
22 this date.)

23 THE CONCIERGE: Sorry to
24 bother you. I see 4.1, et cetera.
25 Which tab?

1 DANIEL WEISS

2 ATTORNEY KORBERG: This is
3 actually tab 3.

4 THE CONCIERGE: Got it, thank
5 you.

6 Q Is this a, to your knowledge,
7 a complete and accurate reflection of the
8 declaration that you submitted in that
9 Montana case?

10 A Looks like the first page.

11 Q Have you ever been
12 disqualified to serve as an expert for a
13 case in which your expertise has been
14 offered?

15 A No.

16 Q Have you ever given any
17 testimony, either written or in person, on
18 any issue that a judge has ultimately
19 declined to credit or consider?

20 A No.

21 Q Turning back to Exhibit 2,
22 which is your CV in this case, page 24.

23 Q Does it sound right that your
24 bibliography lists 23 publications?

25 A I don't remember that. We

1 DANIEL WEISS

2 can scroll down, it will tell you that.

3 Q Sure.

4 Do you have any writing or
5 presentations not reflected in your CV?

6 A I think it's complete in that
7 regard.

8 Q In your report you suggest
9 you participated in 100 clinical trials, but
10 you only list 90 here.

11 Do you know what the ten
12 clinical trials that you didn't include in
13 your CV are?

14 A Let's look through and see
15 what that number is here. Let's see what
16 the last states.

17 Q I will suggest that you -- I
18 will represent to you they are not numbered
19 here, so we just counted them.

20 A I may have miscounted.

21 Q So it's your belief in your
22 report when you say you participated in 100
23 clinical trials, you actually meant to say
24 that you participated in the 90 clinical
25 trials that you listed in your CV, is that

1 DANIEL WEISS

2 right?

3 A If you --

4 ATTORNEY DROZ: Objection.

5 A If you counted them and you
6 got 90, and my declaration says 100, and --
7 you can quibble over the ten.

8 Q Sure, but what I'm asking is
9 was your assertion that you participated in
10 100 clinical trials in your declaration
11 incorrect, or are there ten clinical trials
12 that you participated in that are not
13 reflected on your CV?

14 A So I did want to see the last
15 one listed, because it's possible I may not
16 have listed a few other trials.

17 Can we scroll down to the
18 end?

19 Q That would be page 108, I
20 believe.

21 A That looks complete, and if
22 the total is 90, then, I thought I said
23 approximately 100, but if I said 100 I was
24 off by ten.

25 Q Do any of the 590 total

1 DANIEL WEISS

2 publications and presentations that you
3 reflected in your CV relate to gender
4 dysphoria or gender affirming care?

5 A No.

6 Q Did any of the 590 total
7 publications and presentations reflected in
8 your CV relate in any way to pediatric or
9 adolescent medicine?

10 A State that question one more
11 time?

12 Q Sure.

13 Do any of the 590 total
14 publications and presentations reflected in
15 your CV relate in any way to pediatric or
16 adolescent medicine?

17 A Yes, some of them might,
18 because diabetes management in adults
19 overlaps with diabetes management in
20 adolescents and children.

21 So I did speak on that
22 subject, and that would be part of that.

23 Q Are any of those 590 total
24 publications and representations
25 specifically about pediatric or adolescent

1 DANIEL WEISS

2 medicine, as opposed to on subjects that are
3 incidentally relevant?

4 A There is overlap certainly
5 with pediatric and adolescents, but none of
6 them were solely on pediatric or adolescent.

7 Q Were any of those 590
8 publications predominantly about pediatric
9 or adolescent medicine?

10 A Not that I recall.

11 Q Turning to page 7 of Exhibit
12 2, which is your CV, you list 64 major
13 courses and meetings for continuing medical
14 education you have attended or undertaken,
15 right?

16 A If that's what it says, yes.
17 64, okay. I don't remember the number.

18 Q Have you undertaken any
19 continuing medical education not listed
20 there?

21 A Let's go back to the last --
22 let's go to the last one, because I might
23 not have listed them, some since then.

24 Certainly I have done
25 continuing medical education since the

1 DANIEL WEISS

2 submission of the CV.

3 Oh, there is substantial
4 continuing medical education after that,
5 yes.

6 Q Okay, so the CV that you
7 submitted in this matter doesn't actually
8 reflect all of your continuing medical
9 education, right?

10 A Correct.

11 ATTORNEY KORBERG: Counsel,
12 we would ask you submit an updated
13 CV that accurately reflects the
14 witness' experience.

15 ATTORNEY DROZ: We will take
16 it under advisement.

17 Q Have you undertaken any
18 continuing medical education related to
19 gender dysphoria or gender affirming care?

20 A Yes.

21 Q What were those?

22 A I read the section on Up to
23 Date, on gender dysphoria.

24 Q Can you explain what you mean
25 by you read the section on, Up to Date, on

1 DANIEL WEISS

2 gender dysphoria?

3 A Yes, so Up to Date is an
4 online reference that many physicians use to
5 get guidance on diagnosis and treatment of a
6 variety of medical disorders.

7 It's used throughout the
8 world.

9 Q Okay. So other than reading
10 entries on this online reference source,
11 have you undertaken any continuing medical
12 education on gender dysphoria or gender
13 affirming care?

14 A Well, that online reference
15 source is -- provides AMA category 1 credits
16 for review.

17 So that is continuing medical
18 education.

19 Q And have you, in fact,
20 received category 1 credits for your review
21 of gender dysphoria, entries relating to
22 gender dysphoria or gender affirming care on
23 Up to Date?

24 A Yes.

25 Q When did you receive those

1 DANIEL WEISS

2 category 1 credits for that education,
3 reading that online read source on gender
4 dysphoria or gender affirming care?

5 A I don't remember.

6 Q What specifically did you
7 look up or reference on that online resource
8 relating to gender dysphoria or gender
9 affirming care?

10 A Management of patients with
11 gender dysphoria.

12 Q Other than reading those
13 entries on that online resource related to
14 management of patients with gender
15 dysphoria, have you undertaken any
16 continuing medical education on gender
17 dysphoria or gender affirming care?

18 A No.

19 Q Other than attending a
20 symposium in 1989, have you received any
21 continuing medical education related to
22 pediatric or adolescent endocrinology?

23 A I probably have, although I
24 don't -- I have not -- nothing specific with
25 regard to that, because the Endocrine

1 DANIEL WEISS

2 Society meetings I might have attended, I
3 did attend, and I listed those.

4 I would have gone to sessions
5 that included pediatric and adolescent
6 endocrine issues.

7 Q Okay. So other than
8 attending meetings of the Endocrine Society,
9 where pediatric or adolescent endocrine
10 issues may have incidentally been discussed,
11 have you received any continuing medical
12 education relating to pediatric or
13 adolescent endocrinology?

14 ATTORNEY DROZ: Objection.

15 A I wouldn't use the word
16 incidentally, because the Endocrine Society
17 has many sessions on adolescents, children
18 and adults.

19 But when I list the credits,
20 the CME credits, continuing medical
21 education credits provided at those
22 meetings, I don't list each particular
23 session I went to. That's just not done.

24 And some of those discussions
25 may have been focused on and perhaps even

1 DANIEL WEISS

2 entirely devoted to adolescent or pediatric
3 endocrine issues.

4 I just don't recall.

5 Q Okay. So you may have over
6 the years attended sessions focused on
7 pediatric or adolescent medicine, but you
8 have no specific recollection of having
9 affirmatively done so, right?

10 A Correct.

11 ATTORNEY KORBERG: I would
12 like to introduce as Exhibit 4
13 what's tab 4.1, which is your
14 deposition transcript in K.C. v.
15 individual members of the Medical
16 Licensing Board of Indiana.

17 Q Have you reviewed your
18 transcript in that case?

19 A The deposition transcript?

20 Q Yes, in the Indiana case?

21 A I looked at it briefly.

22 (The above described document was
23 marked Exhibit 4 for identification as of
24 this date.)

25 Q Is there anything inaccurate

1 DANIEL WEISS

2 in your testimony in the Indiana case or
3 anything that you wish to amen?

4 A Well, having not looked at
5 the whole transcript, I can't tell you.

6 ATTORNEY DROZ: Can I stop
7 just a second here, and it's a sort
8 of housekeeping thing, and forgive
9 me.

10 On the Exhibit Share, should
11 these be showing up in my folder as
12 well on the Exhibit Share, or I'm
13 just limited to what's on the
14 screen?

15 THE CONCIERGE: That's
16 affirmative. They should be showing
17 up, and you and the witness and
18 everybody else should be able to
19 independently go through the
20 documents.

21 ATTORNEY DROZ: So I'm
22 showing only 1 and 2.

23 THE CONCIERGE: You have to
24 refresh your web browser.

25 ATTORNEY DROZ: Got it.

1 DANIEL WEISS

2 Thank you. I apologize for the
3 delay.

4 THE CONCIERGE: You're
5 welcome.

6 ATTORNEY DROZ: Please
7 continue, I apologize.

8 Q So you testified that you did
9 review at some point your transcript in the
10 Indiana case, right?

11 A Briefly; in part, not
12 entirely.

13 Q And based on your review, do
14 you recall whether there was anything in,
15 that you read in that deposition transcript,
16 that you believe to be inaccurate?

17 A No.

18 Q And based just on your
19 recollection of what you said in the Indiana
20 case, regardless of whether you read it in
21 the transcript or not, is there anything
22 that you said that you believe to be
23 inaccurate or that you wish to amend?

24 A Not that I recall, no.

25 THE VIDEOGRAPHER: I would

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DANIEL WEISS

like to introduce as Exhibit 5 tab
4.2, which is your written testimony
submitted in Florida in October 24,
2022 to the Board of Medicine.

(The above described document was
marked Exhibit 5 for identification as of
this date.)

Q You have no reason to believe
this is a true and complete copy of your
testimony there, right?

A What's the question?

Q Do you have any reason to
believe that this isn't a true and complete
copy of your testimony to the court?

A It looks correct.

THE VIDEOGRAPHER: Same for
what I would like to introduce as
Exhibit 6, which is tab 4.3.

(The above described document was
marked Exhibit 6 for identification as of
this date.)

Q This is your written
testimony submitted in North Dakota to the
Senate Committee on Human Services regarding

1 DANIEL WEISS

2 HB 1254.

3 Same question, any reason to
4 believe this isn't a true and complete copy
5 when it comes up of your testimony in North
6 Dakota?

7 A Looks correct.

8 ATTORNEY KORBERG: Same with
9 respect to what I will mark as
10 Exhibit 7, which is tab 4.4, which
11 is the written testimony submitted
12 in Ohio in support of HB68.

13 (The above described document was
14 marked Exhibit 7 for identification as of
15 this date.)

16 Q Any reason to believe that
17 this, when it comes up, is not a true and
18 complete copy of your Ohio testimony?

19 A Looks like my testimony.

20 Q And just to be clear for the
21 record, this is your testimony in support of
22 HB 68 in Ohio.

23 ATTORNEY KORBERG: I would
24 like to introduce as Exhibit 8,
25 which is tab 4.5, your written

1 DANIEL WEISS

2 testimony submitted in support of
3 another Ohio law, HB 454.

4 Q And when that comes up, is
5 there any reason to believe that this isn't
6 a true and complete copy of your testimony
7 in Ohio in support of HB 454?

8 (The above described document was
9 marked Exhibit 8 for identification as of
10 this date.)

11 A Looks correct.

12 Q Great.

13 THE VIDEOGRAPHER: And I
14 would like to introduce tab 4.6, and
15 mark it as Exhibit 9, which is --
16 which I believe to be oral testimony
17 that you gave in support of Ohio HB
18 454.

19 (The above described document was
20 marked Exhibit 9 for identification as of
21 this date.)

22 A Yeah.

23 ATTORNEY DROZ: Objection.

24 What is this?

25 ATTORNEY KORBERG: Why don't

1 DANIEL WEISS

2 we click on the link.

3 THE WITNESS: Which one?

4 THE CONCIERGE: It may not go
5 smoothly. I'm just giving you a
6 heads up. So just give me one
7 second.

8 ATTORNEY DROZ: We don't need
9 to do that if counsel is prepared to
10 just represent that those links are
11 links to --

12 Q Okay, I will represent that
13 we have links to your testimony in Ohio in
14 support of HB 454, which we have marked as
15 Exhibit 9, your testimony in support of Utah
16 Senate Bill 16, which we have marked as
17 Exhibit 10, and your testimony in support of
18 Montana SB 99, which we have marked as
19 Exhibit 11.

20 And we would just like to
21 confirm you have no reason to believe that
22 these wouldn't be accurate representations
23 of the testimony you gave there.

24 A No reason to believe.

25 (The above described documents were

1 DANIEL WEISS

2 marked Exhibits 10 and 11 for
3 identification as of this date.)

4 Q So I understand you're here
5 today as an expert witness, and I want to
6 understand which areas or subjects you
7 believe yourself to be an expert in.

8 Do you consider yourself to
9 be an expert in pediatric or adolescent
10 medicine?

11 A Some aspects of that, yes.

12 Q What aspects of pediatric or
13 adolescent medicine do you believe yourself
14 to be an expert in?

15 A Those that focus on endocrine
16 issues.

17 Q There is a Board
18 certification for pediatric endocrinology,
19 right?

20 A I believe so.

21 Q And you are not Board
22 certified in pediatric endocrinology, right?

23 A No.

24 Q And a separate Board
25 certifications for pediatric medicine,

1 DANIEL WEISS

2 right?

3 A I think so, yes.

4 Q And you are not Board
5 certified in pediatric medicine?

6 A No.

7 Q In what aspects do you
8 consider yourself to be an expert in
9 pediatric endocrinology?

10 A In the aspects that we are
11 dealing with here.

12 Q What do you mean by that?

13 A Hormonal interventions in
14 minors who have a condition called gender
15 dysphoria.

16 Q So you believe yourself to be
17 an expert in minors who have a condition
18 called gender dysphoria, is that right?

19 A Yes, well, the hormonal --
20 the effect of hormonal interventions in
21 those children.

22 Q Okay.

23 And what's the basis of your
24 expertise in the effect of hormonal
25 interventions in children with gender

1 DANIEL WEISS

2 dysphoria?

3 A The basis of my expertise is
4 my expertise as an endocrinologist,
5 rationality, my experience, and my review of
6 the scientific literature.

7 Q Is pediatric endocrinology
8 distinct from adult endocrinology?

9 A In some areas.

10 Q In what areas is pediatric
11 endocrinology distinct from adult
12 endocrinology?

13 A Well, for example, a growth
14 hormone treatment in children is different
15 from growth hormone treatment in adults.

16 But the action of
17 testosterone and estrogen is very similar in
18 children and in adults.

19 It's not -- that's not
20 different.

21 Q The action of testosterone
22 and estrogen is --

23 ATTORNEY KORBERG: Withdrawn.

24 Q Is the action of testosterone
25 and estrogen in prepubertal children the

1 DANIEL WEISS

2 same or similar to in adults?

3 A The action is similar. The
4 children are different from adults, but the
5 action of the hormone is similar.

6 Q The action of testosterone
7 and estrogen in prepubertal children is
8 similar to adults, right?

9 A Yes.

10 Q How are they different?

11 A You need to be more specific
12 than that in your question.

13 Q Sure. You said that the
14 action of testosterone and estrogen is, in
15 prepubertal children, is similar to that in
16 adults.

17 A Right, the action on
18 receptors is similar.

19 So the hormone is the same
20 chemical structure, it's just that the
21 results might be different in a person who
22 is an adult versus a person who is a child.

23 Q Do you believe that a
24 pediatric endocrinologist who has never
25 treated an adult is an expert on adult

1 DANIEL WEISS

2 endocrinology?

3 A In general, I think one can
4 become very knowledgeable and be an expert
5 using the general principles of that
6 specialty and extrapolating, based upon that
7 experience, that knowledge, that expertise
8 that you have gained, and then coupled with
9 careful reading of the scientific
10 literature, you can become an expert.

11 So yes.

12 And I should add, I have
13 treated many children earlier in my career
14 with endocrine disorders, including growth
15 hormone problems and other -- even down to
16 the age of 5 I was treating such children
17 based upon my knowledge of the literature,
18 my -- and my training as a pediatric -- in
19 pediatric endocrinology in my fellowship.

20 So I have treated children
21 with endocrine disorders, including growth
22 hormone disorders, congenital adrenal
23 hyperplasia.

24 So I have had that
25 experience, because I have had over 36 years

1 DANIEL WEISS

2 of endocrine practice.

3 In a big group I was in, I
4 was the sole endocrinologist, and I was
5 seeing children.

6 Q Have you ever treated a child
7 or adolescent for gender dysphoria?

8 A I have treated down to the
9 age of 18. I have seen children, I have
10 seen people down to the age of 18 with
11 gender dysphoria.

12 Q But you have never treated a
13 legal minor under the age of 18 for gender
14 dysphoria, right?

15 A So, I think it would be -- it
16 would be unethical, improper and wrong to do
17 so.

18 And as you are familiar with
19 my declaration, I have treated 100 adults
20 with gender dysphoria with opposite sex
21 hormones or hormonal blockade.

22 But at the time I was
23 treating, there were very few minors being
24 treated, and I would consider it completely
25 unethical to do so.

1 DANIEL WEISS

2 So I did not do so.

3 Q I appreciate that.

4 You know, we have a lot of
5 ground to cover today, so it would be
6 helpful if you could answer the questions as
7 I pose them, and then if I would like you to
8 expound on them, I can certainly ask you.

9 But, you know, my question
10 was have you treated a minor under the age
11 of 18 for gender dysphoria?

12 ATTORNEY DROZ: Just
13 objection.

14 Q And the answer is no, right?

15 ATTORNEY DROZ: Objection.
16 He gets to answer the way he feels
17 he needs to answer the question.

18 A I have not treated anyone
19 under 18 with opposite sex hormones.

20 Q Is the efficacy of hormonal
21 treatment similar for adolescents and
22 adults?

23 A You need to define efficacy.

24 Q Sure.

25 Is the effect of hormones

1 DANIEL WEISS

2 similar for adolescents and adults?

3 A Yes, but one needs to keep in
4 mind that each person that's being treated
5 is -- responds differently, and that is in
6 part related to age.

7 Q Well, I understand that you
8 believe yourself to be an expert in the
9 treatment of children and adolescents for
10 gender dysphoria based on your experience
11 treating adults for gender dysphoria, right?

12 A I object to the use of the
13 word treatment.

14 Opposite sex hormones,
15 hormonal blockade and puberty blockers for
16 children with gender dysphoria is not
17 treatment. It's a hormonal intervention
18 which is harmful.

19 I don't call it treatment,
20 and I have thus far not objected to your use
21 of the term gender affirming care, because
22 it's misuse of language.

23 It doesn't affirm the child,
24 it attempts to alter their body and to treat
25 a mental health disorder.

1 DANIEL WEISS

2 So it's not treatment, it's
3 an intervention. But it's not care and it's
4 not treatment.

5 Q Okay, so just to sort of
6 table set, can we agree that when, for the
7 purposes of this deposition, when we use the
8 phrase gender affirming care, what we -- or
9 gender affirming treatment, it is not a
10 judgment on the reasonableness of such
11 treatment, but rather the administration of
12 either puberty blockers or cross sex
13 hormones or potentially surgery to treat
14 gender dysphoria?

15 A I object to the use of gender
16 affirming. I think that's not a neutral
17 statement to call it gender affirming care.
18 I don't like that term.

19 And you're basically
20 supporting it when you are using the term
21 gender affirming care.

22 I prefer that you use the
23 term cross sex hormones, puberty blockers,
24 and it's more specific.

25 Q Okay, same cross sex

1 DANIEL WEISS

2 hormones, puberty blockers, cetera, takes up
3 some space, can we just agree that to the
4 extent I will try to do so, we agree to the
5 extent I'm using the phrase, and we have
6 used the phrase gender affirming care or
7 gender affirming treatment so far, while you
8 object to what you perceive to be a value
9 judgment about that, the administration of
10 those, they are conventions, that we are
11 referring to puberty blockers, cross sex
12 hormones and potentially surgical care?

13 A You can use that term, I will
14 be more specific.

15 Q Great.

16 So you testified earlier that
17 you believe yourself to be an expert in the
18 administration of puberty blockers, cross
19 sex hormones and potentially surgery to
20 minors based on the fact that you have
21 clinical experience performing those
22 interventions on adults, right?

23 A And I have treated children
24 with same sex hormones for delayed puberty
25 in the past.

1 DANIEL WEISS

2 Q So, am I correct, based on
3 what you're saying about your expertise,
4 that experience with, or studies on adults
5 with cross sex hormones, for example, are
6 relevant to adolescents?

7 A Yes.

8 Q And is it fair to say that
9 studies, data, experience, related to the --
10 any potential side effects or risks of the
11 administration of cross sex hormones with
12 regard to adults are also relevant to the
13 effect of cross sex hormones on children?

14 A Yes.

15 Q Can the symptoms of any given
16 endocrine disorder be different in children
17 and adolescents than adults?

18 A They might be.

19 Q Do you consider yourself an
20 expert in psychology?

21 A Knowledgeable in many areas
22 of psychology, yes.

23 Q Do you consider yourself to
24 be an expert in psychology?

25 A How do you define an expert?

1 DANIEL WEISS

2 Q Well, you are appearing here
3 today as an expert witness, right?

4 A Yes.

5 Q And you said that you are an
6 expert in endocrinology, right?

7 A Yes.

8 Q And that you believe yourself
9 to be an expert in the administration of
10 what I call gender affirming care to minors,
11 right?

12 A Yes.

13 Q So, however you meant expert
14 with respect to those subjects, I'm asking
15 you if you consider yourself to be an expert
16 in psychology?

17 A No, not an expert in
18 psychology.

19 Q And why not? What is lacking
20 with regard to your expertise in psychology
21 as distinct from your purported expertise in
22 the effect of these interventions on
23 children suffering from gender dysphoria?

24 A Well, there are certain
25 psychiatric disorders, if I may, psychology

1 DANIEL WEISS

2 is not the same as psychiatry, but I'm not
3 an expert in psychosis.

4 But I am knowledgeable in the
5 comorbidities that are seen in many minors
6 with gender dysphoria.

7 But I am not an expert, for
8 example, in schizophrenia.

9 Q Sure, but I am asking
10 actually sort of a simpler question.

11 You said that you're an
12 expert in the provision of these medical
13 interventions which I call gender affirming
14 care to minors to treat gender dysphoria,
15 right?

16 A Yes.

17 Q And you said you are not an
18 expert in psychology, right?

19 A Yes.

20 Q What expertise are you
21 lacking in psychology such that you cannot
22 say the same thing with respect to
23 psychology?

24 ATTORNEY DROZ: I object to
25 form. You can answer.

1 DANIEL WEISS

2 A I just gave you an example.
3 For example, treatment of psychosis.

4 Q Right.

5 A Or, for example, I am not an
6 expert in providing cognitive behavioral
7 therapy in people with psychological
8 disorders.

9 I'm not an expert in treating
10 post traumatic stress disorder. I am not an
11 expert in treating sexual abuse.

12 Q So is the distinction just
13 that psychology is a broader category,
14 whereas you feel that treating children
15 with -- for gender dysphoria is a narrower
16 category?

17 A No, I have not had extensive
18 years of experience being trained in
19 psychological counseling and psychological
20 disorders.

21 That's the distinction.

22 Q Can you catalogue for me all
23 of the mental health training or education
24 you have undertaken?

25 A Catalogue, no. I have done

1 DANIEL WEISS

2 continuing medical education courses, and I
3 have done reading on my own.

4 Much of it is reading on my
5 own and training in my residency,
6 fellowship, attending courses.

7 Q Do you consider yourself to
8 be an expert in the diagnosis and treatment
9 of mental health disorders?

10 A No.

11 Q Do you consider yourself to
12 be an expert in pediatric psychology?

13 A No.

14 Q Do you consider yourself to
15 be an expert in the diagnosis and treatment
16 of mental health disorders in children and
17 adolescents?

18 A No.

19 Q Do you consider yourself to
20 be an expert in the psychology of gender
21 identity?

22 A I think you need to define
23 what you mean by gender identity. You mean
24 gender identity disorder, gender dysphoria?

25 Q Do you consider yourself to

1 DANIEL WEISS

2 be an expert in the psychology of gender
3 dysphoria?

4 A Yes.

5 Q And what is the basis of your
6 expertise in the psychology of gender
7 dysphoria?

8 A Reading the literature.

9 Q What literature have you read
10 related to the psychology of gender
11 dysphoria?

12 A Much of the published
13 literature in this regard.

14 Q Other than reading published
15 literature relating to the psychology of
16 gender dysphoria, do you have any other
17 basis for your belief that you are an expert
18 in the psychology of gender dysphoria?

19 A No.

20 Q And just to be clear, you
21 have not read all of the literature related
22 to the psychology of gender dysphoria,
23 right?

24 A No one has.

25 Q Do you consider yourself to

1 DANIEL WEISS

2 be an expert in psychology of gender
3 identity development in children and
4 adolescents?

5 A What do you mean by that
6 specifically?

7 Q Would you agree that all of
8 us develop a sense of our own gender
9 identity?

10 ATTORNEY DROZ: Objection,
11 form.

12 A WPATH can't even define
13 gender. Look at the glossary in W path,
14 they can't define gender.

15 Gender identity is a -- is an
16 internal sense of the sex that a person
17 feels that they are.

18 That evolves over time and is
19 modified by many factors.

20 Q Do you consider yourself to
21 be an expert in the diagnosis of gender
22 dysphoria in adults?

23 A I think it's -- I have
24 defined -- I have described gender dysphoria
25 as a social construct, and it's very

1 DANIEL WEISS

2 confusing, even for W path.

3 Am I an expert in it? Yes.

4 Q Are you an expert in
5 diagnosing gender dysphoria in adults?

6 A Yes.

7 Q What's the basis of your
8 expertise?

9 A Reading the scientific
10 literature and my experience in treating
11 adults.

12 Q Is it your belief that
13 someone can be an expert in a subject solely
14 by reading academic literature in that
15 subject?

16 A Yes.

17 Q What qualifications or
18 experience would make someone an expert on
19 the diagnosis of gender dysphoria?

20 A I'm not sure I understand
21 your question.

22 Q Have you ever --

23 ATTORNEY KORBERG: Withdrawn.

24 Q Have you ever diagnosed
25 someone with gender dysphoria?

1 DANIEL WEISS

2 A Yes.

3 Q How many people have you
4 diagnosed with gender dysphoria?

5 A About 100 people.

6 Q And to be clear, I'm not
7 talking about treating someone with gender
8 dysphoria.

9 You are saying you have
10 diagnosed 100 people with gender dysphoria,
11 is that right?

12 A Yes.

13 Q And how did you diagnose any
14 given one of those people?

15 A At that point I was seeing
16 people in what's called gender identity
17 disorder, and those people also had
18 significant comorbidities that I was not
19 addressing, but they had -- they presented
20 to me with a sense of incongruence about
21 their sex, their gender, that was contrary
22 to their natal sex.

23 Q Okay. So you're able to
24 diagnose someone with gender dysphoria when
25 they present to you with a sense of

1 DANIEL WEISS

2 incongruence between their natal sex and
3 their gender, right?

4 A In those people.

5 All those people had
6 significant comorbidities, and I think, my
7 opinion is that if those comorbidities were
8 addressed, they would not have gender
9 dysphoria or gender identity disorder.

10 Q I understand. But I'm just
11 asking you about how you diagnose someone
12 with gender dysphoria.

13 A At that point I was using the
14 criteria, the DSM criteria of gender
15 identity disorder.

16 Q And for each of those 100
17 people, did you do a full assessment to
18 determine whether they met the criteria for
19 gender identity disorder outlined in the
20 DSM?

21 A I don't recall.

22 Q Is there anyone who presented
23 to you with a perception of the incongruence
24 between their natal sex and gender identity
25 who you determined should not be diagnosed

1 DANIEL WEISS

2 with gender dysphoria?

3 A Not that I recall.

4 Q Do you consider yourself to
5 be an expert in the diagnosis of gender
6 dysphoria in children or adolescents?

7 A I think gender dysphoria is a
8 description of an internal mental state that
9 is a result of other comorbidities.

10 Q So, is it possible to
11 experience gender dysphoria without the
12 presence of other comorbidities?

13 A I do not think so.

14 Q And what are all of the
15 comorbidities that you think account for
16 gender dysphoria?

17 ATTORNEY DROZ: Objection,
18 form.

19 A There are many comorbidities,
20 including sexual abuse, autism spectrum
21 disorder plays a role, physical abuse,
22 social contagion is important, although
23 that's not a comorbidity, peer influence is
24 important, bullying, social isolation.

25 All of these are factors

1 DANIEL WEISS

2 in -- I believe that in all cases those can
3 be identified as a precipitant as the cause
4 of the dysphoric state.

5 So I think the gender
6 dysphoria is not the underlying area of
7 focus, it's the comorbidity that's causing
8 it.

9 Q Are there any other
10 comorbidities, other than sexual abuse,
11 autism spectrum disorder, physical abuse,
12 social contagion or bullying that can cause
13 gender dysphoria?

14 A Well, social contagion is not
15 a comorbidity.

16 But those are the main ones,
17 and those need to be identified and
18 addressed for treatment of the psychic
19 distress that we call gender dysphoria.

20 ATTORNEY KORBERG: We have
21 been going about an hour and change,
22 so it might be time for a break.

23 Does that seem fine with you,
24 Dr. Weiss, and the court reporter?

25 THE WITNESS: I am fine.

1 DANIEL WEISS

2 THE VIDEOGRAPHER: Thank you,
3 counsel. This is the videographer.
4 The time is 11:22, this ends media
5 file 1.

6 (At this point in the proceedings
7 there was a recess, after which the
8 deposition continued as follows:)

9 THE VIDEOGRAPHER: We are
10 back on the record. The time is
11 11:31. This begins media file 2.

12 Q Great.

13 I just want to follow up on
14 something that we were talking about just
15 before the break.

16 Which is that you had
17 diagnosed adults with gender dysphoria, but
18 you have never diagnosed someone under the
19 age of 18 with gender dysphoria, right?

20 A That's correct.

21 Q Do you have --

22 ATTORNEY KORBERG: Withdrawn.

23 Q Have you read Dr. Cantor's
24 expert report in this case?

25 A No.

1 DANIEL WEISS

2 Q Do you consider Dr. Cantor to
3 be an expert in diagnosing and treating
4 gender dysphoria in minors?

5 A So, you know, the diagnosis
6 of gender dysphoria is a description by DSM,
7 and in all those children who have it, they
8 have some psychiatric cause or some
9 psycho-social basis for their dysphoria.

10 So, it's not -- it's not a
11 disorder that we need to be focusing on,
12 it's the underlying causes for that
13 dysphoric state.

14 Q Is it possible for someone to
15 be an expert in the diagnosis and treatment
16 of gender dysphoria?

17 A It's possible for someone to
18 be able to diagnose, yes, based upon some
19 criteria that have been established that are
20 evolving over time, gender identity
21 disorder, gender dysphoria, gender
22 incongruence.

23 Certainly many people can be
24 experts on just coming up with a diagnosis
25 based upon those stated criteria. It's

1 DANIEL WEISS

2 easy.

3 Q Okay.

4 Do you consider Dr. Cantor,
5 who is being also offered as an expert
6 witness in this case, to be an expert in
7 diagnosing and treating gender dysphoria in
8 minors?

9 A I can't speak to his
10 expertise.

11 Q So you don't have an opinion
12 one way or the other about whether he's an
13 expert in the things that he professes to be
14 an expert in?

15 A I think he's very
16 knowledgeable in that area, and I read some
17 of his publications.

18 Q Are you familiar --

19 ATTORNEY KORBERG: Withdrawn.

20 Q Have you read Dr. Malone's
21 expert report in this case?

22 A No.

23 Q Do you consider Dr. Malone to
24 be an expert in diagnosing and treating
25 gender dysphoria in minors?

1 DANIEL WEISS

2 A Dr. Malone is an expert in
3 this -- the field of hormonal and medical
4 interventions in the -- in an attempt to
5 modify a person's appearance who has
6 dysphoria that they attribute to an
7 incongruence between their male sex and the
8 sex they believe they ought to be.

9 He is an expert in those
10 aspects.

11 Q And what's the basis of
12 Dr. Malone's expertise in those aspects?

13 A He's an endocrinologist and
14 he knows the scientific literature very
15 well.

16 Q Are you familiar with Dr.
17 Kara Connelly?

18 A Only having read her
19 declaration. I don't know her otherwise.

20 Q And would you consider
21 Dr. Connelly to be an expert in the
22 diagnosis and treatment of gender dysphoria
23 in minors?

24 A Absolutely not, because she's
25 promoting harmful medical interventions on

1 DANIEL WEISS

2 these children, and obviously does not know
3 the scientific literature that indicates
4 that it's harmful and not helpful.

5 So she's the opposite of an
6 expert.

7 Q Okay, because you just
8 testified that Dr. Malone is an expert
9 because he's an endocrinologist and because
10 he knows the scientific literature very
11 well.

12 A Correct.

13 Q So you agree that Dr.
14 Connelly is an endocrinologist, right?

15 A Yes.

16 Q And while you may disagree
17 with the conclusions that you would each
18 draw from the scientific literature, you
19 would agree that she knows the scientific
20 literature very well, right?

21 A Absolutely not. She does --
22 I think it's clear that she doesn't know the
23 scientific literature.

24 Either that or she refuses to
25 accept the scientific literature.

1 DANIEL WEISS

2 I suspect she doesn't know
3 it, and like many pediatric endocrinologists
4 or commonly adolescent med people who are
5 not endocrinologists who intervene by giving
6 opposite sex hormones or puberty blockers on
7 these children with a mental health
8 disorder, the fact that they do this appears
9 to show that they do not know the scientific
10 literature at all, which shows clearly that
11 these interventions are harmful and not
12 helpful.

13 So, she is not an expert.

14 Q Okay, so it would be
15 impossible for someone, regardless of their
16 clinical experience, regardless of the
17 number of studies that they have reviewed,
18 if someone disagrees with you and believes
19 that it is reasonable, at least in some
20 circumstances, to provide gender affirming
21 care to minors, then they cannot be an
22 expert in the provision of gender affirming
23 care to minors.

24 Is that your opinion?

25 ATTORNEY DROZ: Objection to

1 DANIEL WEISS

2 form.

3 A Yes. So I would object to
4 your phrasing. It not a matter of belief,
5 it's a matter of careful and balanced and
6 rational reading of the scientific
7 literature that indicates -- it doesn't
8 matter if she's treated 1,000 people, that
9 means that's 1,000 children that she's
10 harmed based upon the science.

11 And I have given examples in
12 my declaration of people who are so
13 convinced that they are doing the right
14 thing and they have caused harm, because the
15 studies have shown, subsequent studies or
16 studies that have already been published,
17 show that it's not beneficial, and that it's
18 harmful.

19 Q So someone who reads all of
20 the same studies as you have ever read and
21 based on their training and experience comes
22 to a different conclusion about the efficacy
23 of this course of care, then they cannot
24 possibly be an expert, is that your opinion?

25 ATTORNEY DROZ: Objection to

1 DANIEL WEISS

2 form.

3 A It's not care, it's an
4 intervention, it's harmful, and if they
5 come -- it's very difficult to believe that
6 they have read the same studies.

7 I think they haven't read,
8 and many people come out of their training
9 and they stop learning. They stop. I see
10 that all the time.

11 I've taught a lot of people
12 over my 36 years of practice, and I see that
13 people after their residency or fellowship,
14 they just basically continue the same thing
15 and they don't stay current, they don't
16 read, and they are not critical thinkers.

17 And I think that's many of
18 the people, however well intentioned they
19 are, I'm sure Dr. Connelly is well
20 intentioned, she thinks she's doing the
21 right thing, but I suspect she hasn't read
22 the literature.

23 And if she does, she has read
24 it, which I doubt, she is so conflicted by
25 the fact that that's her job, so she can't

1 DANIEL WEISS

2 see the science.

3 And the science clearly shows
4 these interventions are not care, they are
5 not treatment, they are harmful and they
6 should be stopped.

7 Q So, other than the subject of
8 hormonal interventions for minors suffering
9 from gender dysphoria, are there any other
10 subjects where it is your belief that if a
11 fellow doctor reads the same studies as you
12 but comes to a different conclusion, it
13 means that they are not an expert in their
14 clinical -- area of clinical focus?

15 ATTORNEY DROZ: Objection,
16 form.

17 A I don't think such -- I have
18 not seen examples of that, because when
19 there is a difference in opinion, it usually
20 means the person has not read those other
21 studies. That's usually what it means.

22 Or they are not open to
23 scientific discourse and discussion. They
24 are closed minded, they don't want to see
25 the other side.

1 DANIEL WEISS

2 Q Okay, let's think about some
3 other subject in endocrinology, let's call
4 it like you know, some element of diabetes
5 management.

6 And let's say that you have a
7 fellow endocrinologist who practices
8 diabetes management who is Board certified,
9 and some element of diabetes management,
10 despite having reviewed the same literature
11 as you, they disagree about the appropriate
12 course of treatment, okay?

13 Would you assume from that
14 fact, the fact that you disagree about the
15 conclusions of the same literature, that
16 they are not an expert in diabetes
17 management?

18 ATTORNEY DROZ: Objection,
19 form.

20 A I have not seen any
21 circumstance like that.

22 I think there are judgments,
23 and there are different styles and different
24 approaches, but here we are talking about a
25 complete apparent unawareness of the

1 DANIEL WEISS

2 scientific literature that shows that these
3 interventions on minors with normal puberty
4 that cause irreversible changes and don't
5 help their psychic distress, they are not
6 aware of them and it's just -- it's not the
7 same as a minor, oh, I treat diabetes this
8 way and I do this.

9 I mean, there is an example,
10 for example, treating patients with a form
11 of high blood pressure caused by
12 overproduction of a hormone from the
13 adrenals.

14 So there are guidelines on
15 that, treating that, but there is
16 controversy, some people do it this way,
17 some people do it that way, and they are
18 both knowledgeable.

19 I wouldn't use the term
20 expert. My style is to not do surgery on
21 those people.

22 They say oh, you should do
23 these tests and you should do surgery.

24 They are both acceptable,
25 these people, we are all knowledgeable on

1 DANIEL WEISS

2 it, we just interpret it a little
3 differently.

4 But Dr. Connelly appears to
5 not be knowledgable, because if she were
6 knowledgeable on it, and read what's
7 published, she would not be doing what she's
8 doing to children. She just wouldn't.

9 You know, I can't imagine
10 doing that to children if you read the
11 science in a fair way.

12 Q Okay, I'm now talking to you
13 about any subject other than gender
14 affirming care. Okay?

15 A Yes.

16 Q Does the very fact that
17 someone disagrees with you about the body of
18 evidence in the literature disqualify them
19 from being an expert in their field of
20 practice?

21 ATTORNEY DROZ: I object to
22 the form.

23 A In this case, in this
24 situation I say it would disqualify her,
25 because she seems to not be aware of any of

1 DANIEL WEISS

2 the science.

3 Q Dr. Weiss, again, I'm asking
4 you about everything other than gender
5 affirming care.

6 A I can't think of another
7 example. But also --

8 Q You can think --

9 A But I might add that this is
10 the only mental health disorder for which
11 modifications of the physical body are
12 employed to fix the mental health disorder.

13 So it's unique.

14 Q We are talking about whether
15 someone is an expert or not and whether they
16 agree with you or not, okay?

17 A I can't think of anything
18 else, any other condition in which --

19 Q So if there is any other area
20 where there is a body of literature and your
21 fellow doctors may disagree about the
22 conclusions from that body of literature,
23 the fact that they disagree with you doesn't
24 disqualify them from being an expert, it's
25 only if they disagree about gender affirming

1 DANIEL WEISS

2 care for minors, right?

3 ATTORNEY DROZ: Objection,
4 argumentative and form, asked and
5 answered.

6 A So there is a use of the word
7 expert in a legal context, and there is a
8 use of the word expert in -- as a medically
9 knowledgeable person. So, I don't think we
10 should confuse those two.

11 That person might be
12 medically knowledgeable and interpret the
13 science differently.

14 In this case, legally, I
15 don't see how she could be an expert if she
16 makes statements that support the
17 interventions that she is doing on children
18 when the science and the literature shows
19 that it's harmful.

20 So, it seems -- I don't know,
21 that's the best way I can answer that
22 question.

23 Q Do you believe that
24 Dr. Christine Brady is an expert in
25 diagnosing and treating gender dysphoria in

1 DANIEL WEISS

2 minors?

3 A I don't remember who
4 Dr. Christine Brady is.

5 Q She is one of Plaintiffs'
6 expert witnesses. She has a Ph.D. in child
7 clinical psychology, Board certified in
8 psychology, and has treated over 1,000 youth
9 experiencing gender dysphoria.

10 A What's the question?

11 Q Do you believe that she is an
12 expert in diagnosing and treating gender
13 dysphoria in minors?

14 A She may be knowledgeable and
15 an expert in diagnoses, but beyond that I
16 would say no, she's not an expert if she
17 recommended medical interventions to address
18 their psychic distress.

19 That means she's not an
20 expert.

21 Q Could we pull up Exhibit 1,
22 which is your declaration in this case, and
23 go to paragraph 17.

24 So you write, "I have been
25 designated and asked by Defendants to

1 DANIEL WEISS

2 provide expert opinion based upon my
3 clinical experience treating adults with
4 gender dysphoria and my review of the
5 scientific literature concerning the
6 diagnosis and treatment of gender
7 dysphoria."

8 So, first, is there a word
9 missing? Were you asked to provide an
10 expert opinion or expert opinions? What
11 exactly was your assignment in this case?

12 A I'm not sure what the
13 question is.

14 Q You say, "I have been
15 designated and asked by Defendants to
16 provide expert opinion."

17 A Right.

18 Q And I'm asking were you asked
19 to provide an expert opinion, multiple
20 expert opinions?

21 A No, just the one expert
22 opinion.

23 Q Okay.

24 So this sentence tells me
25 what expertise you were asked to draw upon

1 DANIEL WEISS

2 to form your expert opinion.

3 But what question were you
4 asked to provide an opinion on, using that
5 expertise?

6 A The -- relating to the House
7 Bill 71.

8 Q So you were asked to opine on
9 the reasonableness of HB 71 or something
10 else in relation to HB 71?

11 A Yes.

12 Q So it's your expert opinion
13 that HB 71 is a reasonable law?

14 ATTORNEY DROZ: Objection;
15 form.

16 A The science -- the science
17 behind HB 71 and my experience related to my
18 treatment of adults with gender dysphoria
19 was used to form this opinion.

20 Q And do you know what science
21 was behind HB 71, what science the Idaho
22 State Legislature relied upon in passing HB
23 71?

24 ATTORNEY DROZ: Objection to
25 form.

1 DANIEL WEISS

2 A I do not know, but I would
3 imagine it would be at least some of what I
4 have cited in my declaration.

5 Q Okay. So you don't know what
6 science was behind HB 71, so you are not --
7 so your opinion is whether HB 71 is
8 reasonable from a scientific perspective,
9 right?

10 A Yes.

11 Q Turning to paragraph 21 of
12 your declaration, which is just a little bit
13 further down, so here is five bullet points
14 listed here.

15 And if we scroll down on to
16 the next page, right, am I correct that
17 those five bullet points represent a summary
18 of the opinions you are offering in this
19 matter?

20 A Yes.

21 Q Are you offering any opinions
22 not set forth in your declaration?

23 A No, but -- and there are
24 other opinions beyond the summary.

25 Q Can we turn to paragraph 18.

1 DANIEL WEISS

2 You indicate that in
3 preparing this declaration you relied on
4 Idaho House Bill 71, the Complaint, the
5 declarations of Plaintiffs' experts and the
6 references that you cited in the
7 declaration, right?

8 ATTORNEY DROZ: Objection,
9 form.

10 A I did.

11 Q Did you review any other
12 materials in forming the opinions in your
13 declaration aside from those cited in your
14 declaration?

15 A Not that I recall.

16 Q And then in paragraph 19 you
17 write, "I formed my opinion from my clinical
18 expertise and experience, my rationality or
19 common sense, and my critical review of the
20 scientific literature and the publications
21 on the subject."

22 First, what clinical
23 expertise and experience did you use to form
24 your opinions?

25 A As an endocrinologist and as

1 DANIEL WEISS

2 a physician who has treated adults with
3 gender dysphoria.

4 Q And generally speaking, more
5 clinical experience is a better indication
6 of expertise than less, right?

7 A Say that again?

8 Q Generally speaking, if you
9 rely on clinical experience, it's better to
10 have more clinical experience than less in
11 forming expertise, right?

12 ATTORNEY DROZ: Objection,
13 form.

14 A All else being the same, yes.

15 Q What does it mean to form an
16 opinion based on your rationality and common
17 sense?

18 A Well, there are some
19 conclusions one might come to that are not
20 based upon a study.

21 For example, one might say
22 there are no studies that show that crossing
23 the interstate as a pedestrian in the middle
24 of the night is dangerous.

25 But it's rational to think

1 DANIEL WEISS

2 that's a really foolish thing to do.

3 Q Which opinions in your
4 declaration did you form based on your
5 rationality and common sense?

6 A I can't point to any
7 particular one, but the -- it is completely
8 irrational to think, for example, that an
9 adolescent can make a decision that is life
10 long and produces irreversible change and
11 can have any contemplation about being a
12 father or a mother when they are 14 years
13 old.

14 So it's irrational.

15 It's not sensible to offer a
16 judgment like that for an adolescent to
17 make, nor is it rational to modify the body
18 to fix a psychic disorder.

19 That's not rational, it
20 really isn't.

21 But it wasn't just
22 rationality that played a role in those
23 decisions, there is science behind it, and I
24 have cited references too.

25 Q So, is it your opinion that

1 DANIEL WEISS

2 even for an adult, it is not rational to
3 access hormonal interventions or a surgery
4 to address gender dysphoria?

5 A Adults are more able and more
6 competent to make those decisions.

7 I do not think the evidence
8 shows that those hormonal interventions will
9 improve their psychic distress.

10 So if they have gender
11 dysphoria, they will not tend to help them.

12 But it's a different decision
13 in an adult than an adolescent.

14 And I've seen adults, mature
15 adults, regret decisions months after they
16 have had.

17 I mean, I'm talking about
18 with regard to gender affirming care.

19 For example, a man who had
20 orchiectomy, I had two patients who had
21 their testes removed, and within months they
22 regretted it.

23 And they were evaluated by
24 psychologists and were thought to be
25 appropriate candidates for the orchiectomy

1 DANIEL WEISS

2 as so-called gender affirming care.

3 That was harmful intervention
4 and the patients regretted it, and they were
5 mature adults.

6 So.

7 Q But as a matter -- but an
8 adult is, you think an adult is capable of
9 assessing the risks for themselves as to
10 whether the benefits outweigh the risks of
11 gender affirming care, right?

12 A Adults are more likely to be
13 competent, more able -- they can give
14 informed consent.

15 Children cannot give informed
16 consent. They can ascent, but adults are
17 more likely to realize or understand the
18 consequences of their decision.

19 But, as in my example, adults
20 make these mistakes, too.

21 Q So, going to the opinions
22 just there in paragraph 21, the first
23 bullet, can you explain what in your
24 endocrinology training informs your opinion
25 that gender dysphoria is a social construct?

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DANIEL WEISS

ATTORNEY DROZ: Objection to

form.

A So, that training is not --
usual training -- discussion of gender
dysphoria, the diagnosis is not in most
persons' endocrine training.

On the other hand, in my
endocrine fellowship at the University of
Iowa, I saw patients with gender identity
disorder and was treating with opposite sex
hormones in those people.

Q So the basis for your
expertise and ability to -- as an expert
offer the opinion that gender dysphoria is a
social construct, is the fact that during
your fellowship training you treated
patients suffering from what you then
characterized as gender identity disorder,
is that right?

A No, so I think I didn't
probably answer your specific question at
first.

So, it's a social construct
based upon reading of the literature.

1 DANIEL WEISS

2 That's my conclusion.

3 Q What literature tells you
4 that gender dysphoria is a social construct?

5 A Much of the literature.

6 Let's pull up WPATH's
7 definition of gender dysphoria.

8 Q So WPATH's definition of
9 gender dysphoria informs you that gender
10 dysphoria is a social construct?

11 A Yes, that and other reading.

12 Q Have you received any formal
13 training on the social construction of
14 gender?

15 A No formal training on it, no.

16 Q In the second bullet -- can
17 we scroll down, please.

18 Can you explain what in your
19 endocrinology training informs your opinion
20 that hormonal and surgical interventions
21 usually leave psychologic issues unexplored
22 and unresolved?

23 A Well, certainly I can explain
24 that.

25 So endocrinologists are

1 DANIEL WEISS

2 not -- are not trained, any endocrinologists
3 are not trained in that regard.

4 You have to read the studies
5 to understand that these hormonal and
6 surgical interventions do not help
7 psychologic issues in minors with gender
8 dysphoria. They don't help.

9 Q So again, you're appearing as
10 an expert witness in this case to opine that
11 hormonal and surgical interventions usually
12 leave psychologic issues unexplored and
13 unresolved, and the basis for your expert
14 testimony is you have read some of the
15 literature?

16 ATTORNEY DROZ: Objection,
17 form.

18 A So, the scientific
19 literature, the publications, the research
20 that's been done, show that these
21 interventions do not help psychic distress
22 in minors with gender dysphoria.

23 And if Dr. Connelly read this
24 literature and did so in an open minded way,
25 she would not have caused harm to all these

1 DANIEL WEISS

2 children.

3 Q What in your medical training
4 qualifies you to opine --

5 ATTORNEY KORBERG: Sorry,
6 withdrawn.

7 Q Could you just scroll down,
8 please, to the fifth bullet. Great.

9 And you -- one of your
10 opinions is that a perverse set of financial
11 incentives is likely to play an important
12 role in the massive expansion of these
13 harmful interventions in the U.S., right?

14 A Yes.

15 Q What in your medical training
16 qualifies you to opine on the role of
17 financial incentives in certain types of
18 medical care?

19 ATTORNEY DROZ: Objection,
20 form.

21 A State that one more time?

22 Q Yes. What in your medical
23 training qualifies you to opine on the role
24 of financial incentives in certain types of
25 medical care?

1 DANIEL WEISS

2 A This is an example of just
3 rationality, and so this doesn't derive from
4 endocrinology training or medical training,
5 but we know, and there is a multitude of
6 studies show that the more there is a
7 financial incentive, the more people -- the
8 more people will do the procedure.

9 For example, those who have
10 an ultrasound machine in their office, do
11 lots of thyroid ultrasounds, that's what
12 endocrinologists do.

13 If they have a machine in
14 their office, they will biopsy repeatedly,
15 do ultrasounds every year, unnecessarily, on
16 people, because they get money for it.

17 And what I have cited, some
18 of my references, indicate that this is
19 likely.

20 The financial incentives are
21 likely an explanation for the failure to
22 realize the evidence, recognize the evidence
23 that the Europeans have recognized on the
24 harm of these interventions.

25 And the Europeans don't have

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2 financial incentives like we do in the U.S.
3 for surgeries.

4 And the medical treatment of
5 minors with gender dysphoria, and that's why
6 there has been in massive expansion with so
7 many gender clinics now, because there is a
8 financial incentive.

9 There is money made to being
10 involved. At least that would be one
11 explanation why they have failed to see the
12 clear-cut evidence of harm, whereas here
13 they do see it.

14 Q So it's rational to conclude
15 that someone with a financial incentive to
16 provide a particular type of treatment is
17 going to be more likely to employ that
18 treatment to patients, even if providing
19 that treatment is not in the patient's best
20 interests, right? That's your opinion?

21 A Correct. And there is other
22 examples of that when these procedures are
23 performed.

24 Q That's fine, understood.

25 Do you believe that the

1 DANIEL WEISS

2 citations and references that you reference
3 in your report are from reputable sources?

4 ATTORNEY DROZ: Objection,
5 form.

6 A I'm not sure what you mean by
7 that.

8 Q Well, do you think it's
9 important when forming an opinion to
10 reference reputable or reliable sources?

11 A Yes.

12 Q Okay. What makes a source
13 reputable or reliable?

14 A There are many factors to
15 consider.

16 Q What factors did you consider
17 in selecting which references and citations
18 to rely upon in your report in forming the
19 opinions there in?

20 ATTORNEY DROZ: Objection,
21 form.

22 A When I looked at the
23 methodology of the research, if it was a
24 research paper, and I looked at the,
25 basically the methods was the main thing in

1 DANIEL WEISS

2 evaluating references -- references.

3 There are citations that are
4 websites that I might have listed, and
5 that's the website.

6 But for published literature,
7 it was the methodology, the sample size, the
8 conflict of interest that might be involved,
9 the guidelines, the quality of the research,
10 the gray criteria.

11 So it depends on the
12 citation.

13 Q What's the difference between
14 causation and correlation?

15 A Well, correlation is just an
16 association that does not prove that B is
17 caused by A. It's just an association.

18 So, association is
19 interesting, but causation is more
20 meaningful and speaks to something being
21 caused by the event that preceded it.

22 Harder to show causation.

23 Q And it's your belief that
24 gender dysphoria is caused by trauma,
25 history of abuse, autism spectrum disorder,

1 DANIEL WEISS

2 depression, anxiety or bullying, right?

3 A Yes.

4 Q Would you agree that
5 transgender people face higher rates of
6 discrimination and violence than cys gender
7 people?

8 A No.

9 Q You don't think that as a
10 statistical matter a transgender person is
11 more likely to experience discrimination and
12 violence than a cys gender person?

13 A No.

14 Q What's the basis of that
15 belief?

16 ATTORNEY DROZ: Objection,
17 form.

18 A I have not seen any
19 statistics that support that conclusion. I
20 think it's a common narrative. I think it's
21 false.

22 So you have to show me solid
23 evidence that that's the case.

24 I have not seen it. What
25 evidence I have seen is the contrary.

1 DANIEL WEISS

2 Q To the contrary. So it's
3 your belief that transgender people
4 experience less discrimination and violence
5 than cys gender people?

6 A At least no more.

7 Q So, you testified earlier
8 that you saw first, you encountered a small
9 number of patients seeking gender affirming
10 care during your endocrinology fellowship
11 with -- in the 1980s, right?

12 ATTORNEY DROZ: Objection,
13 form.

14 A Yes.

15 Q Do you recall how many
16 patients you saw during your fellowship?

17 A I think that was about 12.

18 Q And do you know how any of
19 those 12 patients are doing now?

20 A Oh, no. That was in the
21 1980s that was in Iowa, I do not know. They
22 were adults, too.

23 Q Um-hum.

24 What do you think is the
25 appropriate role of government in the

1 DANIEL WEISS

2 doctor/patient relationship?

3 A Licensing and ensuring that
4 there is appropriate conduct in the office,
5 so that doctors do not violate the
6 doctor/patient relationship with regard to
7 things like sexual abuse.

8 And to protect persons from
9 harmful interventions such as, in this case,
10 doctors who might be doing inappropriate
11 interventions on minors with -- that are not
12 helpful.

13 Q Are there any other examples
14 where you think it's appropriate for
15 government to legislate what treatment is
16 available to patients and doctors?

17 A Well, we have restrictions on
18 the use of marijuana, for example, medical
19 marijuana.

20 There are requirements to
21 have informed consent for procedures. There
22 are rules on -- there are very clear rules
23 on clinical research.

24 And in this case I think, and
25 I think what you're getting at is are they

1 DANIEL WEISS
2 interfering with the doctor/patient
3 relationship.

4 And I think because it's
5 clear cut that there is harm being done to
6 these children, and there is no end -- there
7 is no -- it's continuing, and the role of
8 the state is to protect children from harm.

9 They are vulnerable, and
10 doctors have been not been able to stop
11 that.

12 It's easy to access these
13 interventions, opposite sex therapy, and
14 even surgery?

15 And for whatever reason,
16 maybe it's financial incentives, it's
17 continuing, and the role of the state is to
18 protect them, because doctors aren't doing
19 it.

20 Medical societies could say
21 this should not be done, it's considered
22 improper, but they are not.

23 Q Okay. Is there any other
24 type of treatment that you think it's
25 appropriate for the government to outlaw?

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2 A Well, this is not a
3 treatment, it's an intervention, that I
4 think when they did pre-frontal lobotomies
5 for a long time, those were then outlawed.

6 And there are procedures that
7 are not being reimbursed by insurance
8 because they are judged to be ineffective.

9 And the insurances, for
10 example, require prior authorization for
11 some procedures that -- that the physician
12 has to prove that this is necessary, because
13 everything else has failed.

14 So there are payment
15 obstacles through insurance or Medicaid in
16 some states to ensure that a person has
17 less, perhaps less invasive treatment before
18 the next step, next iteration in terms of
19 the intervention is performed.

20 So, yes. For example,
21 kyphoplasty for vertebral crush fractures,
22 there is a controversy on the benefits of
23 that.

24 So the insurance might not
25 cover it unless other --

1 DANIEL WEISS

2 Q Sure. That's an insurance
3 question, though, right?

4 How about this. Although you
5 don't support gender affirming care, you
6 would agree that the provision of gender
7 affirming care, which is to say hormonal
8 interventions, to people suffering from
9 gender dysphoria, is the current standard of
10 care medical treatment in the United States,
11 right?

12 ATTORNEY DROZ: Objection.

13 A Absolutely not, absolutely
14 not. I object to the use of standard of
15 care. It's not the standard of care, it's
16 not a care, it's not a standard, it's WPATH
17 guidelines.

18 It's what many people who --
19 people who are on the gender clinics, that's
20 what they do, but many -- most
21 endocrinologists don't treat, don't see
22 patients with gender dysphoria, because they
23 think it's not right to do these hormonal
24 interventions.

25 It's not standard of care.

1 DANIEL WEISS

2 It's typically done by gender clinics, but
3 it's harmful, and it can't be the standard
4 of care, because it doesn't work and it's
5 harmful.

6 Q So it's your opinion that
7 most endocrinologists believe that it is not
8 appropriate to provide cross sex hormones to
9 people suffering from gender dysphoria,
10 right?

11 A Correct.

12 Q What's the basis for your
13 opinion that the majority of
14 endocrinologists think that such care is
15 inappropriate?

16 A The basis of that is my 37
17 years of teaching and interacting with
18 endocrinologists, going to meetings, and
19 most of them do not see these people with
20 gender dysphoria and don't agree with that
21 approach.

22 And one needs to keep in mind
23 that these societies that have come out with
24 statements or guidelines that have been
25 written, have people who are on gender

1 DANIEL WEISS

2 clinics on them, and they have not polled
3 their members in terms of the members'
4 opinions in this regard.

5 Q Do you think that you
6 interact with a representative sample of all
7 endocrinologists in America with respect to
8 their opinions on gender affirming care?

9 A Yes, I do. Over the 36 years
10 of experience, yup. And in fact, in our --
11 just my employer currently, most
12 endocrinologists are, people in the
13 endocrine department are not seeing these
14 people. They decline seeing them.

15 Q Now, the basis for your
16 belief that the majority of endocrinologists
17 do not support cross sex hormones for people
18 suffering from gender dysphoria is that you
19 personally, with regard to the doctors you
20 happen to have encountered, have experience
21 that the majority of those doctors that you
22 happen to have encountered do not support
23 cross sex hormone intervention for gender
24 dysphoria, right?

25 A That's correct.

1 DANIEL WEISS

2 Q Do you have any other basis
3 for your opinion that the majority of
4 endocrinologists are opposed to the
5 provision of cross sex hormones for gender
6 dysphoria?

7 A That basis, and in addition,
8 the fact that very few endocrinologists will
9 treat people with gender dysphoria; very
10 few.

11 Q What's the basis for your
12 belief that very few endocrinologists will
13 treat people for gender dysphoria?

14 A It's easily found on, when
15 you go to endocrinologists and sites and you
16 can call offices.

17 Most of them do not treat,
18 and I have trained people -- I have trained
19 and people I have interacted with over the
20 years, they don't see those people.

21 I was -- in Ohio, I was the
22 only endocrinology in northern Ohio seeing
23 people for years.

24 Q What is your confidence
25 interval in your blanket statement that the

1 DANIEL WEISS

2 majority of endocrinologists do not support
3 cross sex hormones for people suffering from
4 gender dysphoria based on?

5 ATTORNEY DROZ: Objection.

6 A Well, of course, you know
7 that's -- there is no confidence interval.
8 But there is no data to indicate that the
9 majority of endocrinologists do support it.

10 So, on the contrary, on the
11 other hand, there is no evidence that the
12 majority do support it.

13 My experience over 36, 37
14 years is that they don't.

15 Q You agree that the American
16 Medical Association, for example, supports
17 the provision of gender affirming care to
18 treat gender dysphoria, right?

19 A I agree that the American
20 Medical Association made that statement, and
21 they represent less than 25 percent of
22 doctors in the United States. Less than 25
23 percent.

24 Q If you were to add up all of
25 the major medical associations that have

1

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2

expressed their belief that it is

3

appropriate and in patient's best interests

4

in some cases to provide cross sex hormones

5

to people experiencing gender dysphoria,

6

what percentage of the doctor population do

7

you think all of those organizations would

8

cover?

9

ATTORNEY DROZ: Objection.

10

A That's a meaningless

11

question, because it's not a popularity

12

contest, and many of these statements, most

13

of them, I think statements from the

14

organizations are written by a very small

15

group of members who -- and they have not

16

taken account of the majority of their

17

constituents.

18

For example, as I have

19

written in my declaration, we can go to that

20

section about societies, this is not a

21

popularity contest.

22

It's -- the -- the decision

23

should be based on the science.

24

Those statements are not,

25

where they might come out and supported, are

1 DANIEL WEISS

2 not based upon science.

3 The most recent statement
4 from the pediatric group, the large
5 pediatric group which has 66,000 members,
6 they say well, we are still supporting it,
7 but we are going to do a systematic review.

8 Okay, so wait a minute,
9 you're supporting, you're promoting this
10 concept without having done a systematic
11 review?

12 So they are backtracking a
13 little bit.

14 And the Endocrine Society is,
15 they are going to revise their guidelines.
16 How they are going to revise them I don't
17 know, but they are looking at it again.

18 Q Okay, I understand your
19 opinion on that.

20 You would agree with me at
21 the very least that hundreds, if not
22 thousands of doctors, currently provide
23 cross sex hormones to people experiencing
24 gender dysphoria in the United States,
25 right?

1 DANIEL WEISS

2 A No, I don't know that number.
3 I don't think you do either.

4 Q You wouldn't be willing to
5 say that hundreds of doctors provide such
6 care across all the gender clinics and all
7 of the major universities at InterMountain,
8 your employer, even in your state?

9 A It might be a few hundred,
10 yup.

11 Q Okay. Let say a few hundred?

12 A Okay.

13 Q Do you believe that criminal
14 penalties are appropriate for care that
15 hundreds of doctors are providing?

16 A It's not care, and I think
17 when there is harm to vulnerable minors, and
18 the doctors' organizations are not stopping
19 that harm, I think criminal penalties would
20 be appropriate.

21 Q And should there be any
22 exceptions?

23 Like, is imprisonment
24 appropriate for a doctor that honestly
25 believes that the care is in a patient's

1 DANIEL WEISS

2 best interest?

3 ATTORNEY DROZ: Objection,
4 form.

5 A I think these interventions
6 ought to be banned, and whatever it takes to
7 ban them in minors, we are just talking
8 about minors, whatever it takes to ban them
9 would be appropriate, because the medical
10 groups themselves have thus far not been
11 able to stop them.

12 Q Okay, so you think
13 imprisonment is appropriate for a doctor
14 providing interventions that he believes is
15 in a patient's best interests, if those
16 interventions are the provision of puberty
17 blockers to minors suffering from gender
18 dysphoria?

19 ATTORNEY DROZ: Objection,
20 form. You can answer.

21 A I think with full awareness
22 and an understanding of what he or she is
23 doing to that minor, and if he proceeds to
24 cause harm, despite knowing the law, I think
25 yes, then he should suffer the consequences.

1 DANIEL WEISS

2 Q And if the doctor has
3 observed that puberty blockers benefit other
4 patients, other minor patients suffering
5 from gender dysphoria?

6 What if that doctor, based on
7 their clinical experience, disagrees with
8 you that it's harmful?

9 It's your belief that it's
10 still appropriate for that doctor to be
11 imprisoned?

12 A Yes.

13 There is an example of that.
14 You know, with use of -- doctors who are
15 thinking they are doing the right thing by
16 giving narcotics or benzodiazepines,
17 sedatives, and they think I'm really helping
18 that person, and this is even less harmful,
19 because you can stop those drugs.

20 But that doctor will be
21 imprisoned because of regulations on
22 scheduled drugs if they are inappropriately
23 prescribing those drugs.

24 Here we are talking about an
25 intervention which is irreversible on a

1 DANIEL WEISS

2 minor, not on an adult, on a minor.

3 And with full knowledge of
4 the law, that prescriber or that physician
5 does this to a minor, yeah, that's even --
6 that's more justified to imprison that
7 doctor than it is to explain imprisonment of
8 a physician who is prescribing a scheduled
9 drug on an adult.

10 Q What are your opinions on the
11 COVID vaccine mandate?

12 ATTORNEY DROZ: Objection,
13 relevance. I object to form.

14 A I think that's outside the
15 scope of this discussion.

16 Q Well, one of the subjects of
17 this discussion is the proper role for
18 government and law making when it comes to
19 treatment decisions for doctors and
20 patients.

21 Right? That's what this law
22 does.

23 A Yes, and it's dealing only
24 with minors.

25 Q Sure.

1 DANIEL WEISS

2 But you said that you, when I
3 asked you about whether you thought it was
4 appropriate for the government to make
5 treatment decisions for doctors and
6 patients, you said there are other areas
7 where you think it could be appropriate or
8 perhaps not appropriate.

9 So I'm asking you what is
10 your opinion with regard to the COVID
11 vaccine mandate?

12 Do you think that was an
13 appropriate government regulation?

14 ATTORNEY DROZ: Objection to
15 form.

16 A Yes, I do.

17 Q Are there any other courses
18 of medical intervention that are supported
19 by the American Medical Association that you
20 think should result in imprisonment of a
21 doctor who provides that intervention?

22 A I cannot think of any, but I
23 don't stay current on those other AMA
24 endorsements.

25 I used to be a member of the

1 DANIEL WEISS

2 AMA, and then I discontinued my membership.

3 ATTORNEY KORBERG: I think
4 this might be a good point for
5 another break. We have been going
6 for about an hour.

7 THE VIDEOGRAPHER: Thank you,
8 counsel. This is the videographer.
9 The time is 12:31, this ends media
10 file 2.

11 (At this point in the proceedings
12 there was a recess, after which the
13 deposition continued as follows:)

14 THE VIDEOGRAPHER: The time
15 is 12:37. We are back on the
16 record. This begins media file 3.

17 Q So, as a clinician, you only
18 recommend treatment for your patients that
19 you believe is safe and effective, right?

20 A Yes, there is balancing of
21 risks and benefits.

22 Q And you only recommend
23 treatment that you believe is sufficiently
24 supported by evidence, right?

25 A The best evidence that's

1 DANIEL WEISS

2 available, in discussion with the patient
3 and balancing risks and benefits.

4 Q So, at least at the point in
5 time in which you were treating patients
6 with cross sex hormones for gender
7 dysphoria, you believed that such treatment
8 was safe and effective, right?

9 A Yes, at that point. The
10 evidence was much more sparse.

11 Q But at that point you thought
12 that the evidence as it existed when you
13 were providing cross sex hormones to people
14 suffering from gender dysphoria, you
15 believed that your care was sufficiently
16 supported by the evidence that you could
17 ethically provide it to your patients,
18 right?

19 A Yes, and that were adults.

20 Q I understand that you treated
21 patients, you encountered patients suffering
22 from gender dysphoria during your fellowship
23 in the 1980s, right?

24 A Yes.

25 Q And then beginning in 2003

1 DANIEL WEISS

2 you began also treating patients, adult
3 patients for gender dysphoria, right?

4 A Yes.

5 Q Did you treat or diagnose any
6 patients for gender dysphoria between the
7 1980s and 2003?

8 A Not that I recall.

9 Q You write in your declaration
10 that at your independent clinic you became
11 the "key physician responsible for treating
12 patients requiring cross sex hormones,"
13 right?

14 A Yes, in that area of Ohio.

15 Q And what does it mean to be
16 the key physician?

17 A I was the principal physician
18 in the area in northern Ohio seeing people
19 requesting hormonal intervention for their
20 gender dysphoria, and I was listed on an
21 LGBTQ website.

22 Q What steps did you take to
23 establish yourself as a key physician
24 responsible for treating gender dysphoria?

25 A I was just willing to offer

1 DANIEL WEISS

2 treatment, and word got around, and then I
3 was listed on the website.

4 Q Did you play any role in your
5 listing on the website?

6 A No; no, and other
7 endocrinologists declined treatment
8 consistent with what I have said before
9 about endocrinologists not treating.

10 People would call the office
11 and say -- and would convey to me that there
12 was no other endocrinologist who was willing
13 to treat, other than there was a doctor who
14 in inner city Cleveland who was willing to
15 treat.

16 But was less accessible, less
17 accessible.

18 Q Is it your belief that other
19 endocrinologists at the time, in 2003, were
20 unwilling to treat physicians because of the
21 state of the evidence regarding the safety
22 and efficacy of cross sex hormones for
23 gender dysphoria?

24 A I think you misspoke there.
25 Was unwilling to treat patients?

1 DANIEL WEISS

2 Q Yes. Why don't I try that
3 again.

4 Is it your belief that other
5 endocrinologists in 2003 were willing to
6 treat -- unwilling to treat patients with
7 cross sex hormones for gender dysphoria
8 because of the state of the evidence
9 regarding the safety and the efficacy of
10 such treatments?

11 A No, I don't think that was
12 the reason.

13 I think there was -- there
14 were not that many people who felt they
15 were -- had gender dysphoria, and there was
16 an explosion of a number of people after
17 around 2015 or so, and then eventually
18 gender clinics arose.

19 But I don't think it was that
20 there wasn't the evidence.

21 Maybe, let see, in -- there
22 was an Endocrine Society guideline statement
23 already, and WPATH was around.

24 So it wasn't lack of
25 evidence, it was just doctors who were not

1 DANIEL WEISS

2 willing to treat.

3 Q And why do you think doctors
4 were unwilling to treat in 2003 when you
5 were willing to treat, if not for the
6 evidence?

7 A I think some of it was not
8 having experience with it, and I had some
9 experience in my fellowship and I wanted to
10 help people.

11 I felt it was probably the
12 right thing to do. They were adults, I
13 could discuss the possible side effects that
14 I knew of, and my goal as a physician is to
15 help people and reduce suffering, reduce
16 pain and suffering, and I felt this was an
17 appropriate step to do so.

18 And only later did I learn,
19 not just from the fact it wasn't helping
20 them, despite the physical changes, but that
21 the science indicated, especially in minors,
22 that it does not help them.

23 Q What was the principal LGBTQ
24 website that you are referring to?

25 A It no longer exists. I

1 DANIEL WEISS

2 looked for it. It's not there anymore. It
3 was called -- it was called Be All, like Be
4 All You Can Be.

5 Q And how did you determine
6 that was the principal LGBTQ website? Are
7 you familiar with LGBTQ websites?

8 A Well, there is so much, it's
9 changed. It was, I stopped, that was 2010,
10 2003, 2010, 2013, so at that point it was.

11 I would see my listing on
12 there, and -- but that website is not there
13 anymore.

14 And there are a lot of other
15 websites.

16 Q You testified earlier that
17 the patients that you were seeing in 2003
18 and the subsequent years to whom you were
19 providing cross sex hormones for their
20 gender dysphoria, you testified that you
21 were the one to diagnose them with their
22 gender dysphoria, is that right?

23 A No, they would come to me
24 after having seen a therapist.

25 Q Okay.

1 DANIEL WEISS

2 Is there any patient who you
3 diagnosed with gender dysphoria rather than
4 a therapist?

5 A No. They had seen a
6 therapist. Most of them had seen a
7 therapist already and then came to me.

8 Q Okay, of the -- am I right
9 that you believe you saw roughly 100
10 patients during that span?

11 A Yes, correct.

12 Q Of those 100 patients, how
13 many of them were coming to you not having
14 received a diagnosis of gender dysphoria
15 from a therapist?

16 A I think all of them had.
17 They may not -- some of them didn't have
18 letters in support of hormonal
19 interventions, but I think all of them felt
20 they had gender dysphoria or gender identity
21 disorder at the time, and they had at least
22 one visit with a therapist.

23 Q Would you have treated
24 someone suffering from --

25 ATTORNEY KORBERG: Withdrawn.

1 DANIEL WEISS

2 Q Would you have treated
3 someone with cross sex hormones who had not
4 received a diagnosis of gender dysphoria
5 from a mental health professional?

6 A No.

7 Q Did you take steps to
8 independently diagnose those patients with
9 gender dysphoria?

10 A No -- well, I should clarify.
11 I would ask them at their
12 first visit, tell me about your feelings,
13 and to explore the question of gender
14 incongruence to just confirm the diagnosis
15 that the therapist would have made.

16 Q Did you perform a
17 psychological evaluation of those patients?

18 A Well, to the extent that the
19 questioning was, but no formal
20 questionnaires or SF 36 or things like that,
21 Beck Depression Scale.

22 I didn't do those types of
23 things, because I left that to the
24 therapist.

25 Q You testified earlier you

1 DANIEL WEISS

2 took steps to determine whether those
3 patients fit the criteria for either gender
4 identity disorder or gender -- or gender
5 dysphoria under the DSM.

6 Is that still your testimony?

7 A Yeah. Well, just in terms of
8 confirming the diagnosis that the therapist
9 would make. But I didn't do it proactively,
10 before they saw a therapist.

11 Q Would you specifically go
12 through the DSM factors and do an analysis
13 under the DSM guidelines, or were you doing
14 something else?

15 A It was a broad overview of
16 the DSM guidelines, yes.

17 Q Of those -- were there ever
18 any patients that you assessed for gender
19 dysphoria who you determined did not, in
20 fact, meet the DSM criteria for gender
21 dysphoria?

22 A There was one of my patients
23 who wanted opposite sex hormones, and I
24 really was -- felt that they needed more
25 psychological evaluation.

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2 And this female was -- wanted
3 hormones right away, and was going off to
4 college, and that person I was really unsure
5 of, and I declined giving her hormones.

6 And I said, you know, I think
7 that we needed to wait a little bit. So
8 that was one person.

9 Q And when you say female, what
10 was this person's gender identity as
11 expressed to you?

12 A She felt she wanted to have
13 hormones to make her appear like a boy;
14 male.

15 Q And you are referring to this
16 person using she/her pronouns now.

17 Did you do so at the time?

18 A Yes, because she was, she
19 looked like a female and was living like a
20 female at that point, and she was fine with
21 that.

22 Q Do you know whether that
23 person ever did access testosterone?

24 A No, because she didn't follow
25 up with me.

1 DANIEL WEISS

2 Q Did all 100 of the patients
3 that you saw access cross sex hormone
4 therapy?

5 A Yes, all except that one.

6 Q And have you ever prescribed
7 anyone puberty blockers for the treatment of
8 gender dysphoria specifically?

9 A So, I did not use puberty
10 blockers for males or females because I
11 didn't -- I was not seeing minors.

12 Everyone had gone through
13 puberty.

14 Q Did you offer referrals for
15 surgery for any of these 100 patients?

16 A Yes.

17 Q Approximately how many of the
18 100?

19 A This was quite a while ago,
20 but I would estimate -- well, referrals,
21 yes, so referrals is one thing, and those
22 who actually had surgery is another.

23 So, probably about 40 people
24 I referred for surgery and probably about --
25 well maybe 50, hard to remember.

1 DANIEL WEISS

2 Those who had surgery, most
3 of the time that surgery was bilateral
4 mastectomy in biologic females, and perhaps
5 10 to 15 had orchiectomy or production of a
6 neo-vagina, faux vagina.

7 Q Sorry, how many of the 100
8 had bilateral mastectomy?

9 A I would say probably 40.

10 Q So, of the 100, 40 of your
11 patients had bilateral mastectomy, 10 or 15
12 had orchiectomy, and did any of your
13 patients have any other type of surgery?

14 A I think -- I had probably
15 about 5 who had -- well probably about 5 who
16 had vaginal -- vaginoplasty, and then a
17 couple who had neo-phalluses made,
18 phalloplasty.

19 Q So somewhere around 65 of the
20 100, perhaps, accessed surgery for their
21 gender dysphoria, is that right?

22 A That seems high. I don't
23 think it was that high, it was probably --
24 it hard to remember.

25 Probably -- so those who had

1 DANIEL WEISS

2 mastectomies. Some of those had lower
3 surgery, too, others didn't. The majority
4 did not.

5 So, I will leave it at that.

6 Q I mean, you are appearing as
7 an expert in this case and offering all
8 sorts of expert opinions on the provision of
9 cross sex hormones.

10 Based, as I understand it, on
11 your personal clinical experience providing
12 these treatments, right?

13 ATTORNEY DROZ: Objection,
14 form.

15 A And the review of the
16 scientific evidence on these interventions
17 in minors.

18 Q Right. But you would agree
19 your clinical experience with these 100
20 patients is a major part of the basis of
21 your expertise in offering the opinions that
22 you do in your declaration and are today,
23 right?

24 A It's part of that, actually.

25 Q These 100 people are your

1 DANIEL WEISS

2 data set, right?

3 A Right.

4 Q Okay. So I want to
5 understand from you how many of the data set
6 accessed gender affirming surgery.

7 A I think that -- I think the
8 number of mastectomies is probably high.

9 But, you know, I don't
10 have -- that's a long time ago, and I know
11 that some of them had mammoplasty, probably
12 maybe more like 30 or 40 had top surgery,
13 and then about 15 had bottom surgery.

14 Q Okay.

15 So, maybe something like 45
16 to 55 of your patients had some sort of
17 surgery to address their gender dysphoria?

18 A Yes.

19 Q How often did you see these
20 patients?

21 A Usually every three months or
22 so.

23 Q What steps did you take
24 during those visits to assure yourself that
25 the care they were receiving was safe and

1 DANIEL WEISS

2 effective?

3 A I would ask them how they
4 felt and what changes they noticed.

5 I would measure blood tests,
6 and I would ask them about their therapy
7 visits, if they had them.

8 Q Are there any other steps you
9 felt important to take to assure yourself
10 that the care that they were receiving was
11 safe and effective?

12 A Yes. So again, it was a
13 questioning related to symptoms and physical
14 changes, and I would examine them, and the
15 blood tests.

16 Q And were you following the
17 Endocrine Society treatment guidelines at
18 this point?

19 A What were the guidelines that
20 were available, yes, and my best judgment.

21 Q Did you conceive of your
22 role, part of your role as evaluating your
23 patient's mental health status?

24 A Yes.

25 Q And how did you do that?

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2 A I would ask them how they
3 felt, their mood, their interest in things,
4 their sleep, their mental focusing, were
5 they sad or down a lot?

6 Were they anxious, what were
7 their stressors in their life, how was job,
8 how was school, and so on.

9 Q What if someone said that
10 they were anxious or depressed, what would
11 you do then?

12 A Well, I would try to explore
13 why in the time available for the visit, and
14 then often encourage them to follow up with
15 their therapist.

16 Q At any point did you counsel
17 a patient that they should consider stopping
18 hormone therapy?

19 A There were some females,
20 biologic females who were on testosterone
21 where I modified the dose because of a high
22 red cell count.

23 But stopping, no, those, some
24 who had certainly with, after orchiectomy
25 there is no need for -- there is -- it's

1 DANIEL WEISS

2 appropriate to modify dosing at that point,
3 and so that would be a reason to modify or
4 reduce a dose of estrogen.

5 And those would be -- so yes,
6 there were circumstances, there was a
7 modification for discontinuation, usually
8 temporary, of the medication.

9 Q Of those 100 patients, was
10 there ever a patient that you counseled to
11 consider stopping hormone therapy because it
12 was not either safe or effective for them?

13 A So, the principal assessment
14 of efficacy I was looking for, even though
15 one would hope there would be an improvement
16 in psychotic distress.

17 I saw no improvement in
18 psychic distress, but I was primarily
19 looking at physical changes.

20 In those people, no, I didn't
21 stop, because there was inadequate physical
22 changes.

23 So, that's the safe and
24 effective thing. Efficacy was originally
25 designed in the trials for minors with the

1 DANIEL WEISS

2 hope of reducing psychic distress, which it
3 did not do.

4 And in this case, it didn't
5 reduce psychic distress in my adult patients
6 either. At least that was my perception.

7 Q So you perceived that cross
8 hormone therapy and in some cases surgery,
9 did not reduce psychic distress in any of
10 these 100 patients?

11 A No, I think actually it tends
12 to increase it.

13 Q Okay, so let's just -- so
14 zero of the 100 patients experienced an
15 improvement in their psychic distress as the
16 result of hormones or potentially surgery,
17 right?

18 A Right.

19 Q How many of your patients
20 experienced a worsening of their psychic
21 distress as a result of hormones or
22 potentially surgery in this period?

23 A Oh, I can think of one who
24 attempted suicide twice after surgery.

25 No one else that I can think

1 DANIEL WEISS

2 of where it appeared to be worse.

3 Q How did you monitor and
4 evaluate psychic distress in your patients?

5 A So, it's really just talk
6 therapy, talking to them, asking about
7 dysphoria and hedonia, and energy, sleep,
8 those kinds of things aspects of depression.

9 Q Did you have standards of
10 evaluative questions that assess the mental
11 health or psychic distress of your patients?

12 A Not that I recall.

13 Q So, you might ask each of
14 those patients different questions or no
15 questions at all, right?

16 A No, no, I would always ask
17 questions, and it was often open-ended.

18 So I didn't do yes/no type
19 stuff, but more open-ended, to allow for
20 discussion and exploring.

21 Q Have you ever received
22 training in psychologic or psychiatric
23 evaluation of the type that you were doing?

24 ATTORNEY DROZ: Objection,
25 form.

1 DANIEL WEISS

2 A Of continuing medical
3 education and -- would provide some guidance
4 in that regard and reading.

5 Q So you specifically read up
6 on how to perform psychologic evaluation to
7 determine any changes or lack thereof
8 in-patients' psychologic distress?

9 A Well, beyond that, continuing
10 medical education, I've had in that regard
11 and -- so reading and continuing medical
12 education.

13 But I'm not Board certified
14 in psychology. But one can gain expertise
15 and know how with open-ended questions can
16 explore symptoms that relate to anxiety and
17 depression.

18 Q So you felt qualified to
19 assess the absolute and relative level of
20 psychic distress of a patient via a
21 conversation, is that correct?

22 A Yes.

23 Q According to your
24 declaration, you stopped accepting new
25 patients with gender dysphoria in 2013, when

1 DANIEL WEISS

2 you realized the lack of benefit and the
3 harm these interventions caused, is that
4 right?

5 A Yes.

6 Q Was that realization that you
7 had in 2013 sudden or an evolution of some
8 sort?

9 A Oh, it was an evolution.

10 Q Can you describe to me that
11 evolution, how it unfolded, when it
12 unfolded?

13 A It was gradual, and then I
14 also saw people coming to me who did not
15 have, I felt, adequate psychological
16 evaluation.

17 And they had lots of other
18 psycho-social factors that were complex,
19 that needed to be evaluated, and would not
20 be fixed by giving them opposite sex
21 hormones.

22 Q Is that a sudden development
23 that at some point between 2013 and --
24 sorry, 2003 and 2013 you started seeing
25 patients that seemed to have other

1 DANIEL WEISS

2 psycho-social factors separate and apart
3 from their gender dysphoria?

4 A I think it was gradual, I
5 think it was a realization that was a
6 gradual realization.

7 Q Can you roughly pinpoint when
8 in the decade that sort of realization
9 coalesced into a concern?

10 A No.

11 Q And as that realization was
12 developing for you, did you take any
13 additional steps to evaluate the safety or
14 efficacy of the care that you were providing
15 to those patients that you hadn't been
16 taking prior?

17 ATTORNEY DROZ: Objection,
18 form.

19 A Nothing new, really just to
20 still doing the open-ended questioning to
21 explore their psycho-social factors.

22 Q Did that open-ended
23 questioning change at all as you began to
24 develop concerns about the safety and
25 efficacy of the treatment that you were

1 DANIEL WEISS

2 providing?

3 A I don't recall.

4 Q Did you take any steps to
5 quantify or track the psychic distress or
6 well-being of your patients over that time?

7 A No, I didn't quantify it.

8 Q Did you take any steps to
9 qualify it?

10 A It was just my tracking. I
11 didn't write things down.

12 Q If we looked at your patient
13 notes from this time, were you keeping notes
14 of whether a patient's psychic distress was
15 better, worse or the same as compared to the
16 prior time you saw them?

17 A Yes, I would have done that.

18 Q And how would you have
19 notated that?

20 A Just in a dictated -- I would
21 dictate a note.

22 Q Would you have notated
23 whether the patient's psychic distress was
24 better, worse or the same as compared to
25 when they first presented to you for care?

1 DANIEL WEISS

2 A As compared to baseline.

3 Well, it was all qualitative.

4 Q And how did you keep track of
5 it qualitatively?

6 A Just through a description.

7 Q What would be an example of a
8 description?

9 A Patient is feeling sad and
10 down a lot. The doctor went up on the dose
11 of antidepressant.

12 He is feeling bullied at
13 work. He quit his job. Things like that.

14 Q Do you have a very good
15 memory?

16 ATTORNEY DROZ: Objection.

17 A Not as good as it used to be.

18 Q Were you able to determine
19 the relative psychic well-being of your
20 patients based on your recollection of how
21 they appeared to you in your informal
22 conversation three months prior, or were you
23 going by some other -- did you have some
24 other system for keeping track of that?

25 A Oh, I had -- well, I had

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2 excellent -- I would transcribe a detailed
3 note. It was text, it was not an electronic
4 medical record at that point.

5 And I knew these patients,
6 there weren't that many of them, so I
7 recalled exactly what was going on with
8 them, but my medical record would reinforce
9 my previous visit.

10 Q Did you have any like
11 quantitative system, like a scale of 1 to
12 10, for mental health or anything like that,
13 which would allow you to compare the
14 evolution or lack thereof of a patient's
15 psychic distress?

16 A No, no quantitative, no
17 numerical scale, no.

18 Q How did you choose the day
19 that you would no longer accept new
20 patients?

21 A Again, it was a gradual
22 realization that both the science didn't
23 support it, the patients didn't seem to be
24 improving from a psychological standpoint,
25 which was the principal reason that those

1 DANIEL WEISS

2 hormonal interventions were initiated.

3 And lastly, that they did not
4 have adequate psychologic assessment before
5 they were coming to see me.

6 Q So you came to realize that
7 the psychological assessment and diagnosis
8 of gender dysphoria that they had received
9 prior to coming to see you was inadequate in
10 some way?

11 A Well, because the gender
12 dysphoria arose from other issues that had
13 not been addressed.

14 The fact that their parents
15 fought all the time, that their father
16 abused them, that this guy sexually abused
17 them, that they were depressed and anxious
18 for other reasons, and so on.

19 That those were the principal
20 psychologic issues that needed to be
21 addressed, and I wasn't addressing those
22 with hormones.

23 Q Lots of people have parents
24 that fight all the time, have been sexually
25 abused, et cetera.

1 DANIEL WEISS

2 And are cys gender, right?

3 A Say that again, I'm sorry, I
4 missed that.

5 Q Lots of people have had
6 parents that fight all the time or were
7 abused sexually or otherwise and are cys
8 gender, right?

9 A If they don't -- that don't
10 express gender dysphoria, correct.

11 Q Why are you convinced that
12 your patients' gender dysphoria was caused
13 by these other traumatic circumstances that
14 do not cause gender dysphoria in the
15 majority of people who experience them?

16 A I think the --

17 ATTORNEY DROZ: Objection to
18 form.

19 A I think right now it's very
20 clear that there is an increasing number of
21 minors who come out with saying they have
22 gender dysphoria, and that is in part
23 related to peer influence and social
24 contagion and social media, in conjunction
25 with having these stressors.

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2 The treatment for someone who
3 is sexually abused, it's a convenient -- if
4 you're a girl and you are sexually abused by
5 a male, it's an unconscious -- it's just so
6 straightforward that that girl might not
7 want to look like a girl and attract -- and
8 encourage any more sexual abuse, so they
9 want to change their appearance.

10 So that's just -- it's so
11 obvious that that would be an explanation
12 for that desire.

13 And just because someone a
14 so-called cys gender person, someone who
15 doesn't express gender dysphoria dealt with
16 a sexual abuse and doesn't -- isn't dealing
17 with it with an attempt to change their
18 body, doesn't mean that there is a whole --
19 there is a whole group of people who pursue
20 that route.

21 Those who say they are gender
22 dysphoric, but really that's not the
23 problem, the problem is they were sexually
24 abused.

25 So I think there is on the

1 DANIEL WEISS

2 other hand absolutely no evidence to claim,
3 as many people do, who treat those with
4 gender dysphoria, or I should say intervene
5 with hormones, that it's the fact that they
6 are discriminated against or bullied, the
7 so-called minority stress idea, that's why
8 they have the problems with anxiety,
9 depression.

10 For causation, there is no
11 evidence for that.

12 And it makes psychologic
13 sense that they have -- these other
14 psychological problems could be and likely
15 are the cause for their simple, quick fix
16 desire of hormones to change them.

17 That's a long answer, but --

18 Q Why would a young person
19 assigned male at birth who was sexually
20 abused respond to that by accessing cross
21 sex hormones and identifying as and living
22 their life as a woman, when statistically
23 women experience much higher rates of sexual
24 violence and assault?

25 ATTORNEY DROZ: Objection to

1 DANIEL WEISS

2 form.

3 A Yes, so psychological issues
4 are very complicated.

5 So you're presenting a
6 hypothetical case, and there is probably
7 many factors in that unfortunate child's
8 history that need to be explored and
9 addressed, and bonafiding their body
10 experience is not the answer to those
11 psychological problems.

12 And they may actually
13 unconsciously think that modifying their
14 body appearance might fix it.

15 They are a child, they don't
16 know about the statistics about woman being
17 assaulted.

18 So, you are giving me a
19 hypothetical example that likely has many --
20 would in reality have many complex factors
21 that all need to be explored.

22 And those aren't being done.
23 They are just -- they are being approached
24 by hormonal interventions.

25 Q When I asked you why you

1 DANIEL WEISS

2 became convinced that your patients' gender
3 dysphoria was caused by all these other
4 traumatic circumstances that don't cause
5 gender dysphoria in the majority of people
6 who experience them, you talked about social
7 contagion, right?

8 A Yes.

9 Q Do you believe that the
10 patients who were coming to you in 2003,
11 2004, were experiencing social contagion?

12 A There was peer influence and
13 there was likely social factors, seeing it
14 on media, on social media; very likely some
15 of those people.

16 Especially later on in that
17 period.

18 Q In your expert opinion you
19 say that you stopped providing care because
20 of what you determined to be a lack of
21 benefit of interventions for gender
22 dysphoria, right?

23 A Yes.

24 Q What do you mean when you
25 refer to lack of benefit?

1 DANIEL WEISS

2 A I mean the psychic distress
3 that they were feeling, that they attributed
4 to this discordance between their natal sex
5 and their internal sense of what they were,
6 was not fixed.

7 Their anxiety, depression,
8 other factors, were not mitigated by the
9 hormonal intervention.

10 And there was concern about
11 harm from those hormonal interventions.

12 Q Let's talk about that.

13 First, did any of those 100
14 patients express to you pleasure or
15 satisfaction or happiness about the physical
16 changes they were experiencing as a result
17 of cross sex hormones?

18 A Yes.

19 Q How many, would you say?

20 A Maybe 15, 20, something like
21 that.

22 Q So, 15 or 20 of the 100
23 expressed subjective happiness at the
24 results of the treatment that you were
25 providing, right?

1 DANIEL WEISS

2 A The physical changes, yes.

3 Q Did you ever ask why the 80
4 to 85 who didn't express affirmative
5 happiness at the results of the treatment
6 were continuing treatment?

7 A There is a substantial number
8 who didn't -- during those ten years, they
9 chose not to follow up.

10 Q Well --

11 A So I don't know what happened
12 to those people.

13 Q Um-hum, sure.

14 A So they either stopped, maybe
15 they went to another doctor, or maybe they
16 just desisted, or the child, say, thought
17 oh, this is not really helping me that much,
18 I got the physical changes, but I'm still
19 anxious, depressed, whatever.

20 Q Or maybe they moved?

21 A Yup.

22 Q Did any of your 100 patients
23 ever tell you that they were discontinuing
24 hormone treatment because they were
25 dissatisfied with the results?

1 DANIEL WEISS

2 A No.

3 But you know, the literature
4 that we have available shows that those who
5 stop, 70 percent or so never inform their
6 doctor.

7 Q Okay. But you would still
8 expect some number of -- you would expect
9 someone, even if it was just 70 percent, to
10 inform you why, right?

11 But nobody ever did, right?

12 ATTORNEY DROZ: Objection to
13 form.

14 You can answer if you
15 understand.

16 A Yes, correct.

17 Q Did you determine there was a
18 lack of benefit of all of the interventions
19 you were providing to patients for their
20 gender dysphoria?

21 A There was -- the benefit in
22 terms of the physical changes was seen.

23 So if they were seeking
24 physical changes, they did get changes with
25 those hormonal interventions.

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2 On the other hand, if the
3 condition we are treating, which is this
4 psychic distress related to this gender
5 incongruence, I don't think they -- most of
6 them had benefit from them.

7 Q But some did, you believe?

8 A Perhaps, yes.

9 Before -- I don't know
10 whether it was that or maybe the counseling
11 they were getting was helping.

12 So, we don't know, we don't
13 know because it was a before and after
14 thing.

15 Association, not causation.

16 Q Did you have a requirement
17 that anyone in your care continue to receive
18 mental health treatment while they were in
19 your care?

20 A I did not have a requirement
21 that they had to continue to, no. I think
22 it's a good idea, but no.

23 Q Did you ever speak to your
24 patients' mental health provider and get
25 their assessment of whether the treatment

1 DANIEL WEISS

2 you were providing was beneficial in
3 relieving the psychological distress of
4 gender dysphoria?

5 A Not after I embarked upon
6 treatment. But early on, whether the person
7 was appropriate for prescribing it, I did
8 converse I think on a couple of occasions
9 with their therapist.

10 Q So a couple of times out of
11 the 100 you spoke to one of your patients'
12 therapists?

13 A Yes, early on.

14 Q As over the course of that
15 decade, 2003 to 2013, you came to believe
16 that the treatment that you were providing
17 was not actually relieving your patients'
18 psychic distress.

19 Did you at that point
20 undertake any effort to consult with anyone
21 else as to whether that hunch might, in
22 fact, be true?

23 ATTORNEY DROZ: Objection to
24 form.

25 A I was reading some literature

1 DANIEL WEISS

2 there, and it wasn't really clear that it
3 was helpful from a scientific literature.
4 But as I stated, I continued to provide
5 those interventions. I didn't discontinue
6 them.

7 And those patients who
8 continued under my care, I continued to
9 prescribe them and encouraged those people
10 to follow up with therapy more frequently.

11 Q But you didn't take any steps
12 to ensure that your patients did, in fact,
13 follow up with therapy more frequently,
14 right?

15 A Say that again?

16 Q You didn't take any steps to
17 ensure that your patients did, in fact,
18 follow up with their more frequently, right?

19 A I could just encourage them,
20 I couldn't enforce that; no.

21 But I was going to not
22 abandon them. I continued to provide this
23 hormonal treatment, which they -- those who
24 stayed with me, wished to continue.

25 And so I was going to

1 DANIEL WEISS

2 continue to offer that to them.

3 Q So you refer to both what you
4 came to believe was a lack of benefit of the
5 interventions you were giving your patients,
6 and also the harm of the interventions you
7 were giving your patients for gender
8 dysphoria, right?

9 A Yes.

10 Q What do you mean when you
11 refer to the harm?

12 A Well, the harm can occur, I
13 have detailed possible harms in my
14 declaration at great length, and most of
15 those data are in adults, because we have
16 very little data that's been gathered in
17 minors, and it's harm, that's long term
18 harm.

19 But I saw, for example,
20 patients who had very high hemoglobin
21 content, that's their red -- their blood
22 becomes very thick on testosterone,
23 worsening in sleep apnea, because, perhaps
24 related to testosterone.

25 So those are two examples of

1 DANIEL WEISS

2 harm from those -- that intervention.

3 Q And when you had patients
4 with very high hemoglobin content, you
5 testified earlier that you adjusted their
6 dose of testosterone to bring their
7 hemoglobin down, right?

8 A I adjusted the dose. Some of
9 them I encouraged to have -- to donate
10 blood.

11 Q Were there any harms that
12 your 100 patients experienced that you were
13 not able to address with medication
14 management?

15 A Not that I recall.

16 Q Did you ever raise with any
17 of your patients your belief that the
18 treatment you were providing them was not
19 benefiting them?

20 A No, I didn't. I did raise
21 the risk of harms like blood clots with
22 estrogen therapy, mineral imbalances with
23 spiro lactone and so on.

24 But if they -- but I did not
25 raise the concern that it was not helping

1 DANIEL WEISS

2 them.

3 Q And why not? Why didn't you
4 raise the concern that with your patients
5 that the treatment that you were providing
6 them was not helping them?

7 A Well, I think they were
8 convinced that it was the right thing to do,
9 and it was, again, as I said, a gradual
10 evolution.

11 When I came to conclude that
12 it was really not the appropriate and best
13 and most effective intervention for them, it
14 was really more therapy counseling that they
15 needed to focus on.

16 Q But by 2013, you had reached
17 the conclusion that the treatment you were
18 providing was not effective, right?

19 A Yes.

20 Q But that's not something that
21 you told the patients that you continued to
22 provide treatment to, right?

23 A Right.

24 Q Is it your belief that all
25 interventions for gender dysphoria cause

1 DANIEL WEISS

2 harm?

3 A Well, gender dysphoria
4 arises, as I said, I think from other
5 factors, and those need to be addressed.

6 And we are not addressing
7 them when we focus on modifying physical
8 appearance to fix this sense of
9 incongruence, and there is a potential to
10 cause harm with all those interventions.

11 And so they are not
12 addressing the underlying harm, and there is
13 a risk of harm.

14 Now, in an individual case, a
15 person may or may not be harmed.

16 But why should we be
17 intervening with a treatment that's not
18 directed to the underlying cause?
19 Especially when it has a risk of harm.

20 We shouldn't.

21 Q Did you take any steps during
22 your clinical practice to test your theory
23 that gender dysphoria is solely the product
24 of some other mental health condition or
25 trauma?

1 DANIEL WEISS

2 A That's not something -- I
3 wouldn't do an experiment in my clinical
4 practice.

5 So, that sounds like a
6 clinical research trial, and that would be
7 unethical, to conduct that on patients.

8 Q So, I understand your theory
9 of why sexual assault would cause someone to
10 experience gender dysphoria and desire to
11 undergo cross sex hormone treatment.

12 What about eating disorders,
13 which is another one of the causal factors
14 that you have said for gender dysphoria?

15 What's your theory for why
16 eating disorders cause some people to
17 experience gender dysphoria?

18 A Where do I say eating
19 disorders --

20 ATTORNEY DROZ: Objection to
21 form.

22 Q Sure, it's in your
23 declaration, we can pull that up.

24 We can return to that,
25 actually. Let's put a pin in that one.

1 DANIEL WEISS

2 A But eating disorders is -- I
3 know, and I have cited that in the
4 declaration, is a -- we are seeing less of
5 it now than we did years ago.

6 But eating disorders often
7 occur in a setting of peer influence and
8 social contagion.

9 So, that has some analogy to
10 gender dysphoria.

11 You know, adolescent
12 development is very complicated, and
13 children want to fit in, they want to be
14 liked, and they might feel bullied, they
15 might feel isolated.

16 And it's not just my theory
17 that these underlying psychiatric and
18 psycho-social factors could contribute to
19 the development of gender dysphoria in a
20 child.

21 There is, you know, others
22 who, in published literature, who describe
23 this as a concern, and that those underlying
24 factors must be addressed before you embark
25 upon hormonal interventions if you are

1 DANIEL WEISS

2 thinking that that's an appropriate thing to
3 do.

4 Q What's your theory for, let's
5 see, I believe let's go to paragraph 27,
6 let's pull up Exhibit 1, which is your
7 declaration, paragraph 27.

8 You say, "Discomfort or
9 distress with regard to one's body is
10 especially common in those with anxiety,
11 autism, eating disorders or history of
12 trauma," right?

13 A Right.

14 Q And earlier I believe you
15 testified, we can go through the exercise of
16 it, but the rough transcript here should say
17 that as a causal matter you believe that
18 gender dysphoria is caused by these totally
19 separate conditions and circumstances,
20 right?

21 ATTORNEY DROZ: Objection,
22 form. That's not what he said.

23 A I think it's simplistic to
24 claim that one's psychiatric condition is
25 totally separate from another, that's really

1 DANIEL WEISS

2 silly, and that each individual needs to be
3 carefully evaluated through a supportive
4 exploratory approach to understand the
5 dynamics involved in the development of
6 eating disorders, their anxiety, their
7 distress and their depressive symptoms, and
8 why that child might respond with a hope
9 that changing their body is going to fix
10 these issues.

11 And that is manifested, they
12 call it gender dysphoria, and it overshadows
13 then all of these other psychiatric and
14 psycho-social factors that must be
15 addressed.

16 And it just -- it makes no
17 sense to intervene with modifying the body
18 to fix or help children who have all these
19 other factors that are -- that need to be
20 addressed, and safely.

21 If you look at just the
22 risk/benefit thing, you are doing physical
23 changes on the body with the hope of a --
24 making the child a little more happy right
25 at the moment, because that's what they

1 DANIEL WEISS

2 think is the answer.

3 So complicated problems that
4 need to be addressed without changing their
5 body.

6 Q Okay, we will come back to
7 that.

8 How did you communicate your
9 decision to stop accepting new patients
10 suffering from gender dysphoria to your
11 front desk?

12 A Oh, I just said I'm not going
13 to be seeing new people.

14 The patients who are
15 established in my practice, I will continue
16 to see.

17 But if patients call for a
18 visit, no, and for about, gee, maybe even a
19 year or longer after I stopped, I still
20 would be getting calls for patients to be
21 seen, patients requesting that I see them;
22 new patients, that is.

23 Q Um-hum.

24 And was it the standard
25 practice then for a new patient calling in

1 DANIEL WEISS

2 to have some sort of screening interview in
3 which the front desk asked what they were
4 seeking treatment for?

5 A Remember, something very
6 short, you know, what are we seeing you for.

7 And patients could refer
8 themselves. They didn't have to have a
9 referral from -- I was very welcoming in
10 that regard.

11 Patients did not have to have
12 a doctor's note to be seen by me.

13 They could just say I'm being
14 seen for -- I'm transgender. Okay.
15 Dr. Weiss is not seeing new people, I'm
16 sorry, at this time, and we can give you the
17 name of this other clinic.

18 Q And how did you -- you didn't
19 tell them that you were no longer providing
20 gender affirming care, right?

21 A I was no longer seeing new
22 people with gender dysphoria, we told them
23 that.

24 Q You did tell them that?

25 A Yes.

1 DANIEL WEISS

2 Q And did you say why?

3 A No.

4 Q Did anyone ever ask why you
5 were no longer accepting patients?

6 A Not that I know of.

7 Q Did you communicate to your
8 existing patients who you were going to
9 continue to provide treatment to that you
10 were no longer accepting new patients
11 seeking the care that you were providing
12 them?

13 A I think probably just in a
14 few situations where they said they were
15 going to refer their friend, I would just
16 convey to them oh, I'm sorry, I'm not seeing
17 new people.

18 Q Did you specify you weren't
19 seeing new people for gender affirming care,
20 or did you leave it more broadly, as if you
21 weren't accepting new patients, period?

22 A I think I was pretty clear
23 that I was just not seeing new people who
24 had gender issues.

25 Q And what reason did you give

1 DANIEL WEISS

2 your existing patients who were in fact
3 receiving that care from you, as to why you
4 were not accepting new patients to provide
5 that care to them?

6 A That's a very good question.
7 I don't recall giving them a
8 reason, and I don't think they asked.

9 But my practice was very busy
10 in general. It took maybe four months for
11 most patients to get in to be seen.

12 And those patients with -- I
13 had been seeing with gender identity
14 disorder, I would make special effort to get
15 them in sooner, because there was no other
16 doctors providing readily available care.

17 So during those ten years I
18 would -- they would get priority, frankly.

19 Q Why did you think it was
20 important that they not wait very long
21 amounts of time, to not have to wait long
22 amounts of time to begin receiving cross sex
23 hormones?

24 What was the urgency?

25 A Well, I wouldn't call it

1 DANIEL WEISS

2 urgency, but I was feeling that -- again, as
3 a physician I went into medicine because I
4 want to relieve people's suffering.

5 And I felt that they were
6 seeking help, no one else was there for
7 them.

8 Their primary care doctor
9 certainly wouldn't do it, and I wanted to
10 help them, so I just wanted to relieve their
11 distress.

12 Q Did your decision to stop
13 accepting new patients for gender affirming
14 care coincide with any changes in your
15 personal beliefs?

16 A No.

17 Q Did your decision to stop
18 accepting new patients to provide --

19 ATTORNEY KORBERG: Withdrawn.

20 Q Did your decision to stop
21 accepting new patients seeking gender
22 affirming care coincide with any changes in
23 your personal religious beliefs?

24 A No.

25 Q Did any of those 100 patients

1 DANIEL WEISS

2 begin treatment for their gender dysphoria
3 while they were minors not with you, I
4 understand you didn't ever provide care to
5 minors, but prior to seeing you?

6 A Maybe one person was getting
7 some hormones on the internet, and that's
8 the only one I can think of.

9 Q And they began receiving
10 those hormones prior to turning 18?

11 A No, I don't think so, no. He
12 or she was an adult.

13 Q And am I correct that after
14 you stopped accepting new patients you
15 continued to treat your existing patients
16 with cross sex hormones for a number of
17 years, until 2022?

18 A Correct.

19 Q And when in 2022 did you stop
20 providing gender affirming care treatment to
21 your existing patients?

22 A Well, when I moved from out
23 of Ohio and relocated to Utah, I was not
24 going to be doing it from Utah, and so that
25 would have been the last day of practice in

1 DANIEL WEISS

2 Ohio, which was I think December 2nd, 2022.

3 Q Why do you choose to continue
4 to treat your existing patients with care
5 that you thought was not efficacious and was
6 potentially causing them harm after 2013?

7 ATTORNEY DROZ: Objection,
8 form.

9 You can answer.

10 A So those patients who
11 continue to follow with me, some of whom had
12 surgery, a fair number who were living as
13 the opposite sex, required some hormonal
14 intervention, because they maybe had
15 orchiectomy or oophorectomy, and they chose
16 to, the patients, wanted to stay on those
17 hormones, or they needed to for other
18 reasons.

19 So it was only appropriate to
20 still continue that.

21 Q Did you only continue
22 providing care to patients who had undergone
23 surgeries that would affect their hormone
24 production?

25 A No, some who chose to stay on

1 DANIEL WEISS

2 opposite sex hormones or blockers who still
3 had their gonads, and they just preferred to
4 do that.

5 And they were not going to be
6 changing their conception of whether they
7 felt it was helpful or not.

8 And most of those people I
9 think were getting psychological counseling,
10 were on antidepressants, and had been on
11 treatment for some time, and they just chose
12 to stay on it.

13 These are all adults, of
14 course.

15 Q How many people did you
16 continue to treat for gender dysphoria after
17 2013, when you stopped accepting new
18 patients?

19 A How many did I continue to
20 treat? I think it was about 30 people I was
21 still seeing at that point.

22 Q How many of those 30 people
23 underwent a surgery that affected their
24 hormone production?

25 A Maybe about five to eight or

1 DANIEL WEISS

2 so.

3 Q For the rest you continued to
4 provide cross sex hormones to, regardless
5 of, right?

6 A Yes.

7 Q And you didn't tell any of
8 those patients that you believed that the
9 care that you were providing to them had a
10 lack of benefit and, in fact, was
11 potentially harming them, right?

12 A Well, I always talk about
13 potential harm and the benefit from the
14 psychiatric standpoint, psychological
15 standpoint.

16 That's where I continued to
17 recommend if, depending upon how they were
18 doing, psychiatric or psychologic follow-up.

19 And some of them were doing
20 fine, they were adapted, they were okay, and
21 it was just a regular routine visit looking
22 at general medical care.

23 Q How many of those 30 patients
24 were doing fine on cross sex hormone
25 treatment?

1 DANIEL WEISS

2 A From a psychological
3 standpoint, I don't recall at this point.

4 Q Do you have a rough sense of
5 the proportion? Was it the majority?

6 A I would say maybe 10, so the
7 majority were not.

8 Most of them had ongoing
9 depression and anxiety. One had a suicidal
10 attempt, and that was a person who had had
11 surgery in Thailand, I think.

12 It was a male to female.

13 Q And that was the one person
14 out of the 100 that you said, that you
15 believed was really harmed by the treatment
16 in a way that wasn't addressable with
17 medication management, right?

18 A So, you know, as it -- to be
19 able to honestly evaluate it, I can't prove
20 causation. It's just -- again, it's an
21 association thing.

22 That person had surgery, had
23 reassignment, had a faux vagina created and
24 was on antidepressants and had a suicidal
25 attempt, and was on estrogen.

1 DANIEL WEISS

2 And what was the cause of
3 that severe depression and suicidal attempt?
4 I don't know.

5 But hormones at least and
6 surgical reassignment didn't fix that
7 person, because there was significant
8 depression for years after.

9 Q Did your political beliefs
10 change in any way in 2022?

11 ATTORNEY DROZ: Objection.

12 A No.

13 Q Do you feel that doctors have
14 an ethical obligation to provide patients
15 continuity of care if they have to
16 discontinue treating a patient?

17 A I think it depends on what
18 the science shows in terms of interventions.

19 And my knowledge of the
20 science is much more than it was back in
21 2013 now.

22 And so I have learned a lot,
23 even from then, and I looked at the new
24 guidelines and the systematic reviews, and a
25 lot of publications have come out in the

1 DANIEL WEISS

2 last ten years.

3 But in general, if there is
4 no other option for treatment, and the
5 intervention is the best intervention we can
6 offer the person, then the physician should
7 continue following that person.

8 Even if it was withdrawing,
9 let's say, a medication that might be pulled
10 from the market because it showed some risk,
11 like Vioxx, it was harmful, it was pulled
12 from the market, but patients might have
13 loved it because it provided pain relief.

14 Well, if the studies showed
15 that it caused harm, we are going to stop
16 it. We will try to use something else.

17 Q If you hadn't moved to Utah
18 in 2022, would you still be treating
19 those -- your existing patients today?

20 A Yes.

21 Q Do you know how many of the
22 100 patients over that period experienced
23 some sort of physical harm, like the blood
24 thickening, that you ultimately addressed
25 with medication management?

1 DANIEL WEISS

2 A I think it was just a few,
3 just -- those are the things that come to
4 mind.

5 But the harms that are
6 described in the literature, with literature
7 as poor as it is, suggest increased risk of
8 stroke, clots in the legs, heart attacks,
9 and in many of those harms are shown only
10 with longer term follow-up.

11 And of course the literature
12 does not describe long term harms in minors
13 treated who would be, then have longer
14 exposure to these interventions than adults.

15 Q Sure, but out of your 100
16 person data set, some of whom you followed
17 for a decade, none of the -- none of your
18 patients experienced any of those types of
19 harms, right?

20 ATTORNEY DROZ: Objection.

21 A Other than what I had just
22 came to mind, the worsening of sleep apnea
23 and the erythrocytosis, thickening of the
24 blood.

25 ATTORNEY KORBERG: We have

1 DANIEL WEISS

2 been going for a while now. Is it a
3 good time to take a break?

4 ATTORNEY DROZ: I'm okay with
5 it.

6 THE VIDEOGRAPHER: Thank you.
7 This is the videographer. I'm going
8 to go off the record, if that's
9 okay. The time is 1:55. This ends
10 media file 3.

11 (At this point in the proceedings
12 there was a recess, after which the
13 deposition continued as follows:)

14 THE VIDEOGRAPHER: The time
15 is 2:06. We are back on the record.
16 This begins media file 3.

17 Q So, returning to the patients
18 that you were treating who you no longer
19 treated when you left the state in 2022, did
20 you make any attempts to find alternative
21 care for them?

22 A Yes.

23 Q How did you do that?

24 A I talked to the
25 endocrinologist I had hired who was

1 DANIEL WEISS

2 remaining in the practice, and he was
3 willing to see those people who were stable
4 from a hormonal standpoint, and was willing
5 to continue providing their hormones.

6 Q And did you talk to that
7 doctor about your concerns that providing
8 cross sex hormones to people suffering from
9 gender dysphoria was not safe and effective?

10 ATTORNEY DROZ: Objection,
11 form.

12 A Well, at that point, those
13 patients that he was willing to see, I think
14 they had all had gonads removed.

15 So, I don't think there was
16 any safety issue in those people from that
17 standpoint.

18 They were primarily on
19 hormonal replacement, opposite sex hormone
20 replacement.

21 Q You talked earlier of the 30
22 who you were still seeing at the time of
23 which you moved to Utah, only 5 to 8 had had
24 some sort of surgery that would require some
25 form of hormone replacement, right?

1 DANIEL WEISS

2 A Right.

3 Q So, what happened? Did you
4 continue to see the, you know, 25 or so
5 patients who you were providing care who had
6 not received surgery that would require some
7 form of hormone replacement?

8 A I don't recall seeing any of
9 those particular people in that last year I
10 was there.

11 So I couldn't convey that to
12 them.

13 Q So, just naturally, like 25
14 of your patients stopped coming to you for
15 care, and the only ones that were remaining
16 were the ones that happened to need some
17 form of hormone replacement therapy as a
18 result of therapy?

19 A That's my recollection, yes.

20 Q Did that happen all at once?

21 A That was gradual, and it was
22 attrition over the course of years.

23 So, there was, again, a fair
24 number of people who for whatever reason
25 stopped returning.

1 DANIEL WEISS

2 Q So it's your understanding
3 that the only patients receiving care for
4 gender dysphoria that your colleague
5 continued to treat, were those who needed
6 some form of hormone replacement therapy?

7 A Right. They had their --
8 they had orchiectomy or off oophorectomy,
9 yes.

10 Q Earlier I believe you
11 testified that at the time you left your
12 practice in Ohio and you moved to Utah, you
13 were still seeing 30 patients --

14 A Well.

15 Q -- for gender affirming care?

16 A I may have misspoke, but that
17 last year I don't recall any patients that I
18 would have turned over to my partner there
19 that were on -- that still had their gonads.

20 So probably the other
21 remaining patients I might have seen the
22 year before, 2021.

23 Some of them would come in
24 less frequently, every 6 to 12 months, and
25 then there were a lot of patients who just

1 DANIEL WEISS

2 did not come back.

3 Q Does that mean by the time
4 you ended your practice you were only seeing
5 patients who had been assigned male at
6 birth?

7 A No, I saw both, biologic
8 females and biologic males.

9 One of the patients I had
10 seen for many years was a biologic female
11 who had had a penis created, had an
12 oophorectomy, had a mastectomy.

13 I had seen that person for
14 many years, and saw that person even that
15 last year I was there.

16 Q And were you seeing any
17 patients who were assigned female at birth
18 who did not have an oophorectomy?

19 A In that last year it was
20 actually, now that I think of it, there was
21 I think one person who lived relatively far
22 away, and that person still had ovaries, was
23 on testosterone.

24 I had followed that person
25 for quite some time, and I think that person

1 DANIEL WEISS

2 was following up with another doctor.

3 Q Not the doctor in your
4 practice who you transferred the rest of the
5 patients to?

6 A Correct.

7 Q And did you discuss with that
8 doctor your belief that providing gender
9 affirming care was potentially not safe and
10 effective?

11 A No, and that person I was
12 treating had mastectomy and was -- wanted to
13 continue on the same course.

14 Q Do you think it was in that
15 patient's best interest to continue
16 receiving cross sex hormones despite not
17 needing them from a surgical perspective?

18 A I don't know.

19 That needed to be judged on
20 an ongoing basis, pros and cons versus risks
21 and benefits, with their treating physician.

22 Q And at least as of the last
23 moment that you were their treating
24 physician, you believed that the benefits of
25 receiving cross sex hormone treatment

1 DANIEL WEISS

2 outweighed the risks, right?

3 A Yeah, that person was about
4 38 years old.

5 Q For those patients that you
6 continued to treat between 2013 and 2022, do
7 you believe that your patients would have
8 benefited by losing access to cross sex
9 hormone treatment?

10 A I don't know. I think
11 probably they would benefit more from more
12 supportive psychotherapy, which they weren't
13 getting, and they would have benefited more
14 than the cross sex hormones.

15 Q Sure, but imagine a world
16 where you hold the amount of therapy they
17 were getting constant.

18 Would they have been better
19 off, worse or the same if they were unable
20 to get cross sex hormone treatment during
21 that time?

22 A I think those people that I
23 was caring for would be better off if they
24 would just have taper-off.

25 Even with therapy unchanged,

1 DANIEL WEISS

2 they would be better off without it.

3 Q But you continued to provide
4 them hormone therapy and cross sex hormones,
5 right?

6 A I did.

7 Q So you provided them care
8 that you thought they would have been better
9 off had you not provided it to them, right?

10 A That's my thinking now, yes.

11 I think having studied the
12 scientific literature, and in retrospect,
13 seeing the psychological challenge that
14 these people were dealing with, the social
15 factors, and the science all would point to
16 them being better off without it.

17 But that's adults, too.

18 Q Presumably every time you
19 wrote a prescription or refilled a
20 prescription for your patients, you were
21 making an individualized assessment of the
22 risks of that treatment versus the likely
23 benefit of that treatment, right?

24 A Correct.

25 Q And you determined to

1 DANIEL WEISS

2 continue writing those prescriptions,
3 refilling those prescriptions and providing
4 them that treatment, right?

5 A In these adults, that's
6 correct.

7 Q And you did so believing that
8 the harms of those treatments actually
9 outweighed the benefits for each of those
10 patients, right?

11 ATTORNEY DROZ: Objection,
12 form.

13 A I was worried about the
14 harms, especially when the lack of evidence
15 to support the benefits.

16 But I did continue them,
17 because it was an individualized decision in
18 discussing it with kind of so-called shared
19 decision-making with the patient.

20 Q So even if a doctor believes
21 that it is -- that the harms of treatment
22 outweigh the benefits of the treatment, if a
23 patient capable of sound decision-making
24 determines that they would like to continue
25 treatment, you believe the doctor should, in

1 DANIEL WEISS

2 fact, continue to provide that treatment,
3 even if the doctor believes it is more
4 harmful than beneficial?

5 ATTORNEY DROZ: Objection.

6 A No, I would not make an
7 absolute statement like that, no.

8 I think sometimes the doctors
9 don't know the evidence. Sometimes the
10 doctors are conflicted, and often the
11 patient isn't adequately informed or may not
12 be competent to make that judgment.

13 So, it's complicated, and I
14 think certainly, in the setting of minors,
15 that's -- especially when doctors treat and
16 minors are not competent to make long term
17 decisions, I think that's where the role of
18 the state comes in, I think.

19 Q Sure. But in 2021, in your
20 own practice, you continued to provide cross
21 sex hormones to people despite the fact that
22 you are now telling me you believe they
23 would have been better off had you not done
24 so, right?

25 A Yes, based upon my

1 DANIEL WEISS

2 understanding of the science.

3 ATTORNEY DROZ: Objection to
4 form.

5 A Which I didn't know as much
6 back then, and there has been systematic
7 reviews that have been published since then.

8 So I think that more is known
9 about the lack of benefit and the potential
10 harm than was known two years ago.

11 Q So in 2021, did you think the
12 benefits of providing the treatment
13 outweighed the harms of providing those
14 patients cross sex hormone treatment?

15 A Yes, at that point I did.

16 Q And what were the benefits
17 you believed you were providing your
18 patients?

19 A Well, the physical changes
20 that they felt were positive in their mood,
21 outlook, approach to life, social
22 interactions.

23 Q Do you think that all doctors
24 should stop providing gender affirming care
25 to adults?

1 DANIEL WEISS

2 A I think it's -- I think they
3 should, based upon the science. But it's a
4 different matter with adults, who are more
5 likely, although often not, able to be
6 competent and have informed consent.

7 But adults are a different
8 matter than minors.

9 But I think the data on
10 adults doesn't support it either, these
11 hormone interventions.

12 So I don't think they
13 should -- I don't think they should be doing
14 it, but it's available, and it's okay with
15 an adequately informed adult when they seek
16 that intervention.

17 So I don't think it should be
18 banned for adults.

19 Q And why did you think gender
20 affirming care should not be banned for
21 adults?

22 A I think adults are more
23 likely to be able to make a sound decision
24 on risks and benefits.

25 Some people want that --

1 DANIEL WEISS

2 those physical changes, and if they are
3 consented and they -- adequately, which is
4 very difficult, they can be offered that
5 intervention.

6 But I think that -- I think
7 it's bad, I think there is substantial risk
8 with it.

9 And that consenting process,
10 as one would do in an experiment, that
11 consenting process has to be fair, balanced
12 with a complete exchange of alternative
13 interventions and the potential harms that
14 might result.

15 And I think patients who are
16 fully informed, if they are mentally
17 competent adults, are more likely to decline
18 the intervention.

19 Q In your personal knowledge,
20 your personal clinical experience with
21 gender affirming care --

22 ATTORNEY KORBERG: Withdrawn.

23 Q Outside of reviewing
24 literature, your personal knowledge about
25 gender affirming care is limited to your own

1 DANIEL WEISS

2 clinical experience, right?

3 A Yes, so opposite sex hormones
4 and blockers relate to my scientific
5 literature, careful review of the scientific
6 literature and my clinical experience, yes.

7 Q You haven't personally
8 visited any other clinics other than your
9 own, right?

10 A That treat persons with
11 gender dysphoria with hormones?

12 Q Um-hum.

13 A No.

14 Q And you say in your
15 declaration that you observed that your
16 patient has minimal psychologic evaluation
17 and treatment for their significant psychic
18 distress, right?

19 A Right.

20 Q Do you know if people seeking
21 gender affirming care in Idaho have minimal
22 psychologic evaluation and treatment for
23 their psychicspsychic distress?

24 A I know that Planned
25 Parenthood provides prescriptions with

1 DANIEL WEISS

2 usually the first visit and virtually no
3 psychologic evaluation.

4 And that's routine.

5 Q Okay. Do you know if the
6 majority of people who get gender affirming
7 care in Idaho do so with minimal psychologic
8 evaluation and treatment?

9 A No, but I suspect that's the
10 case. I do not know that as a fact.

11 Q So, does the fact that your
12 adult patients at your clinic, some of whom
13 you were treating more than a decade ago,
14 had what you viewed to be minimal
15 psychologic evaluation and treatment,
16 necessarily mean that minor patients at
17 other clinics have minimal psychologic
18 evaluation and treatment?

19 ATTORNEY DROZ: Objection.

20 A So the descriptions of
21 parents and patients with whom I have --
22 patients I have communicated with, parents
23 of children with gender dysphoria, what's
24 online, desistors, detransitions, all
25 indicates it's virtually universal.

1 DANIEL WEISS

2 The experience with the Gibbs
3 Clinic in the U.K., it's all lip service
4 that the whistle blowers, Tammy Reed, it
5 doesn't happen.

6 They get hormones, basically.

7 They say the word gender, and
8 they are already on the path to hormonal
9 interventions. So there psychologic
10 evaluation is virtually nonexistent.

11 They dismiss the psychiatric
12 comorbidities, and that's not -- that's
13 consistent with the 100 patients that I had,
14 that those adults, they didn't have much
15 evaluation before I started them on
16 treatment.

17 But what's described
18 extensively in these other settings that I
19 just delineated, there is no significant
20 evaluation, you know.

21 And WPATH says they should
22 evaluate them, but they don't really
23 specifically say there should be any
24 treatment.

25 They just need to be,

1 DANIEL WEISS

2 basically make sure it doesn't interfere
3 with the medical interventions.

4 Q Okay. So the basis for your
5 belief that minors accessing gender
6 affirming care in Idaho are getting minimal
7 to no psychologic evaluation or treatment is
8 Reddit, a whistleblower in the U.K.

9 Anything else?

10 A The whistleblower was
11 Washington University, Hannah Barnes'
12 lengthy description of the U.K. site,
13 parents with inconvenient truths for
14 transgender site, my interviews online with
15 parents and minors who have had hormonal
16 interventions.

17 Did I leave anything out?

18 That's it.

19 Q What steps have you taken to
20 become knowledgeable about how gender
21 affirming care is given to minors in Idaho?
22 Which is the subject of this lawsuit.

23 Have you visited any clinics
24 in Idaho?

25 A No.

1 DANIEL WEISS

2 Q Have you spoken to any gender
3 affirming care providers in Idaho?

4 A No.

5 Q Have you taken any other
6 steps to become knowledgeable about the
7 provision of gender affirming care for
8 minors in Idaho?

9 A Specifically in Idaho, no.
10 But there is no reason to think Idaho would
11 be an exception to what's happening around
12 the world.

13 Q And it's your understanding
14 that in Idaho, gender affirming care
15 surgeries are performed on minors, right?

16 A I don't recall. Did I state
17 that in my declaration?

18 Q You do.

19 A Okay, then that's my
20 understanding.

21 Q And the sole source of
22 support for that suggestion is something
23 called the Gender Mapping Project?

24 A Is that a question?

25 Q Yes. What is the Gender

1 DANIEL WEISS

2 Mapping Project?

3 A It is a resource online of
4 clinics that provide hormonal interventions
5 for children, and I believe adults, too,
6 with gender dysphoria, and also surgery
7 sites that will do that.

8 Q Do you consider the Gender
9 Mapping Project a trustworthy source?

10 A I'm not sure. I have no way
11 of evaluating it's -- it's quality.

12 It's a resource where people
13 will report what they see in their locale
14 and they report it without -- because there
15 is concern about being exposed when reported
16 to the site, and they apparently assess it,
17 its accuracy.

18 But I don't know, I can't
19 speak to its authenticity.

20 Q But it's the sole support
21 that you rely on for your opinion that
22 gender affirming surgeries are provided on
23 minors in Idaho, right?

24 A Correct. I did not call that
25 clinic and make up some story that my

1 DANIEL WEISS

2 daughter wants to have her breasts removed
3 and she's 14.

4 And people have done that
5 kind of thing to provide that information to
6 the Gender Mapping Project, I believe.

7 Q Do you consider the Gender
8 Mapping Project an unbiased source?

9 A I think they are -- their
10 belief is that these interventions on minors
11 are not right.

12 If you call that bias, then
13 yes. But that's a belief based upon what
14 they believe is best.

15 Q Do you have any qualms about
16 having the sole support for assertions that
17 you make in your declaration be sources that
18 you didn't independently verify, and in
19 fact, think are biased?

20 ATTORNEY DROZ: Objection,
21 form.

22 A I didn't say they were
23 biased, and you would have to define biased,
24 too.

25 So I think that that's, the

1 DANIEL WEISS

2 Gender Mapping Project raises that concern
3 that surgery is being performed on minors.

4 I think that needs to be
5 further evaluated.

6 I'm concerned that that is,
7 in fact, taking place. And we know that
8 hormonal interventions occur, and
9 mastectomies are the most common surgical
10 intervention on minors with gender
11 dysphoria, and they are being done very --
12 with increasing frequency throughout the
13 U.S.

14 Q Do you ever facilitate
15 patients seeking to lose weight with gastric
16 bypass surgery?

17 A Yes.

18 Q Talking now about the
19 population of your patients receiving
20 hormonal interventions which were not
21 suffering from gender dysphoria, okay?

22 A Okay.

23 Q What are the risks when
24 estrogen is provided to cys women?

25 A Women who are

1 DANIEL WEISS

2 post-menopausal, their estrogen has dropped
3 down, and if they have hot flashes from low
4 estrogen, then the risk with estrogen
5 depends upon their presence of a uterus or
6 not.

7 If they have a uterus, they
8 need to also have progesterone, because
9 estrogen alone increases the risk of cancer
10 of the lining of the uterus.

11 If they don't have a uterus,
12 they can just take estrogen.

13 There were doctors for quite
14 some time believing that you should give
15 post-menopausal women estrogen, and it would
16 reduce the risk of heart attacks.

17 And only a big study showed
18 that that was -- that was foolish, and that
19 estrogen increased blood clots, risk of
20 strokes, and progesterone increased risk of
21 breast cancer.

22 So, it took a large study to
23 show that and doctors were doing what was
24 not best for people until that study came
25 out.

1 DANIEL WEISS

2 Q Do the risks that cys gender
3 women without uteruses taking estrogen face
4 differ from those that transgender women
5 taking estrogen face?

6 A So, transgender women are
7 biologic males. So there is no -- there is
8 no long term studies on giving males,
9 biologic males estrogen.

10 So we have some data that
11 estrogen increases risk of heart attacks
12 from some old data when they were using it
13 for prostate cancer.

14 So, there is published data
15 now in adults followed with opposite sex
16 hormones, and I have cited that in the
17 declaration.

18 I would have to go back to
19 give you details on that, but there is, yes,
20 there is adverse events in giving estrogen
21 to biologic males.

22 Q Do those adverse events
23 differ from the possible adverse events of
24 giving estrogen to cys gender women who do
25 not have uteruses?

1 DANIEL WEISS

2 A Probably, probably, but the
3 data are -- it's not that clear. There are
4 two different people, two different -- two
5 different sexes.

6 Q So if the data is not clear,
7 why do you say probably?

8 A Because the data is weak, so
9 you can't be sure.

10 Q Right, so you can't be sure.
11 Why do you assume that there is?

12 A Let's look at the declaration
13 of what it says, because I don't remember
14 those numbers.

15 Q I'm just asking you as a
16 general matter.

17 A I can't answer it as a
18 general matter. There is increased risk of
19 giving biologic males estrogen, yes, there
20 is increased risk.

21 And what is that risk?

22 There is blood clots, it's
23 strokes, those are clear. And maybe some
24 other things, too.

25 Q But do those differ from the

1 DANIEL WEISS

2 risks of giving estrogen to cys gender women
3 who do not have uteruses?

4 A We don't know, we don't know.

5 Q So you don't know, it's not
6 probably?

7 A It experimental.

8 Q You are changing your answer.
9 You don't know whether those risks are
10 different or not?

11 ATTORNEY DROZ: Objection.

12 You are being argumentative.

13 A I think it is not known.

14 Q So, am I correct that after
15 32 years as a member of the Endocrine
16 Society you cancelled your membership in
17 2022?

18 A Yes.

19 Q And you cancelled your
20 membership over the Endocrine Society's
21 guidelines relating to the provision of
22 gender affirming care for minors, right?

23 A It wasn't so much the
24 guidelines, it was the fact that they were
25 arguing in the Tavistock case that minors

1 DANIEL WEISS

2 should be allowed to or should be treated in
3 that fashion.

4 Q So even after you stopped
5 accepting new patients seeking gender
6 affirming care in 2013, you remained a
7 member of the Endocrine Society for another
8 nine years, right?

9 A Correct.

10 Q When you were a member of the
11 Endocrine Society, did you generally follow
12 their guidelines for the treatment of
13 patients?

14 A Some of them. It depends. I
15 critically evaluate each one. There is --
16 each one is different.

17 Q So other than gender
18 affirming care, are there any Endocrine
19 Society guidelines you choose not to follow
20 or that you disagree with?

21 A I would have to look at each
22 individual one.

23 Q So sitting here today you
24 can't think of any other Endocrine Society
25 guidelines that you choose not to follow or

1 DANIEL WEISS

2 disagree with, right?

3 A Yes, I can think of the
4 approach to aldosterone excess.

5 Q And what do you disagree
6 with?

7 A My approach is they recommend
8 extensive evaluation with the hope of doing
9 surgery on some of those people.

10 And my reading of the
11 scientific literature is that surgical
12 interventions are often not helpful in those
13 patients with aldosterone excess, and
14 medication often is sufficient in addressing
15 their problem.

16 Q In paragraph 177 of your
17 declaration, you say that in the United
18 States there are over 400 clinics and
19 medical offices offering medical
20 interventions for minors with gender
21 dysphoria.

22 For how many of those 400
23 clinics do you know how care is provided to
24 minors with gender dysphoria, and whether
25 adequate psychological evaluations are done

1 DANIEL WEISS

2 prior to initiating hormone treatment?

3 A I would reiterate just what I
4 said before, that the -- my discussions with
5 parents and with minors who have had these
6 interventions, my -- what's seen on Reddit
7 and Pitt and what was seen in the U.K. and
8 the whistle blowers, all of those reports
9 are congruent, and indicate that there is
10 minimal psychologic evaluation in minors
11 with gender dysphoria.

12 Q Sure. But of the 400, how
13 many of those clinics do you have knowledge
14 about?

15 A I don't have specific
16 knowledge about any of them.

17 Q Your report refers to
18 jeopardy in quotes. Why is that?

19 A Because I think it's really a
20 description of a person's feeling.

21 Q Do you put all feelings in
22 quotes?

23 A This particular one I do.

24 Q Why do you put this
25 particular one in quotes?

1 DANIEL WEISS

2 A Because I think it's -- it's
3 usage is problematic.

4 Q Why?

5 A Why are we here today? This
6 is a very difficult area.

7 The diagnosis -- the term
8 gender even can't be defined by WPATH.

9 Gender clinics describe that
10 they follow WPATH guidelines, and the
11 diagnosis of this gender identity disorder,
12 gender dysphoria, gender incongruence, it's
13 constantly evolving and changing, and
14 basically it's a self-report of the person's
15 description of their feeling.

16 So I put it in quotes.

17 Q You do agree that some people
18 really do experience gender related
19 distress, right?

20 A I would say that many people
21 feel that their distress derives from this
22 discordance or incongruence between what
23 they are in reality, their biologic sex in
24 reality and what they feel they are.

25 That's affected by so many

1 DANIEL WEISS

2 factors, what's culturally acceptable,
3 stereotypes.

4 And so I think their
5 attribution of this being gender related
6 is -- is a misattribution.

7 And that's part of the reason
8 I put it in quotes.

9 Q Okay. But you do agree that
10 some people experience gender related
11 distress, right?

12 Regardless, we can dispute
13 the origins of that distress, but you agree
14 that some people experience gender related
15 distress, right?

16 A What do you mean by that?

17 Q Okay, well, let's go to
18 Exhibit 1, which is your declaration,
19 paragraph 40.

20 A Okay.

21 Q You say the goal of treatment
22 of patients with gender dysphoria should be
23 to relieve gender related distress.

24 A Okay.

25 Q So what did you mean by

1 DANIEL WEISS

2 gender related distress, if you will not
3 agree that some people experience gender
4 related distress?

5 A So, what I mean is this, is
6 in reference to those studies, from the
7 Dutch protocol, that claim that the children
8 they were treating, who were all thoroughly
9 evaluated from a psychologic standpoint and
10 were excluded if they had significant
11 psychological problems, at least in that
12 study, that they felt that their distress
13 was related to this gender.

14 Q Okay. So you would agree
15 with me that some people experience gender
16 related distress, right?

17 A Distress that they relate to
18 their gender, yes.

19 ATTORNEY KORBERG: You can
20 take down the declaration.

21 Q How would you diagnose gender
22 dysphoria if not via the DSM checklist?

23 A I would -- I don't think -- I
24 think gender dysphoria, again, the reason I
25 put it in quotes, is people who have these

1 DANIEL WEISS

2 symptoms that they feel is related to their
3 gender, they have something else that's
4 explaining it.

5 And so calling it gender
6 dysphoria, I'm not diagnosing it, I would
7 have a therapist see them.

8 If they say it's gender
9 dysphoria, that's fine. But I don't think
10 the intervention that is promoted addresses
11 the underlying problem.

12 This is like an epi
13 phenomenon. They are saying it's gender,
14 it's not from their -- this is a feeling
15 that they have, but they have other things
16 going on.

17 And the DSM criteria, you can
18 use that, it's going to be different next
19 year, there is ICD 11 criteria, it changing
20 all the time in response to a variety of
21 factors.

22 But basically, it's distress
23 related to what the child feels is this
24 incongruence between their biologic sex and
25 what they feel that child feels their sex

1 DANIEL WEISS

2 ought to be or their gender ought to be.

3 Q Do you disagree with the
4 DSM's diagnosis of gender dysphoria?

5 A No. It's a description,
6 nothing wrong with it.

7 But, you know, the WPATH
8 doesn't require, in adolescents, doesn't
9 require any distress.

10 WPATH just requires
11 incongruence, and there is WPATH now has no
12 lower age limit.

13 And in fact, a child can say
14 I identify nonbinary, or I identify as a
15 eunuch, and I think I would want to have my
16 testes removed. That's in WPATH.

17 No lower age limit.

18 Q Sure. We are talking about
19 the DSM here, though?

20 A Sure, but that relates to the
21 diagnosis of gender dysphoria.

22 Q Do you believe that gender
23 dysphoria should be recognized as a
24 psychiatric diagnosis?

25 A Yes.

1 DANIEL WEISS

2 Q Is it possible to suffer from
3 gender dysphoria and not suffer from other
4 mental health disorders?

5 A I don't think so.

6 Q So, for example, I,
7 personally, told you that I have experienced
8 gender dysphoria since I was a child,
9 consistent with the DSM diagnostic criteria.
10 You would tell me that I have
11 to be suffering from some other mental
12 health condition, is that right?

13 A Correct.

14 Q There is no way possible that
15 I do not suffer from any other mental health
16 condition?

17 A Is that a question?

18 Q Yes.

19 A Oh, I would say no, you just
20 haven't identified it, and you're focusing
21 on gender dysphoria as the sole condition,
22 and that we ought to do whatever medical
23 interventions to help you is misguided at
24 best.

25 Q Okay. But do you think there

1 DANIEL WEISS

2 is any possibility that I could suffer from
3 gender dysphoria and not have another mental
4 health disorder?

5 A And you have significant
6 psychic distress related to an incongruence
7 between the fact that you are this biologic
8 sex and you feel you should be another
9 biologic sex or nonbinary, that's what
10 you're telling me?

11 Q Sure, yes.

12 A Not possible.

13 Q There is no way?

14 A Not possible you have
15 something else going on.

16 You have psychiatric
17 issues -- psychological issues,
18 psycho-social issues that are not addressed.

19 They are complicated, and you
20 might not get to them, but you have them.

21 Q And how are you so certain?
22 What is that based on?

23 A I think it's just rational,
24 and the literature would be supportive of
25 that, too.

1 DANIEL WEISS

2 Q The certainty that I am
3 suffering from some other health disorder is
4 rationality, it would be impossible, it
5 would be irrational to think that I do not
6 suffer from some other mental health
7 disorder?

8 A Right.

9 ATTORNEY DROZ: Objection,
10 form.

11 A It doesn't have to be
12 serious, and the scientific literature also
13 would be consistent with that.

14 And especially these last,
15 you know, 15 years or so, most of these
16 children, 70 percent, they have identified a
17 problem, they have identified psychological
18 disorders.

19 And that's, you know, you
20 have to carefully study each person, but you
21 would identify significant ones I think in
22 everyone.

23 Q So what about the 30 percent
24 for whom there has been no identified other
25 psychological disorder other than gender

1 DANIEL WEISS

2 dysphoria?

3 A I think you would identify it
4 in 100 percent if you carefully evaluated
5 each one, 100 percent.

6 Q How do you know that the
7 gender -- the gender dysphoria isn't causing
8 the various other mental health conditions
9 identified in that purported study?

10 A Right. So you're saying that
11 it could be that this psychic distress
12 related to the person's feeling about their
13 being wrong, in the wrong body, that would
14 be another way of saying it, is the real
15 cause for these other things?

16 It's completely absurd.

17 Q Why is that absurd?

18 Why is it not possible that
19 the feeling of and the distress of having
20 been born in the wrong body and perceived by
21 the world as someone other than who you are,
22 would cause anxiety or depression?

23 A There is no evidence to
24 support that, that so-called minority stress
25 kind of concept.

1 DANIEL WEISS

2 People are not born in the
3 wrong body, they are born in the right body,
4 and it's just they may have distress related
5 to growing up, adolescence, social factors,
6 again, a variety of other things in their
7 environment.

8 It's just -- there is nothing
9 to support causation from gender dysphoria.

10 Q What is there to support
11 causation from depression or sexual assault
12 or an eating disorder or autism to gender
13 dysphoria?

14 ATTORNEY DROZ: Objection,
15 form.

16 A Because interventions, in
17 some cases just supportive exploratory
18 therapy resolves the dysphoria.

19 And there are many people
20 over time who no longer have gender
21 dysphoria without treatment.

22 And there is -- and there is
23 desistors and detransitioners who regret
24 having had these interventions.

25 And they say I really had

1 DANIEL WEISS

2 this problem and that problem, and it wasn't
3 gender that was the issue, it was the fact
4 that I was physically abused, sexually
5 abused, there was depression, I felt
6 bullied, I felt I had no friends, I wanted
7 to fit in.

8 There is emerging and more
9 and more evidence that it's not causal, it's
10 a description that people latch onto to try
11 to feel better, and doctors are offering
12 this as a simple quick fix.

13 And then, in addition to
14 that, the statement about gender dysphoria
15 that maybe this is the cause, how do you
16 explain there is a statement that people say
17 well, it's fixed, the gender identity is
18 fixed, you don't change, but then on the
19 other hand, there is all this evidence about
20 fluidity?

21 So if you're dysphoric and
22 then you've got fluidity, a third of them
23 have fluidity, it doesn't -- it's not
24 consistent to say that gender dysphoria can
25 be the fundamental cause for all these other

1 DANIEL WEISS

2 things in the presence of that evidence.

3 Q As a scientist, how can you
4 tell me that the fact that there exists on
5 Reddit someone who says that they didn't
6 actually experience gender dysphoria, they
7 were really just experiencing anxiety, mean
8 that it is impossible for someone else to
9 legitimately experience gender dysphoria and
10 not have anxiety be the cause of that
11 dysphoria?

12 ATTORNEY DROZ: Objection,
13 form.

14 A I'm just citing Reddit, which
15 has whatever, 49,000 members, I'm citing
16 desistors, detransitioners, the resolution
17 of dysphoria untreated, and I have cited
18 those studies, and the presence of gender
19 fluidity.

20 So, I think the gender
21 dysphoria, you remember, is -- it's a new
22 creation.

23 It used to be gender
24 identity. We have had depression and
25 anxiety as DSM diagnoses for decades.

1 DANIEL WEISS

2 But gender identity disorder
3 and then gender dysphoria are -- they are
4 novel.

5 And I think to say that they
6 were the cause of these other things makes
7 lessens, and is not based upon any good --
8 you have to have -- in order to show that
9 its gender dysphoria is the cause for that,
10 you would have to have a treatment that
11 affects just -- it a gender dysphoria pill
12 and then everything else gets better after
13 that.

14 And we don't have that. We
15 have now modification of the body for a
16 feeling.

17 Q So in order to prove
18 causality, what we would need is a pill that
19 treats what we think is the underlying
20 cause, and then if the secondary cause still
21 persists, then we have proven that there was
22 no causality, right?

23 So we can treat depression,
24 right, with pills.

25 There are people who --

1 DANIEL WEISS

2 ATTORNEY DROZ: Objection to
3 form.

4 Q Who take pills for depression
5 who continue to experience gender dysphoria.
6 Their depression is resolved.

7 They are not depressed by any
8 metric. How then is that not using the very
9 criteria you say to prove causality here?

10 A Because, again, you're giving
11 me kind of a general picture here, but the
12 individual person needs to be carefully
13 evaluated, and there is a lot of factors
14 going on.

15 And I would like to see that
16 study where you're treating the depression
17 and the person still has gender dysphoria.

18 What else is going on in
19 those people or are is that person sexually
20 abused, and they are maybe no longer
21 dysphoric and hedonic, so they don't meet
22 the criteria for depression, but they still
23 want to exchange their body because they
24 were sexually abused.

25 So that doesn't answer

1 DANIEL WEISS

2 anything.

3 Q Design a study, prove to me
4 that gender dysphoria is caused by
5 depression, anxiety, autism or abuse?

6 A I think --

7 ATTORNEY DROZ: Objection.

8 A The evidence for the
9 improved -- the resolution with watchful
10 waiting, the evidence that treating post
11 traumatic stress disorder, people figure out
12 that this was really not what I needed to
13 do.

14 The reports on
15 detransitioners and desistors, those are all
16 evidence that the intervention, because you
17 are only talking about one intervention,
18 which is modification of the body to change
19 a psychologic -- a feeling, a feeling in a
20 person's body that they don't like the way
21 their body is, they feel they are born in
22 the wrong body.

23 It makes -- it's as much --
24 it's as sensible as, you know, modifying --
25 I give the example of a girl who has

1 DANIEL WEISS

2 anorexia. She feels she's fat, but she's
3 really underweight.

4 And she wants to have weight
5 affirming care. We don't help her lose
6 weight, we get her to psychological
7 problems.

8 Q So your proof that gender
9 dysphoria is necessarily absolutely in all
10 cases caused by some other mental health
11 disorder, is that you have desistors
12 self-reporting a comorbidity, depression or
13 abuse, and then assigning causality
14 themselves to that comorbidity.

15 That's your data, right?

16 A No.

17 ATTORNEY DROZ: Objection.

18 A No, it's much more than that,
19 because the diagnosis of depression is not
20 just self-reporting, it's diagnosis of
21 depression and post traumatic stress and
22 sexual abuse and physical abuse. That's
23 more than just self-reporting.

24 And those, and treating those
25 disorders is certainly less harmful than

1 DANIEL WEISS

2 modifications to the body.

3 Q Sure, that may be true for
4 some subset. How does the fact that -- are
5 you saying that there is a study that shows
6 that treating depression cures someone's
7 gender dysphoria?

8 ATTORNEY DROZ: Objection;
9 form.

10 A There are publications where
11 they have done just therapy, and people's
12 gender dysphoria resolves because they are
13 addressing past traumas -- yes, so there are
14 studies.

15 They are small, though.

16 Q Does the fact that that works
17 for some subset of the population, if it
18 does, mean that there is not someone else in
19 the population for whom their gender
20 dysphoria is not caused by other mental
21 health concerns and would not be addressed
22 by other mental health treatment?

23 A So, there is -- there is --
24 those other mental health or psycho-social
25 factors would need to be addressed, and

1 DANIEL WEISS

2 everyone is different, they are complicated,
3 they are complex.

4 But that doesn't mean that
5 modification of the body in those people who
6 say they are or meet the criteria for gender
7 dysphoria is the treatment for those people.

8 It is not a treatment, it's
9 an intervention that has shown in minors to
10 not be beneficial.

11 The data shows it's not
12 beneficial.

13 So the original study was the
14 Dutch protocol, where they didn't even have
15 these kids with psychiatric comorbidities,
16 or at least they said they didn't.

17 They ended up having 55 of
18 them there, and at the end of the study,
19 there is no convincing evidence from that
20 where they manipulated the questionnaire or
21 earlier on, where they had more people, that
22 their psychic distress improved.

23 So the data we have shows
24 that the intervention, which is the
25 intervention you are promoting, is not

1 DANIEL WEISS

2 helpful and there is clearly evidence of
3 potential harm.

4 So that's just pretty
5 clear-cut.

6 Q How does the fact that gender
7 affirming care doesn't resolve gender
8 dysphoria for all people in all
9 circumstances prove that there is not some
10 subset of the population for whom gender
11 dysphoria is unrelated to other mental
12 health conditions?

13 ATTORNEY DROZ: Objection to
14 form.

15 Q As a scientist, how does that
16 work?

17 A So, I think we are talking
18 about two different things.

19 Opposite sex therapy
20 treatment, opposite sex hormones, puberty
21 blockers and surgical -- surgery, the data
22 shows in minors it does not resolve their
23 psychic distress.

24 There is no data that shows
25 that it does. And there is potential harms.

1 DANIEL WEISS

2 In the event study, which was
3 in U.S. gender clinics, I cited that. It
4 had opposite sex hormones, this was in the
5 gender clinics, opposite sex hormones
6 followed over two years; males, no
7 improvement in their psychic distress, none.

8 And two suicides while on
9 treatment.

10 You I shouldn't call it
11 treatment, on these opposite sex hormones,
12 it didn't help them. So that's one thing.

13 The interventions and medical
14 interventions modifying the body do not help
15 the dysphoria, period.

16 The other thing is well,
17 what's the case for the dysphoria?

18 There is at least 70 percent
19 have these comorbidities.

20 It's a certainly safe
21 intervention and a reasonable intervention
22 to sort out what is going on in that child's
23 life and just to help their distress,
24 whatever it is, because often it's claimed
25 to be related to be just gender, easily

1 DANIEL WEISS

2 fixed by trying to change their body.

3 But if you look at harm
4 versus benefit, the least invasive
5 intervention would be addressing these
6 comorbidities.

7 To answer your question, you
8 said how do I know there is not some who
9 might just have persistent gender dysphoria,
10 and they might not have anything else.

11 I don't know of any data that
12 shows that.

13 And there is no -- and there
14 is, I don't know how that would be studied,
15 but it certainly is clear that from the
16 Dutch study where they didn't have any
17 apparent comorbidities, and they were
18 minors, they did not benefit from
19 modification of the body.

20 And the more recent studies,
21 where lots of these kids have comorbidities,
22 they don't benefit from those modifications
23 to the bodies.

24 So I don't know, what's your
25 next question?

1 DANIEL WEISS

2 Q Is there any circumstance in
3 which it would be appropriate to provide
4 gender affirming care where, for example,
5 you have a 17 year old who is in regular
6 exploratory therapy, has no history of
7 trauma or other co-occurring disorders, and
8 has persistent gender dysphoria since
9 childhood?

10 A Such a child does not exist.

11 Q You're certain that such a
12 child does not exist? It's impossible that
13 a 17 year old could be in regular gender
14 exploratory therapy, could have no history
15 of trauma or other occurring disorders and
16 had gender dysphoria consistently since
17 childhood?

18 A So, there are two -- there
19 are three papers that I cited in the
20 declaration that have described changes in
21 gender identity, gender fluidity and
22 resolution of dysphoria in adolescents with
23 no treatment. No treatment.

24 So, I would say --

25 Q How does the existence of

1 DANIEL WEISS

2 someone improving with treatment prove that
3 there isn't someone who is in gender
4 exploratory therapy, has no history of
5 trauma or co-occurring disorders, and has
6 persistent gender dysphoria, they are
7 totally unrelated, how does what you just
8 suggested prove that?

9 ATTORNEY DROZ: Objection to
10 form.

11 A The conclusion is that person
12 should continue on gender exploratory
13 therapy, because they often change their
14 feelings, or their dysphoria resolves with
15 time.

16 Q So the way this works is if I
17 presented you someone who is in gender
18 exploratory therapy for five years without
19 history of trauma or co-occurring disorders,
20 and their gender dysphoria didn't resolve,
21 you would just tell me they need five more
22 years of therapy, and then five more years?

23 It is impossible to prove to
24 you that you are perhaps not correct?

25 ATTORNEY DROZ: Objection,

1 DANIEL WEISS

2 argumentative; form.

3 A It's possible to prove to me
4 if you give me a sensible example. That's
5 not sensible and that person does not exist.

6 Because the usual approach
7 now for an adolescent who might say they are
8 gender dysphoric is the conveyor belt of
9 social transition and then hormonal
10 interventions and then often surgery.
11 That's the usual approach.

12 It's -- I can't imagine a
13 child with gender dysphoria that appears to
14 only have gender dysphoria having five years
15 of exploratory psychotherapy, most kids
16 don't have exploratory psychotherapy at all.

17 Q So the fact that most kids do
18 in fact get to receive gender affirming care
19 means that it is impossible that there is a
20 child, who instead of receiving gender
21 affirming care, is put by his parents,
22 perhaps, who don't believe gender dysphoria
23 is real, into gender exploratory therapy?

24 A They probably lose custody of
25 the child and domestic services will get

1 DANIEL WEISS

2 them, for not affirming them.

3 Q It's your belief that someone
4 who does not give their child cross sex
5 hormones is going to have Child Protective
6 Services take away their child?

7 A Often.

8 Q Not in Idaho, right? In
9 Idaho it is literally going to be illegal
10 for that child to get gender affirming care,
11 right?

12 A Do you have a question?

13 Q Does having access to
14 hormones or surgery preclude patients from
15 also accessing gender exploratory treatment
16 that you think is more appropriate for
17 gender related distress?

18 A It depends on the state laws.
19 So, some laws have required therapists only
20 to so-called affirm.

21 Q I don't understand that. Is
22 it impossible for someone to be receiving
23 hormones or hormonal gender affirming care
24 and also be in gender exploratory therapy?

25 A No, that's possible.

1 DANIEL WEISS

2 Q So let's assume that you are
3 right, that a regime of puberty blockers,
4 opposite sex hormones and ultimately surgery
5 doesn't work for everyone.

6 Is it still possible that a
7 regime of publicity blockers, opposite sex
8 hormone and ultimate surgery would benefit
9 some people, person suffering from gender
10 dysphoria?

11 ATTORNEY DROZ: Objection,
12 form.

13 A Well, the question, I think
14 we need to be clear about what you mean by
15 benefit and work.

16 If you are talking about
17 psychic distress related to this just gender
18 incongruence, it might help them with that,
19 but it might be a much less -- much simpler
20 and less harmful intervention where they can
21 understand where their rejection of their
22 natal sex derives from, and feel less
23 anxious, less depressed and so on.

24 Q Is the only way in your mind
25 to treat gender dysphoria to have, at the

1 DANIEL WEISS

2 end of the day, the person say that they
3 identify with the sex they were assigned
4 with at birth?

5 A Absolutely not, no.

6 No, we are talking about
7 minors, of course, but the goal of any
8 intervention, as per the Dutch Protocol, the
9 developer of the Dutch Protocol and others
10 say is to relieve psychic distress, period,
11 just psychic distress.

12 Whatever they have, and if
13 they attribute it to gender dysphoria,
14 gender incongruence, fine, you still want
15 the relief of psychic distress.

16 Whatever gender they or
17 non-binary they feel comfortable with, they
18 identify with, you want their psychic
19 distress to be relieved.

20 So, that's the goal of
21 treatment, to have them not depressed, not
22 anxious, be good in terms of psycho-social
23 functioning, job, family, so on, work.

24 Q Okay, so it's possible that
25 for some people, cross sex hormones helps

1 DANIEL WEISS

2 relieve gender related distress, even if you
3 believe it would have been more efficacious
4 to have just had gender exploratory therapy?

5 ATTORNEY DROZ: Objection,
6 form.

7 A So, in your question you are
8 implying causation.

9 I don't think the opposite
10 sex hormones, gender affirming surgery and
11 all that would be the reason for the
12 improvement.

13 Maybe the person would have
14 improved over time. Maybe they got
15 psychological counseling also.

16 So it's complicated, but --
17 so just because they improved after that
18 intervention, doesn't mean that was the
19 reason that they improved.

20 And that's the problem with a
21 lot of these very poor, low quality evidence
22 that's published.

23 There are psychological
24 interventions in the example I gave, the
25 study by Chen, et al, published by the New

1 DANIEL WEISS

2 England Journal of Medicine this year, he
3 had two years of treatment.

4 These were minors who were
5 seen in QS gender clinics.

6 They had opposite sex
7 hormones and they -- the males did not
8 improve at all in terms of their psychic
9 distress.

10 And again, there was two
11 suicides, a very high suicide rate in this
12 group.

13 Now, maybe the females got
14 better. Was it from the opposite sex
15 hormones they got?

16 I don't know. Maybe it was,
17 two years they would have gotten better,
18 maybe it was the support of being in a
19 study, maybe it was the psychological
20 counseling.

21 So I don't think we -- we
22 shouldn't be sure about causation just
23 post-hoc here or propter hoc.

24 Q Right, we cannot be -- I
25 certainly agree we cannot be certain of

1 DANIEL WEISS

2 causation.

3 You would agree, likewise,
4 that if you had a study where people
5 suffering from -- there are some number of
6 people suffering from gender dysphoria
7 attempted suicide, we cannot know how many
8 people would have -- how many more people
9 would have attempted suicide had they not
10 gotten access to gender affirming care,
11 right?

12 ATTORNEY DROZ: Objection,
13 form.

14 A Right. Or how many less
15 people would have been attempted suicide if
16 they didn't get these interventions.

17 Because I think the bulk of
18 the evidence shows it actually increases
19 suicide risk.

20 You can argue with the
21 quality of the evidence, but the best
22 evidence suggests it increases suicide risk,
23 not decreases.

24 I would argue with any
25 suggestion otherwise.

1 DANIEL WEISS

2 Q What's the causal proof of
3 that?

4 Is there a control study
5 where you have people from the same
6 population who were denied access to gender
7 affirming care?

8 A So, those who promote these
9 interventions refuse to do any comparative
10 studies, any controlled studies.

11 But the studies we have,
12 which are described in my declaration, all
13 point to an apparent increased suicide rate
14 as compared to a control population who --
15 control population.

16 For example, in the Chen
17 study, this is just over a two year period,
18 we are talking about minors, most of the
19 data is with adults, but in the Chen study
20 they had minors, and they had two suicides
21 in this small study, two suicides in a small
22 study over two years on opposite sex
23 hormones.

24 Now, that's pretty
25 embarrassing to have that happen in these

1 DANIEL WEISS

2 top notch gender clinics during treatment
3 with these hormones that are supposed to
4 help their mood, depression, anxiety,
5 dysphoria, that suicide rate is 45 times
6 higher than the general population in that
7 age range, 45.

8 That's much higher than even
9 children who would have depression. That's
10 really high.

11 Q Okay, but again, we are just
12 talking about correlation. There is nothing
13 in that study to suggest causation, right?

14 A That's correct, but -- that's
15 right, we don't have good data, but the data
16 that is available doesn't look like it's
17 helpful.

18 Q Okay, let's look, let's turn
19 to page 28 of Exhibit 1 of your deposition,
20 which is where we discuss this.

21 ATTORNEY KORBERG: Can we
22 pull up that Exhibit 1, please.

23 ATTORNEY DROZ: Are we
24 getting close to a point for a
25 break, lunch a little bit?

1 DANIEL WEISS

2 ATTORNEY KORBERG: Sure, we
3 can do that now.

4 ATTORNEY DROZ: Whenever you
5 are ready, I am just throwing it out
6 there.

7 ATTORNEY KORBERG: Yeah,
8 since we are here now, why don't we
9 do this, then we will take a break.
10 Somehow that --

11 ATTORNEY DROZ: Sounds great.

12 Q Can you go to the top of page
13 28.

14 So your conclusion is that
15 hormonal and surgical treatments for gender
16 dysphoria do not reduce suicide risk, right?

17 A Yes.

18 Q And I have to admit that this
19 section really confused me, and the reason
20 it confused me is because every single study
21 that you cite merely concludes that
22 transgender people committed suicide at
23 higher rates than non-transgender people.

24 Do you agree with that?

25 A In general, yes. The studies

1 DANIEL WEISS

2 I'm citing also are in people on -- already
3 treated.

4 Q Sure. The only conclusion we
5 can draw from your studies, though, is that
6 transgender people committed suicide at
7 higher rates than non-transgender people,
8 and that cross sex hormones did not entirely
9 eliminate suicidality, right?

10 A I think it's a little more
11 nuanced there.

12 So the -- in that first, in
13 the section 89, the rate of suicide in youth
14 with distress attributed gender appears
15 similar to the rate in youth with other
16 mental health disorders.

17 That's one, right?

18 So, yes, it's higher than the
19 youth who are not seen for psychiatric
20 disorders. It's higher in those with gender
21 dysphoria.

22 But on the whole, the suicide
23 rate in transgender youth is low. I mean,
24 that 13 out of 100,000 versus 15 -- sorry,
25 11.8 out of 100,000.

1 DANIEL WEISS

2 So it's not a high suicide
3 rate. It is actually very low, although
4 it's higher than people have with mental
5 health disorders.

6 Q Can you point me to any study
7 that compared suicide rates for transgender
8 people who had received hormonal and/or
9 surgical treatment against the suicide rates
10 for transgender people who were denied
11 access to hormonal and/or surgical
12 treatment?

13 ATTORNEY DROZ: Objection to
14 form.

15 A I'm looking at my declaration
16 here. No, the comparisons are to -- you
17 have a general population. These are --
18 these are people with gender dysphoria who
19 had interventions, they had access to the
20 interventions, and -- one moment.

21 No, so if you are looking for
22 a prospective group, prospective study, this
23 is what you need, a prospective study, to
24 show that those who had the -- these
25 interventions compared to a similar matched

1 DANIEL WEISS

2 group who were not given the interventions,
3 had whatever, lower, higher, similar suicide
4 rates.

5 That study has not been done.

6 Q Okay, great.

7 So you would agree with me
8 that it is impossible to conclude that
9 hormonal and surgical treatments for gender
10 dysphoria do not reduce suicide risk without
11 comparing suicide rates of trans people who
12 received hormonal or surgical treatments
13 versus similar trans people who were denied
14 hormonal and surgical treatments, right?

15 ATTORNEY DROZ: Objection to
16 form.

17 A I don't think I would agree
18 with that. Because I think if you're
19 claiming that these interventions really
20 reduce the risk of suicide, the suicide risk
21 in people who have had hormonal or surgical
22 interventions are extremely high, they
23 remain extremely high as compared to the
24 control population.

25 And if they were -- these

1 DANIEL WEISS

2 interventions were really effective, they
3 would not be that high.

4 Q Well, that's a different
5 question, isn't it?

6 That's a question of how
7 effective are they.

8 I'm talking about -- you have
9 your opinion the hormonal and surgical
10 treatments for gender dysphoria do not
11 reduce suicide risk, right?

12 It may be that they reduce
13 suicide risk some small amount, but you have
14 no proof that hormonal and surgical
15 treatments for gender dysphoria do not
16 reduce suicide risk, right?

17 A I would say --

18 ATTORNEY DROZ: Objection to
19 form.

20 A I would say that the hormonal
21 and surgical interventions, that despite
22 hormonal and surgical interventions, suicide
23 risk in these people is extremely high, and
24 it's not clear whether they -- these
25 interventions increase or decrease or do not

1 DANIEL WEISS

2 change the suicide risk at all.

3 They are extremely high as
4 compared to the control population.

5 But they obviously don't
6 decrease it much, because they are so much
7 higher than the control population, despite
8 the interventions.

9 Q Okay. But you cannot say
10 that hormonal and surgical treatments do not
11 reduce suicide risk, right?

12 A I would say I can't say it
13 versus an untreated population.

14 ATTORNEY KORBERG: This is a
15 good time for a break.

16 THE VIDEOGRAPHER: This is
17 the videographer. The time is 3:24.
18 This ends media file 4.

19 (At this point in the proceedings
20 there was a luncheon recess, after which
21 the deposition continued as follows:)

22 THE VIDEOGRAPHER: The time
23 is 3:47. We are back on the record.
24 This begins media file 5.

25

1 DANIEL WEISS

2 CONTINUED EXAMINATION BY

3 ATTORNEY KORBERG:

4

5 Q So Dr. Weiss, you are here as
6 an expert witness in support of HB 71,
7 right?

8 A Yes.

9 Q Can you please explain to me
10 what you know about HB 71, what exactly it
11 prohibits, what the penalties are for
12 violations, et cetera?

13 A It bans hormonal and surgical
14 interventions on minors with gender
15 dysphoria.

16 Q And what are the penalties
17 for violations?

18 A I don't recall the penalties.

19 Q Did you ever know what the
20 penalties were for HB 71?

21 A Yes, I read the bill, but I
22 just don't remember them right now.

23 Q Are there any penalties that
24 you think would be too extreme for doctors
25 providing gender affirming care to minors?

1 DANIEL WEISS

2 A That would in general be too
3 extreme?

4 Q Yes.

5 A Execution would be too
6 extreme.

7 Q What about life imprisonment?

8 A I think that would be
9 extreme.

10 Q What about 30 years'
11 imprisonment?

12 A I think that's extreme, too.

13 Q What about 20 years'
14 imprisonment?

15 A That's extreme.

16 Q What about 10 years'
17 imprisonment?

18 A Not sure.

19 Q What about 15 years'
20 imprisonment?

21 ATTORNEY DROZ: Objection.

22 A I'm not sure. I think the
23 intent I think of the bill is to make it --
24 to ban it, is to stop it, and you have to
25 have firm penalties to discontinue this

1 DANIEL WEISS

2 harmful, these harmful interventions.

3 Q So up to 15 years'
4 imprisonment for doctors providing gender
5 affirming care might be reasonable in your
6 mind?

7 A I'm not sure.

8 Q Do you have any concerns
9 about HB 71 going into effect?

10 ATTORNEY DROZ: Objection to
11 form, vague.

12 A Not that I can think of at
13 this time, no.

14 Q So if I let you know that HB
15 71 carries the same penalties as, criminal
16 penalties as manslaughter, including up to
17 10 years' imprisonment, does that change
18 your opinion on the reasonableness of HB 71?

19 A No.

20 Q Do you think there should be
21 any exceptions to HB 71?

22 ATTORNEY DROZ: Objection,
23 form, vague.

24 A Not that I can think of, no.

25 Q So HB 71 would ban clinical

1 DANIEL WEISS

2 research into gender affirming care for
3 minors in Idaho. Would you agree?

4 A Yes.

5 Q Do you support that, a ban on
6 clinical research on gender affirming care
7 for minors?

8 A I believe some research is
9 being done, and I would support a ban in
10 Idaho into such research.

11 Q You would support a ban on
12 such research in Idaho because such research
13 is being legally done otherwise, is that
14 right?

15 A I don't think there is need
16 for clinical research on hormonal
17 interventions in children who have normal
18 puberty.

19 But, for those people who
20 feel it's important to do such research,
21 there are venues for such research in the
22 world.

23 Q So it's your opinion that
24 there is not sufficient data to prove the
25 safety and efficacy of gender affirming care

1 DANIEL WEISS

2 for minors, right?

3 ATTORNEY DROZ: Objection,
4 form, vague.

5 A There is evidence that the --
6 these interventions on minors are harmful
7 and do not improve psychic distress related
8 to gender dysphoria or other psychic
9 distress.

10 Q Do you think there is
11 sufficient evidence to prove that hormonal
12 interventions on minors are harmful?

13 Is that correct?

14 ATTORNEY DROZ: Objection,
15 form.

16 A There is sufficient evidence
17 that hormonal interventions in minors with
18 gender dysphoria is not helpful, and there
19 is reason to believe based upon the evidence
20 that we have that it's harmful.

21 Q So, you cannot yet conclude
22 from the evidence that it is harmful for
23 minors to receive hormonal interventions,
24 but you think the evidence suggests that
25 there is reason to believe that's the case,

1 DANIEL WEISS

2 is that right?

3 A No, it is harmful in that it
4 interferes with normal puberty, brain
5 development and many other things.

6 So, there is evidence of
7 harm, and there is no evidence of benefit.

8 Q So the evidence of harm is
9 that hormonal interventions interfere with
10 puberty and brain development, is that
11 correct?

12 A We can go through our
13 declaration, my declaration, listing
14 concerns about harms.

15 Much of those are derived
16 from data in adults, but there is evidence
17 of harm, and one obvious harm is you're
18 interfering with normal pubertal development
19 in children.

20 Q Is there any evidence of harm
21 for children who delay puberty through
22 puberty blockers and then experience a
23 puberty consistent with the cross sex
24 hormones that they subsequently take?

25 A There is evidence of harm to

1 DANIEL WEISS

2 the children who had puberty blockers and
3 then opposite sex hormones when those are
4 used for treatment of gender dysphoria, yes.

5 Q And is there always harm,
6 regardless of the period of time where
7 puberty was delayed before the
8 administration of cross sex hormones?

9 A The data would indicate that
10 yes, there is always harm.

11 Q And what data is that?

12 A Well, let's go -- I would
13 go -- let's go to my declaration and we can
14 look at opposite sex hormones section.

15 Q Do you think that all gender
16 affirming care for minors should be
17 outlawed?

18 A All hormonal --

19 ATTORNEY DROZ: Objection,
20 just vague as to --

21 A All hormonal interventions in
22 minors who are being treated for gender
23 dysphoria, yes.

24 I think those hormonal
25 interventions which are intended to relieve

1 DANIEL WEISS

2 psychic distress attributed to gender
3 dysphoria should be outlawed.

4 Q Would you support HB 71
5 becoming the law of the land in the United
6 States?

7 A Yes.

8 Q You would agree if HB 71
9 became the law of the land in the United
10 States, there would be no more clinical
11 research into cross sex hormones or puberty
12 blockers on minors in the United States,
13 right?

14 A Correct.

15 Q And you don't have any
16 concerns about the -- there being no more
17 advancement in terms of U.S. research into
18 gender affirming care for minors?

19 A There would be -- there could
20 be advancements, absolutely could be
21 advancements.

22 How?

23 Don't use opposite sex
24 hormones.

25 Don't use medical

1 DANIEL WEISS

2 interventions to modify the body to help
3 people who have psychic distress related to
4 gender dysphoria.

5 You could still research it,
6 you can do other interventions where they
7 are helping people's psyche and relieve
8 their distress through other means that do
9 not produce irreversible changes in their
10 body, potential infertility and other harms.

11 Q Okay. So as a scientist, you
12 don't think that there needs to be any more
13 clinical research into the effects of
14 providing puberty blockers or cross sex
15 hormones to children, minors who are
16 experiencing gender dysphoria, is that
17 right?

18 A That's correct.

19 Q Can you conceive of a version
20 of this law you would support as protecting
21 patients, but was less extreme in some way?

22 ATTORNEY DROZ: Objection,
23 form.

24 A Well, these medical
25 interventions and often subsequent surgery

1 DANIEL WEISS

2 on children with a mental health disorder, I
3 think they are extreme.

4 Q What would your opinion be of
5 a law that required parents to pass a test
6 on the risks of gender affirming care for
7 their minor children?

8 ATTORNEY DROZ: Objection,
9 form; vague.

10 A Say that one more time?

11 Q Sure.

12 So, let's take a step back.

13 Adolescents, do you believe
14 that adolescents can't give informed consent
15 under any circumstances, right?

16 A Correct. They can't, they
17 can give ascent, but not informed consent,
18 correct.

19 Q And the way that adolescents
20 receive medical treatment, including
21 experimental medical treatment, is that
22 their parents give informed consent on their
23 behalf, right?

24 A Right, and the child can give
25 ascent, correct.

1 DANIEL WEISS

2 Q Do you think that parents
3 should be prohibited from giving informed
4 consent on behalf of their minor children as
5 a general matter?

6 A No.

7 Q Do you think that parents
8 should be prohibited from giving informed
9 consent on behalf of their minor children to
10 access gender affirming care and puberty
11 blockers and cross hormone treatment?

12 A Yes, I think they should --
13 they should not be giving informed consent
14 or approving a procedure that is not
15 beneficial, clearly, and it's harmful.

16 So that would be, the same
17 reason that a parent cannot deny, for
18 example, or in many states, they can't deny
19 chemotherapy for a treatable cancer.

20 Q So this is an area where I
21 think no matter how informed parents are,
22 they just should not be able to give
23 informed consent?

24 A Not for this, not for this,
25 correct, because it's not -- it's not --

1 DANIEL WEISS

2 there is -- it's very difficult to get
3 adequate informed consent because of those
4 people who are convinced that it's the only
5 way to go and because this -- the scientific
6 evidence that is available indicates harm
7 and not benefit.

8 Q So let's say hypothetically
9 that there is a 17 year old who has been
10 suffering from gender dysphoria their whole
11 life, and their parents come to you and say
12 we would love to -- we have all the time in
13 the world, we are incredibly educated, we
14 would love you to explain to us all of the
15 risks and walk us through the science on why
16 you think it is harmful for our child to
17 access puberty blockers or cross sex
18 hormones, okay?

19 A Right.

20 Q And let's say at the end of
21 multiple days of sitting with you these
22 parents just disagree about the literature.

23 A Okay.

24 Q Do you think that they and
25 their child's doctor, if a doctor thinks it

1 DANIEL WEISS

2 is likewise in that 17 year old's best
3 interest to access gender affirming care, do
4 you think that they should be prevented from
5 getting that medical care for their child?

6 A Yes.

7 I would also say I probably
8 didn't explain it to them well if they still
9 are convinced that it's the way to go.

10 Q What would your opinion be of
11 a law that says that minor children can only
12 receive hormonal treatment if they first
13 have been treated with psychotherapy and
14 that psychotherapy proved unsuccessful at
15 relieving their suffering?

16 A I would still be opposed to
17 such a law, because it would imply that the
18 hormonal interventions, opposite sex
19 hormones, puberty blockers, surgery, are
20 helpful interventions, whereas the evidence
21 we have is that they are not helpful and
22 that they are harmful.

23 Q In your declaration you
24 assert that countries with longer experience
25 than the U.S. have curtailed hormonal and

1 DANIEL WEISS

2 surgical interventions, right?

3 A Yes.

4 Q And you refer to a number of
5 countries, including the U.K., Sweden and
6 Denmark, among others, right?

7 A Yes.

8 Q Do you agree with the current
9 approach that each of those countries takes
10 with regard to gender affirming care for
11 minors?

12 A I think they should be --
13 some of them should be even more firm.

14 The U.K. bans basically bans
15 these interventions on children under the
16 age of 16. So I think that's a clear
17 approach.

18 And the others are pretty
19 close to bans.

20 Q Just to be clear, are there
21 any of these countries where you think we
22 should adopt their approach?

23 A No, I think the -- the ban
24 that Idaho has is a very reasonable
25 approach, given the environment in the

1 DANIEL WEISS

2 United States, where some more -- somewhat
3 more cautious approaches are stated in some
4 of these European countries.

5 Now, all of them place
6 psychological counseling as the primary
7 intervention, and great reserve or caution
8 in the use of any kind of or bans in the use
9 of any client of irreversible medical
10 intervention.

11 But in the United States, I
12 think that kind of more -- somewhat more
13 liberal approach that's not quite as strict
14 would not work, for whatever reason, I don't
15 think it would work.

16 Q Why would such an approach
17 not work in the United States?

18 A I think because these are --
19 each of these countries, their healthcare
20 system is different than the U.S.

21 So there can be kind of
22 healthcare guidelines that govern the whole
23 country.

24 And here we have various
25 states with their different regulations, and

1 DANIEL WEISS

2 we have, in the United States, financial
3 incentives that play a role in healthcare,
4 and you don't have that in Denmark, U.K.,
5 France and so on.

6 Q So, just to be clear, are
7 there any countries that you think have an
8 appropriate legal policy with regard to
9 gender affirming care for minors?

10 A I think the U.K. looks --
11 it's good from what I have seen of their
12 most recent statement, which is basically no
13 medical interventions in children under 16.

14 And the primary intervention
15 in those 18 -- under 18 is psycho-social
16 intervention and psychological support.

17 So they have a window of 17,
18 18, where they will give you at least a
19 little bit, perhaps, unclear there.

20 There still is psychological
21 intervention, but they may allow for medical
22 interventions there. And that's the U.K.

23 Q And you would agree that the
24 U.K. policy is that teens who have already
25 been receiving gender affirming care can

1 DANIEL WEISS

2 continue to receive that treatment, right?

3 A No. No, they have to not
4 have started before the age of 16, otherwise
5 it's discontinued.

6 Q Well, let's break this down.

7 Is it your opinion that the
8 U.K. bans treatment, or that the U.K. just
9 won't have public funding, like through the
10 NHS for gender affirming treatment for
11 minors under the age of 16?

12 A I'm not sure on that. My
13 understanding is it was a ban for under 16.

14 Q So if I told you that even in
15 the U.K., as long as you privately fund
16 treatment, you can access gender affirming
17 care and hormone treatment for your minor
18 children under the age of 16?

19 A That's unfortunate if that's
20 true.

21 Q Okay. So you also -- does
22 that mean that you also don't agree with the
23 legal regime in the U.K.?

24 A If it allows for under 16
25 year olds, yes, to access it outside of a

1 DANIEL WEISS

2 governmental system, yes.

3 Q Is there any country that you
4 think takes an appropriate legal approach to
5 gender affirming care for minors?

6 A Well, multiple countries are
7 very close to bans, but they are not strict
8 bans like we are looking at here with this
9 bill.

10 But again, their healthcare
11 is quite different, and most people do not
12 seek care outside of the government system.

13 Q So, just to be clear, no
14 country in the world, to your mind, goes far
15 enough with regard to banning gender
16 affirming care without exception, right, for
17 minors, without exception, right?

18 A Yes. If indeed, as you said,
19 you can access it in the U.K. outside of the
20 government system, I would agree, yes, they
21 do not go far enough.

22 But they are moving, you
23 know, it's taken them a long time, decades
24 of experience, and they have finally learned
25 from their studies that these interventions

1 DANIEL WEISS

2 appear to be experimental, not helpful, and
3 so psychological support is the primary
4 intervention that's used.

5 And if we did -- if they had
6 something like that in Idaho where oh, we
7 would encourage psychological support, we
8 are not going to ban it, it's going -- it
9 won't change the situation, I think, there
10 would still be perfunctory psychological
11 intervention, and unless there is penalties,
12 there will be no improvement, no reduction
13 in the harm that minors are suffering.

14 Q Are there any studies showing
15 that puberty blockers alone, absent cross
16 sex hormones, impact fertility?

17 A No, but most of those -- not
18 that I know of, but 95 percent or so of
19 children who start puberty blockers for
20 gender dysphoria go onto opposite sex
21 hormones.

22 So that kind of -- it's a
23 little immaterial, because if it's only 5
24 percent that don't, you're basically making
25 infertile all those children who are -- who

1 DANIEL WEISS

2 move on, 95 percent, who move on from
3 puberty blockers to opposite sex hormones,
4 you are impacting their fertility.

5 Q So it's your opinion that
6 everyone on opposite sex hormones is
7 rendered infertile by those hormones?

8 A It depends on when they
9 are -- when that intervention occurs.

10 If it's after gametes are
11 formed in late puberty, there may be some
12 chance to have -- they might be able to have
13 fertile gametes, but it's expected that they
14 will be infertile.

15 And that's why there is
16 guidance now for all those children on
17 opposite sex hormones, that they be
18 counseled on fertility preservation or
19 gamete preservation, sperm, oocyte
20 preservation, because it is expected that
21 they will be infertile.

22 Q And it's actually not clear
23 to me from your declaration, but what are
24 all the risks that you believe are
25 associated with puberty blockers?

1 DANIEL WEISS

2 A Well, let's go to that
3 section.

4 Q Sure, why don't you direct
5 us.

6 A That would be page 32.
7 Let's start with 110, hot
8 flashes, weight gain, fatigue, mood
9 disorders, seizures, hip disorders,
10 reductions in bone density, increases in
11 pressure in the brain, called pseudo tumor
12 cerebrae, reduction in the development of
13 the external genitalia, such that it may be
14 very difficult to create a vagina-like
15 structure if you are treating biologic males
16 early on in puberty.

17 Orgasmic dysfunction has been
18 described, and there is -- there are
19 concerns about brain, you're stopping brain
20 development that occurs, normal brain
21 development that would occur in puberty with
22 a puberty blocker, and so cognitive changes
23 may be seen.

24 There is one study where it
25 showed a reduction in IQ in children treated

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2 for precocious puberty with puberty
3 blockers.

4 We talked about infertility.

5 Q Are any of these purported
6 risks of puberty blockers different from the
7 risks that a cys gender minor receiving
8 puberty blockers for some reason other than
9 gender dysphoria might experience?

10 A It's not known, because there
11 is no comparative studies.

12 And there is very little
13 data. I think most of this is, that I have
14 quoted, most of it I have cited is in people
15 with treated with precocious puberty.

16 Because the data on treating
17 minors with gender dysphoria is just so
18 poor, it's not captured.

19 Q And were any efforts
20 undertaken to separate out what risk factors
21 and health concerns might actually just be
22 correlated with precocious puberty itself as
23 opposed to the administration of puberty
24 blockers?

25 A That's of course an excellent

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2 question, and it's hard to know.

3 For example, like seizures,
4 well, did they have seizures because they
5 have something going else on in their brain
6 or is it from the puberty blockers?

7 But causation association,
8 its difficult to know.

9 It's not like there were --
10 in most of these there is not controlled
11 studies, it just is these are descriptions
12 that -- of adverse events that occur in
13 people on puberty blockers, and it's
14 uncertain to what extent.

15 In some of these cases, the
16 puberty blockers is the cause.

17 Now, with brain development
18 and bone density, that's pretty clear. With
19 the orgasmic dysfunction, with the small
20 genitalia being inadequate to create a
21 pseudo vagina, those -- that's pretty clear.

22 Some of the other things, hot
23 flashes are clear, weight gain is probably
24 real and related to the puberty blockers,
25 and maybe some mood alterations.

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2 But some of them may not be,
3 may be from the associated disorder that the
4 child has as precocious puberty.

5 Q Returning to our discussion
6 about the regime in the U.K., I understand I
7 have now clarified to you the actual state
8 of the law in the U.K.

9 But would you be okay with a
10 ban on gender affirming care for minors
11 under the age of --

12 ATTORNEY KORBERG: Withdrawn.

13 Q Would you support an approach
14 where 16 year olds and 17 year olds were
15 allowed to access gender affirming care for
16 gender dysphoria, but not adolescents who
17 are younger than 16?

18 A No.

19 ATTORNEY DROZ: Objection,
20 vague.

21 Q So you think that the only
22 legal regime you would support is one where
23 only those 18 and older were able to access
24 gender affirming care, is that right?

25 A Yes; and in fact, you know,

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2 people even in their 20s, the
3 decision-making is not optimal. So, but 18
4 would be the minimum.

5 Q So you think the reason for
6 that doesn't have to do with some difference
7 in the risks of gender affirming care when
8 you're 17 versus 18, but rather with the
9 fact that we believe that 18 year olds are
10 mentally competent to make informed
11 decisions about risks and benefits?

12 A It relates to mental
13 competence at age -- that's right.

14 Q And you would agree that the
15 adult parents of children accessing gender
16 affirming care are mentally competent to,
17 just as mentally competent as an 18 year old
18 to assess the risks and benefits of care,
19 right?

20 ATTORNEY DROZ: Objection,
21 vague, form.

22 A So, parents are mentally
23 competent, yes, but again, if they are asked
24 to assess or approve of a harmful
25 intervention on their child, that should not

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2 be an intervention that should be performed.

3 So, regardless of parental
4 ascent, a minor should not be on or be given
5 medical interventions that modify their body
6 for gender dysphoria.

7 Q Is it fair to say that you
8 are opposed to gender affirming care because
9 you believe the evidence of efficacy is of
10 low quality?

11 A I think it's an irrational
12 intervention for a mental health disorder.

13 There is evidence of harm,
14 add the -- and the evidence that is
15 available shows harm and no benefit.

16 So, part of it is there is no
17 quality evidence that shows benefit, and the
18 evidence that's available shows harm.

19 Q Is there any high quality
20 evidence that supports that psychotherapy
21 alone can treat gender dysphoria?

22 A No, it's not high quality.

23 It's low quality evidence,
24 but it's an intervention that's not harmful.
25 It doesn't induce -- it doesn't cause

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2 irreversible changes that the child might
3 regret years later.

4 And exploratory psychotherapy
5 doesn't cause infertility.

6 Q Do you think that politics
7 should play a role in the practice of
8 medicine?

9 A No. It should be science.

10 Q Do you think that religion
11 should play a role in the practice of
12 medicine?

13 A No.

14 Q Your CV states that you are a
15 senior fellow at Do No Harm Medicine, is
16 that right?

17 A Yes.

18 Q Can you tell me about Do No
19 Harm?

20 A Do No Harm is an organization
21 that supports the elimination of politics
22 from medical care.

23 They want what's best for
24 training doctors to provide the best care
25 for patients and to leave politics out of

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2 medicine.

3 Q How did you become involved
4 with Do No Harm?

5 A It's a long story, but I will
6 make it short.

7 I joined when I heard about
8 the organization and their mission. I
9 happened to send an e-mail, or -- e-mail I
10 think it was, in support of Florida's ban.

11 I didn't know about Florida's
12 ban until I was notified by Do No Harm that
13 if I was interested I could support their
14 efforts to protect children with gender
15 dysphoria.

16 And then subsequently Do No
17 Harm contacted me by e-mail and said if you
18 wrote a letter in support of Florida, would
19 you send it to us?

20 After that they contacted me
21 and asked me to join.

22 Q So, you wrote an e-mail in
23 support of Florida's ban on gender affirming
24 care and Do No Harm found out about that
25 e-mail and then got in touch with you, is

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2 that right?

3 A Correct.

4 Q And you hadn't known about Do
5 No Harm prior to Do No Harm reaching out to
6 you, is that right?

7 A No, no, no, so, you missed
8 the first part.

9 So, I heard about Do No Harm
10 some way online, and I saw their mission
11 statement and what their goal was, to keep
12 politics out of medicine, and I said I'm
13 going to join, I'll be a member.

14 They said a noble effort,
15 noble cause, let's not bring these kinds of
16 ideologies into medicine, let's just do the
17 best for patient care, and that's what their
18 goal is.

19 And I joined, and then
20 subsequently they contacted me.

21 Q And they asked you -- did
22 they ask you to write an e-mail to Florida
23 or --

24 A They sent an e-mail out, they
25 said if you're interested and you have --

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2 you provide -- if you are willing to provide
3 input on Florida's ban, on Florida's
4 legislation, please write to them.

5 Q Okay. And when was this?

6 A I don't remember. It was
7 probably within the last couple of years or
8 so, I don't remember.

9 It's probably mentioned in --
10 let me see, did my CV mention I'm on Do No
11 Harm?

12 Q Yes, your CV says you are a
13 senior fellow at Do No Harm.

14 A It was within the last oh,
15 probably 18 months.

16 Q How much time elapsed between
17 when you sent this letter to Florida with Do
18 No Harm's encouragement and when you became
19 a senior fellow at Do No Harm?

20 A I don't recall exactly, but
21 to estimate probably four or five months.

22 Q And did you have any contact
23 with Do No Harm in those four or five months
24 before you became a senior fellow?

25 A No, I don't think so, no.

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2 Q And how did it come to be
3 that you became a senior fellow?

4 A They -- we had a discussion,
5 we had like a Zoom call, and they said --
6 because they know I was experienced in
7 treating adults with gender dysphoria, and
8 so they knew my view on this matter,
9 particularly with regard to treating minors
10 or giving these interventions on minors.

11 And they asked whether I
12 would be interested in working with them.

13 Q How many senior fellows are
14 there at Do No Harm?

15 A I don't remember. Maybe --
16 I'll guess and say seven, something like
17 that.

18 But you could find it on
19 line, it pulls right up.

20 Q And what do you do as a
21 senior fellow at Do No Harm?

22 A No, I have -- I am basically,
23 my efforts primarily have been in support of
24 legislation; that's basically it.

25 Q In the gender dysphoria

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2 context, what are the goals of Do No Harm?

3 A The goals are to protect
4 minors, and I think very clearly to not
5 interfere with the adult gender dysphoria,
6 but to stop medical, opposite sex hormones,
7 puberty blockers and surgery on minors with
8 gender dysphoria.

9 Q Is it a goal of Do No Harm to
10 in any way limit adults' access to treatment
11 for gender dysphoria, including cross sex
12 hormones?

13 A No, not that I'm aware of at
14 all, no.

15 Q Is a goal of Do No Harm to
16 end clinical research on gender affirming
17 care for minors?

18 A I'm not sure what their
19 stance is on that.

20 Q Is it your goal to end
21 clinical research on gender affirming care
22 for minors?

23 A I think it's -- I think
24 hormonal interventions, I can't justify any
25 clinical research of hormonal interventions,

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2 even in the research setting, on minors with
3 gender dysphoria.

4 I think it's unethical.

5 Q And you provided testimony in
6 several states in support of bills banning
7 gender affirming care for minors, is that
8 right?

9 A Yes.

10 Q Those states are Indiana,
11 Ohio, Montana, Utah, Wyoming and North
12 Dakota, right?

13 A Sounds right. Your list is
14 probably better than my memory.

15 Q Were all of those testimonies
16 in connection with your role as a senior
17 fellow at Do No Harm?

18 A I think most of them -- one
19 or two might not have been, but I believe
20 most of them were as a senior fellow with Do
21 No Harm.

22 And I would have listed that
23 on, it would probably be the testimony might
24 even have been submitted on Do No Harm
25 letterhead.

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2 Q So, if your testimony wasn't
3 submitted on Do No Harm letterhead, can I
4 infer from that that you were testifying in
5 your individual capacity and not as a senior
6 fellow of Do No Harm?

7 A Correct.

8 Q Is there any difference in
9 your testimony if done in your individual
10 capacity or as a senior fellow at Do No
11 Harm?

12 A My thoughts and my
13 understanding of the science might have
14 evolved over time, so the testimony might
15 have changed a little bit because of that.

16 For example, I testified in
17 Ohio before I think even Do No Harm existed,
18 what they called the SAFE Act, and you maybe
19 cited that earlier on, and that was my own
20 testimony.

21 There was no involvement with
22 Do No Harm.

23 ATTORNEY KORBERG: By the
24 way, can we take down the
25 declaration?

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2 Q Other than the extent to
3 which your understanding may have evolved
4 over the period in which you were testifying
5 before legislators, is there any difference
6 in the testimony you give on your behalf
7 versus the testimony you give in your
8 capacity as a senior fellow at Do No Harm?

9 A Not that comes to mind, no.

10 Q Have you provided testimony
11 to any state legislators considering laws
12 outside the context of gender affirming
13 care?

14 A One testimony comes to mind,
15 and that was in, I think it was Indiana,
16 related to surgery on prisoners.

17 Do you have that one?

18 Q I don't.

19 A You missed that in your
20 search?

21 Let me see, that was one.

22 I also had testimony in
23 Texas, a statement, this is a statement
24 submitted related to medical care for
25 detransitioners. I bet you don't have that

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2 either.

3 Q No. Why don't you go ahead
4 and explain to me. Let's start with Texas.

5 What was -- what sentiment
6 were you expressing to the state for their
7 medical care for detransitioners?

8 A Sure. So if someone had
9 hormonal or surgical interventions for
10 gender dysphoria the insurances should cover
11 any complications that might arise from
12 that, or in those persons who chose to
13 detransition.

14 Q You wanted to make sure that
15 someone that received hormonal or surgical
16 interventions for gender dysphoria had
17 insurance coverage for any complications
18 that arose from that treatment, right?

19 A Right. We can't abandon
20 these people, however number there might be,
21 2 percent, 1 percent, 5 percent, doesn't
22 matter.

23 They need medical care, and I
24 wanted to support both the state and private
25 insurers to cover those problems that might

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2 arise.

3 Q Let's say that someone
4 accessed surgery that made it such that they
5 needed hormone replacement.

6 Were you advocating that
7 insurers cover cross sex hormone coverage
8 for those people?

9 A I'm very sorry, I missed that
10 first part. Can you restate it?

11 Q Sure. So let's say that
12 someone has surgery, and it is a type of
13 surgery that thereafter requires some form
14 of hormone replacement therapy.

15 Were you advocating for
16 insurance to cover the provision of cross
17 sex hormones as a form of hormone
18 replacement therapy for those people?

19 A No, this was a statement in
20 support of those people who had a
21 complication related to their procedures or
22 had -- needed medical care, now that they
23 decided to return to their natal sex.

24 Q I see. So this was only
25 advocating for people who decided to cease

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2 accessing gender affirming care?

3 A They desisted or stopped the
4 medical interventions, or they decided, we
5 use the term detransition, to go back to
6 their natal sex.

7 Or they had a complication,
8 let's say they had genital reconstruction,
9 and they had a complication, lots of
10 infection, suffering, pain, chronic pain,
11 whatever, related to that, that that medical
12 care was covered.

13 Not just for those people who
14 were no longer -- those people who still
15 identified with say the opposite sex, if
16 they had a complication related to that
17 intervention.

18 Q And your Indiana testimony,
19 what was your testimony with respect to
20 prisoners and surgery?

21 A I don't remember the details
22 on that.

23 It had something to do with
24 should the state require -- should the state
25 pay for surgery in a person with gender

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2 dysphoria who insisted upon surgery because
3 they had gender dysphoria and they wanted
4 those surgical modifications.

5 Q And what position did you
6 take, should the state pay for that or not
7 pay that?

8 A Not pay for it.

9 Q Am I right that you also
10 testified against vaccine mandates in Ohio?

11 A I think it was specifically
12 COVID vaccine, COVID vaccine mandate.

13 Q I believe earlier you
14 testified that you were supportive of the
15 COVID vaccine mandates, is that right?

16 A No, that's incorrect.

17 Q Okay.

18 A I'm opposed to it. I'm
19 opposed to the COVID -- I opposed the COVID
20 vaccine mandate, and this is a completely
21 separate scientific area where we can go at
22 great length.

23 I don't want to use up your
24 time, but it's very complicated, and I
25 oppose the COVID vaccine mandate in Ohio.

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2 Q And do you believe that the
3 COVID vaccine is not safe and effective?

4 A That's correct. It's unsafe
5 and ineffective, and any careful reading of
6 the literature, which is very biased,
7 reveals that it's bad.

8 It's bad, it's a messenger
9 RNA, it's experimental, and many people
10 suffered because of it.

11 The reporting of the studies
12 were fraudulent, they covered up adverse
13 events. I can go on and on. It's not safe
14 and it's not effective.

15 Even Dr. Fauci says it does
16 not prevent transmission or infection. They
17 claimed it only reduced severity of
18 infection.

19 Q Are you compensated by Do No
20 Harm for your work as a senior fellow?

21 A Yes.

22 Q How much are you compensated
23 by Do No Harm for that work?

24 A \$325 an hour.

25 Q And since you became a senior

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2 fellow with Do No Harm in the last year or
3 so, how much money has Do No Harm paid you
4 in total for your activities either as a
5 senior fellow or otherwise?

6 A I don't remember that, I will
7 have to go look it up.

8 Q Roughly?

9 A \$15,000; \$12,000 to \$15,000.

10 Q And that's the total amount
11 you would have received from Do No Harm for
12 all of your various activities, whether as a
13 senior fellow or otherwise?

14 A Correct, that's my best
15 estimate.

16 Q Has Do No Harm compensated
17 you for your work as an expert in Indiana,
18 Montana or in this case?

19 A No, absolutely not. They
20 know nothing about that work.

21 Q Do you know what groups
22 provide funding to Do No Harm?

23 A No, I don't.

24 Do you? I think -- it not
25 apparent, but they are funded, not as well

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2 as ACLU.

3 Q Do you -- did you have any
4 concerns or curiosity about where the money
5 that was funding your work was ultimately
6 coming from?

7 A Oh, no concerns at all. I'm
8 curious, but no concerns.

9 Unfortunately, you know, the
10 funding is substantial on -- for your
11 viewpoint, it's very extensive, as you know.

12 Q Have you ever asked anyone at
13 Do No Harm where the funding that is
14 ultimately flowing to you is coming from?

15 A Not specifically -- I
16 think -- no, I haven't asked directly that
17 question.

18 But I think it's kind of,
19 it's kept discrete, because if that person,
20 persons announced that they were funding it,
21 they would be cancelled, assaulted,
22 attacked.

23 There would be protests and
24 whatever.

25 Q Do you have a guess or a

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2 hunch as to who is funding Do No Harm?

3 A Not at all, no idea.

4 Q Do No Harm also opposes, "The
5 radical ideology of anti-racism," is that
6 right?

7 A I believe that's correct,
8 yes.

9 Q What does that mean?

10 A Well, I'm not a fellow in
11 that regard, but I think what they are
12 referring to is the promotion of ideas that
13 states that white people are oppressors, and
14 people of color are victims.

15 And that within medicine
16 there is systemic racism that we as
17 physicians, especially if we are white, are
18 racist, and then it impacts on our care of
19 patients.

20 And we need to say that we
21 have white privilege, and all this nonsense.
22 I believe it's nonsense, that's not true.

23 Q Do you believe that minority
24 populations have unequal access to
25 healthcare in the United States?

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2 A No.

3 ATTORNEY DROZ: Objection,
4 irrelevance.

5 A No.

6 Q Do you agree that healthcare
7 outcomes are ever different for minority
8 populations than for white people in the
9 United States?

10 ATTORNEY DROZ: Objection,
11 relevance.

12 A So, this is the kind of, you
13 talk about association and causation.

14 So, I would say a thoughtful
15 person, I think you should know that this is
16 the standard kind of conclusion, that if the
17 outcomes are different, it must be that
18 something wrong is being done where we are
19 failing in terms of treating these people.

20 So sure, the outcomes are
21 different, but there are so many factors.
22 And to claim that the outcome of a person
23 who has a darker skin is worse because I am
24 providing bad care to them is wrong, or
25 that, or that the access isn't good.

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2 Well, there are many factors.
3 There is drug use, there is broken homes,
4 there is poverty, there is crime, there
5 is -- all these are factors.

6 And to say oh, there is a
7 difference in outcomes, it must be racism,
8 that's an inappropriate and unwarranted
9 conclusion.

10 Q Is Do No Harm a politically
11 motivated organization?

12 A No, I think on the contrary,
13 they are motivated to eliminate politics
14 from medicine and from healthcare, to
15 eliminate it, to focus on the best outcomes
16 and the science.

17 Q What's your definition of a
18 politically motivated organization?

19 A An organization which makes
20 decisions based upon ideology and not
21 science and medicine.

22 Q Is the American Medical
23 Association a politically or religiously
24 motivated organization?

25 A The leadership I believe is,

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2 I think their politics and ideology, that
3 is, that has captured their leadership.

4 And remember, only about 25
5 percent at most of doctors are members of
6 the AMA.

7 Q What about the American
8 Pediatric Association, do you think that's a
9 politically or religiously motivated
10 organization?

11 A It's not -- I don't think
12 there is religion in the leadership there.

13 There is politics, there is
14 ideology in the leadership.

15 They have 66,000 members.
16 They do not poll the members to get their
17 input on how to help children who have
18 psychic distress that is attributed to
19 gender, they just made this statement
20 without a review of the literature.

21 So, they are politically
22 motivated.

23 Q Are the leadership of Do No
24 Harm politically motivated?

25 A I don't think so.

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2 Q Is there any major medical
3 group that supports the provision of gender
4 affirming care for minors suffering from
5 gender dysphoria that you believe is not
6 principally motivated?

7 ATTORNEY DROZ: Objection,
8 vague and ambiguous.

9 A No, I think all of those --
10 any medical organization that evaluates the
11 scientific evidence on hormonal and surgical
12 interventions on children with gender
13 dysphoria will conclude that or will decide
14 not to support it.

15 And they will look at the
16 comp reviews, they will look at the
17 systematic reviews, they will look at the
18 European experience, and they will say no,
19 we do not support it.

20 So, I think those that are
21 supporting are either not knowledgeable,
22 they just kind of go along, and I think
23 there are organizations that just will go
24 along with maybe the AMA or the Endocrine
25 Society.

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2 They may not be politically
3 motivated, but they are kind of lazy and
4 they can't really do their own research.

5 And they might be afraid to
6 come out and oppose it, because it's very
7 difficult for people to be outspoken and
8 challenge this narrative, very difficult.

9 It's scary. People are
10 attacked and there is -- we have seen
11 violence, threats and so on.

12 Q Is it your belief that any
13 physicians that support gender affirming
14 care for minors are either lazy, afraid or
15 politically motivated?

16 ATTORNEY DROZ: Objection.

17 A You know, the lazy in terms
18 of -- maybe I shouldn't use that word, lazy,
19 they didn't put the effort into looking at
20 the science. That's what I mean by that.

21 They either didn't put the
22 effort in to study it, or they are afraid,
23 because they don't want to speak out and
24 challenge it.

25 So that's why often they

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2 won't treat children who are, or even adults
3 with gender dysphoria, or they are
4 politically motivated.

5 I think the politically
6 motivated people is relatively small, but
7 they happen to be often on these leadership
8 committees that come out with these
9 statements.

10 Q And the leadership of these
11 organizations are all physicians, right?

12 A It depends what you mean by
13 all.

14 So, pediatricians, yes.
15 Endocrine Society, some of them might be
16 Ph.D.s, theory searchers, and not M.D.s.

17 Q Okay, how about this way.
18 You agree that there is a number of doctors
19 that support gender affirming care for
20 minors, right?

21 ATTORNEY DROZ: Objection,
22 vague. And I don't want to do a
23 speaking objection, but we keep
24 talking about gender affirming care,
25 and I don't know what that includes.

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2 And so maybe just so we can
3 all get on the same page as to what
4 that is.

5 ATTORNEY KORBERG: We did
6 that like hours and hours and hours
7 ago.

8 We agreed on a definition of
9 gender affirming care, which
10 actually the doctor provided to me.

11 Would you like to change his
12 definition?

13 ATTORNEY DROZ: No.

14 ATTORNEY KORBERG: Okay.

15 A It's okay, I will restate.

16 I think what we are talking
17 about with the gender affirming care term,
18 phrase, is opposite sex hormones, puberty
19 blockers and surgical treatment to modify
20 body appearance to the child's, person's
21 choice of appearance, gender.

22 It might be just, it might be
23 removal of gonads, their testes, because
24 they identify as a eunuch.

25 So that is what's being

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2 called gender affirming care.

3 So there are doctors who
4 support that, and there is, for WPATH
5 guidelines, there is no lower age limit for
6 that.

7 If they say they endorse
8 WPATH, they are endorsing a 6 year old.

9 I should also add WPATH says
10 there may be some children who don't want
11 hormones first.

12 That is, they don't want
13 opposite sex hormones, they just want their
14 gonads removed or they want the surgery, and
15 they are fine with that.

16 So one needs to keep that in
17 mind, that those doctors, like Dr. Connelly,
18 who endorsed WPATH, are endorsing this
19 approach.

20 So there are doctors who
21 support it, yes.

22 Q Yes. And doctors all take an
23 oath to do no harm, right?

24 A I don't know what the
25 current -- you know, they have changed the

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2 Hippocratic oath, so they have kind of
3 eliminated it, and it's really become
4 substantially modified.

5 But that is a fundamental
6 principle of not harming, Do No Harm in
7 evaluating any intervention looking at the
8 benefit and potential risk.

9 Q And is it your opinion that
10 financial incentives in part explain the
11 provision of gender affirming care in the
12 United States?

13 A Yes.

14 Q Is it your opinion that
15 anyone who provides gender affirming care is
16 too biased to have an opinion on the
17 provision of such care?

18 A No, I think there are some
19 people who are just -- may not be informed,
20 they didn't put the effort into really
21 studying it, and, you know, it's a
22 complicated matter, there is a lot of
23 material, and they just may go along.

24 But there are others who are
25 running gender clinics, and they don't have

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2 an incentive to look at the science, because
3 that's their job.

4 They don't want to lose their
5 job, so they are convinced that what they
6 are doing is right, and they don't want
7 to -- they have a confirmation base, they
8 don't want to see anything that challenges
9 that.

10 Q Your employer, InterMountain
11 Health, has a gender clinic in Utah that
12 provides gender affirming care to minors,
13 right?

14 A They do provide -- they were
15 providing opposite sex hormones, puberty
16 blockers, I believe, and in some cases
17 surgery for persons with gender dysphoria in
18 the northern part of the state.

19 Q And is it your belief that
20 your colleagues at InterMountain providing
21 such care are doing so despite the fact that
22 it is against the fundamental medical
23 principle to do no harm because they stand
24 to gain financially from that?

25 A I don't know the reason.

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2 I'm concerned about finances
3 playing a role, and I think some of them
4 just may have that's their principal job,
5 and some of them may be biased or other
6 reasons.

7 But I think, I like to think
8 that everyone wants what's best for these
9 children, but I just -- I am puzzled as to
10 why they are encouraging these interventions
11 which are not best for these children.

12 They are harmful, they don't
13 help.

14 Q What is your affiliation with
15 the Society for Evidence Based Gender
16 Medicine?

17 A So, I'm not a member, but I
18 do communicate with them periodically.

19 Q Is it fair to say that you
20 generally agree with the positions taken by
21 SEGM?

22 A Most of them, but not all.

23 Q Do you believe that SEGM is a
24 biased organization?

25 A No, not at all.

1 DANIEL WEISS

2 Q Do you believe that the Yale
3 School of Medicine is a biased organization?

4 A Which one, Yale?

5 Q The Yale School of Medicine?

6 A I can't speak to a whole
7 school of medicine.

8 I can speak to a comment or a
9 statement or a publication written by
10 someone written on staff there.

11 Q Are you a member of the
12 American Association of Physicians &
13 Surgeons?

14 A I am.

15 Q I understand that that
16 membership was included on your CV when you
17 testified in Indiana, but has since been
18 removed.

19 Is that deliberate?

20 A No, really, it got removed?
21 That's a surprise. No, it should be on
22 there.

23 It's not on there?

24 Q I don't believe so, but --

25 A I don't have my CV, but

1 DANIEL WEISS

2 that's an oversight, maybe, when I was
3 updating it. No, I'm still a member.

4 Q And what's the extent of your
5 involvment in AAPS?

6 A I've been a member since the
7 '90s, and I just endorse many of their
8 viewpoints and stances.

9 And their basic position
10 mission is the sanctity of the
11 patient/physician relationship, and keeping
12 meddling and interference out of that.

13 Q Do you pay dues?

14 A Yes.

15 Q How much are those dues?

16 A I don't remember, something
17 on the order of \$250.

18 Q Do you receive the AAPS
19 newsletters?

20 A Yes.

21 Q And do you read those
22 newsletters?

23 A Usually.

24 Q Last month's AAPS newsletter
25 explained that, "The switch to third person,

1 DANIEL WEISS

2 plural gender neutral language is a weapon
3 of mass psychological destruction, far more
4 lethal than bullets or bombs, which begins
5 in our late childhood.

6 "This is part of the
7 globalist agenda to destroy the U.S. and
8 merge it into its own boundaryless planetary
9 unistate."

10 Do you agree with that
11 position taken by AAPS in its newsletter?

12 ATTORNEY DROZ: Objection.

13 A Was that written by Dr.
14 Orient?

15 Q It was in the AAPS
16 newsletter.

17 A Yeah, I think it's
18 interesting, and it's some -- I agree with
19 some of that.

20 I think controlling people's
21 language is a powerful tool.

22 I don't know, I'm not sure
23 about the globalist agenda.

24 Q So you don't think there is a
25 globalist agenda to destroy the U.S. and

1 DANIEL WEISS

2 merge it into a boundaryless planetary
3 unistate?

4 A No.

5 Q But you do agree that the use
6 of they/them pronouns is a weapon of mass
7 destruction, far more lethal than bullets or
8 bombs?

9 A I wouldn't say that.

10 I think controlling someone's
11 language is a powerful tool.

12 I wouldn't use the same
13 verbiage that was used there.

14 Q So I use they/them pronouns,
15 is personal use of they/them pronouns a
16 weapon of mass psychological destruction
17 that's more lethal than bullets or bombs?

18 A No.

19 Q The AAPS issued a press
20 release protecting physicians who prescribe
21 hydroxychloroquine and Ivermectin to treat
22 COVID-19.

23 Did you know that?

24 A I think I did, yes. It's
25 hydroxychloroquine is how you pronounce it.

1 DANIEL WEISS

2 Q Do you think there is
3 evidence that hydroxychloroquine or
4 Ivermectin treats COVID-19?

5 A Absolutely. They are very
6 safe, too.

7 Q What's your support for the
8 notion that hydroxychloroquine and
9 Ivermectin treat COVID-19?

10 ATTORNEY DROZ: Objection,
11 relevance.

12 A Yeah, I really think this
13 is -- I mean, if you have another two hours
14 I could teach you about this, but it's
15 really complicated, and it relates to COVID
16 infection, clinical experience, what's
17 published, what's allowed to be published,
18 where it's published, retractions, the
19 government effort to crush any medical
20 therapy for COVID infection, the promotion
21 of the shots.

22 It's really complicated, and
23 there is a lot of clinical experience that
24 those drugs are effective for treatment of
25 COVID infection when given early.

1 DANIEL WEISS

2 Q And do you believe with that
3 the AAPS that abortion causes breast cancer?

4 A No, I think there is -- the
5 data on that is very unclear. There is one
6 or two studies that suggest that, but it's
7 not clear; no.

8 Q Do you agree with AAPS that
9 HIV does not cause AIDS?

10 A No; I disagree with that.

11 Q I understand -- what is your
12 involvement with the Center for Christian
13 Value?

14 A So, they contacted me when I
15 was in Ohio, so they alerted me to the SAFE
16 Act and that was -- that was kind of the
17 impetus to give testimony back, what, maybe
18 a year before last, 2021, I think.

19 You can check that.

20 Q Okay.

21 Do you generally agree with
22 the views of the Center for Christian Value?

23 ATTORNEY DROZ: Objection,
24 relevance.

25 A Yeah, I don't follow them,

1 DANIEL WEISS

2 they just -- they contacted me, I know their
3 stance on gender dysphoria and hormonal
4 interventions in children, and I agree with
5 that position.

6 But otherwise I am not
7 familiar with their other views.

8 I suspect that they are
9 opposed to abortion, because they are
10 religious.

11 Q "Among CCV's mission is
12 ensuring government policy promotes strong
13 families and strong marriages between one
14 man and one woman."

15 Is that a mission that you
16 also endorse?

17 ATTORNEY DROZ: Objection,
18 relevance.

19 A Yeah, I am fine with any
20 marriage between any sexes, but I think a
21 family is very important. It's good to have
22 two parents.

23 Q What's your involvement with
24 the American College of Pediatricians?

25 A I don't have any involvement

1 DANIEL WEISS

2 with them.

3 Q Is there a difference between
4 desistance and regret?

5 A So, regret is -- so, there
6 are different definitions. There are
7 articles on this. I reference some of them.

8 So regret, I would describe
9 as expressing regret that a person has
10 undertaken a particular step in life or
11 accepted a certain intervention or
12 procedure.

13 So a person might regret and
14 still stay on their opposite sex hormones,
15 for example.

16 And a person might desist,
17 stopping the hormones and not detransition.

18 So it's complicated, and we
19 need to define terms whenever we use them.

20 But --

21 Q And it's possible that a
22 person might stop receiving hormones, but
23 not regret having received them, right?

24 A That's possible, yes.

25 Q And of the 100 patients that

1 DANIEL WEISS

2 you treated for gender dysphoria between
3 2003 and 2013, how many of those do you
4 believe desisted?

5 A I think the majority.

6 Probably 50, 60, maybe even
7 70 of them. But I don't know, that's
8 because they didn't come back and say I'm
9 stopping hormones. They just didn't come
10 back.

11 And as you said, maybe some
12 moved, I doubt that. Maybe some went to
13 another doctor, I doubt that, too, because
14 there were not options and they didn't
15 prefer -- the one other option was a person
16 who was in another area of town and people
17 didn't particularly like that clinic.

18 So I think most likely those
19 who did not return just decided they weren't
20 going to take them anymore.

21 Did they just stop the
22 hormones and not regret it or did they just
23 stop the hormones and regret it?

24 I don't know. I don't have
25 that data.

1 DANIEL WEISS

2 Q And again, you don't actually
3 know that they stopped taking hormones at
4 all, right?

5 A I don't know who would have
6 given them to them. As I said, there
7 weren't options, there was no multitude of
8 options available at that point.

9 I was the principal
10 prescriber of hormones in northern Ohio at
11 the time.

12 Q Well, the Cleveland Metro
13 Clinic continued to provide cross sex
14 hormone care, correct?

15 A Yes. And there would have
16 been no reason to have gone there if they
17 were seeing me, and I was closer.

18 Let's say -- maybe they got
19 disenchanted with my care, but there was
20 nothing to suggest that with the previous
21 visits.

22 Patients, really -- I got
23 very good reviews, they loved me.

24 Q Of the 100 patients that you
25 cared for, did any ever express regret to

1 DANIEL WEISS

2 you regarding their gender affirming care?

3 A No. Well, I should say one
4 person -- two people, sorry, so two people,
5 went recently, recently, last year, I had a
6 biologic male who had an orchiectomy in
7 Philadelphia after being presumably
8 evaluated by a therapist, had an
9 orchiectomy. Within months he regretted it.

10 So he was on testosterone,
11 same sex hormone, and then he wanted some
12 estrogen, he went back and forth, and then
13 he saw me, and so he was one person.

14 He was not originally seen by
15 me, so that was one.

16 There was another man in
17 his -- man, I can call him a he, he lived as
18 a male, he had auto-gynephilia.

19 He really -- and I realized
20 that later on, he was married to a female,
21 having sex with her, had a ponytail, but
22 lived as a male, basically, and wanted
23 female hormones.

24 And I obliged him, and he
25 seemed happy with that. He went by he, and

1 DANIEL WEISS

2 then came back after a hiatus of several
3 months and said I'm having a little harder
4 time getting erections since my surgery.

5 I said to him, what surgery?

6 Well, he had undergone
7 orchiectomy, he had his testicles removed,
8 having seen a psychologist first, I won't
9 name the institution, and then had the
10 orchiectomy.

11 And then he said this is not
12 good, I'm having a hard time getting
13 erections, having sex with my wife.

14 And so I called the urologist
15 up I said how come you hadn't contacted me?
16 I was following this guy for years, and he
17 seemed to be fine on a little bit of
18 estrogen, he just wanted some breast tissue
19 and a little feminization.

20 That's all he wanted. And
21 now he's having problems with erection.

22 So this urologist was
23 surprised that this was the case. And I
24 don't know why they didn't contact me, and
25 the patient regretted having had the

1 DANIEL WEISS

2 surgery, and I had to put him back on -- I
3 had to put him on testosterone.

4 So that's a person who's an
5 adult in their, what did I say, 30s, he was
6 in his 40s.

7 Q So other than those two of
8 your 100 patients, each of whom had
9 orchiectomy, did any of your patients
10 express to you regret over any surgery or
11 cross sex hormone that they had to address
12 their gender dysphoria?

13 A I had one person who had a
14 vaginoplasty, the full vagina created.

15 I wouldn't say that person
16 had clearly regret, but was really
17 distressed, had problems after the surgery
18 that were happening related to infection and
19 drainage and -- but strictly speaking, the
20 word regret was not used.

21 Q So none of the patients
22 expressed regret over the cross sex hormones
23 that you had been providing to them, right?

24 A Well, no, the two with the
25 orchiectomy, they had regret over the

1 DANIEL WEISS

2 surgery.

3 Q Yes, but none of your
4 patients expressed regret over the
5 administration of cross sex hormones, right?

6 A Correct.

7 Q Among the patients that you
8 have cared for outside of the gender
9 affirming care context, let's get a number,
10 how many patients have you --

11 ATTORNEY KORBERG: Withdrawn.

12 Q Roughly how many patients
13 have you cared for in the course of your
14 career outside of the gender affirming care
15 context?

16 A Oh, thousands, and thousands.
17 Yes.

18 Q And have any of them ever
19 expressed regret about some aspect of their
20 treatment?

21 A Sure.

22 Q So how many of them would you
23 say have expressed regret over some form of
24 hormone therapy that is not cross sex
25 treatment?

1 DANIEL WEISS

2 A I can't think of anyone who's
3 expressed regret about hormonal treatment.

4 It would be other medications
5 they might have expressed regret, because
6 they had a complication from the medication
7 that was not hormonal.

8 Q Okay. So how many of your
9 patients have, roughly, have expressed
10 regret, felt some aspect of their treatment
11 or surgery outside of the gender affirming
12 care context?

13 A That's a difficult to
14 estimate. There are thousands. Maybe I
15 don't know, 100, 150.

16 THE VIDEOGRAPHER: Just to
17 note for the videographer, counsel,
18 we have about ten minutes to a media
19 change break.

20 ATTORNEY KORBERG: Thanks.

21 Q Roughly, like what percentage
22 of that, would you say?

23 A I don't know. You can do the
24 math.

25 Q When you say thousands, like

1 DANIEL WEISS

2 how many thousands do you think, like 2,000
3 patients you have seen, 1,000 patients?

4 A Oh, more than that, probably
5 10,000.

6 Q Okay.

7 And what percent of minors
8 diagnosed with gender dysphoria who received
9 gender affirming care do you believe come to
10 regret that care?

11 A So the answer to that is not
12 clear, but there is emerging evidence of
13 increasing number of minors, and I have
14 documented some of that in my declaration.

15 So we can turn to that
16 section about desistance and regret and
17 detransition.

18 Q So you don't have a
19 particular percentage in mind?

20 A I think it's not well
21 studied.

22 There is not prospective
23 data, and the people, the adolescent
24 medicine people and the pediatric
25 endocrinologist people, they don't see these

1 DANIEL WEISS

2 people, they stop seeing them usually at the
3 age of 18.

4 So, we don't know.

5 Q So, generally speaking, what
6 would you say is an acceptable regret rate
7 for surgery?

8 A For this type of surgery?

9 Q No, for any type of surgery.
10 What's an acceptable regret rate where you
11 should say okay, people should still provide
12 that surgery?

13 A Well, you have to look at the
14 other options, so the alternative
15 treatments, harm/benefit, so it depends;
16 depends.

17 Q What about for cosmetic
18 surgery, what's an acceptable regret rate
19 for cosmetic surgery?

20 ATTORNEY DROZ: Objection.

21 A I don't know the answer to
22 that, and I would ask -- I would have to
23 look at the plastic and cosmetic and
24 aesthetic literature for surgery.

25 I would say it should be very

1 DANIEL WEISS

2 low.

3 Q So if, for example, there was
4 a 20 percent regret rate for a surgery, do
5 you think that surgery should be
6 criminalized?

7 ATTORNEY DROZ: Objection,
8 speculative.

9 A So, I don't think it's
10 appropriate to compare treating a mental
11 health disorder with surgery or hormonal
12 interventions with -- in minors to aesthetic
13 or cosmetic surgery in adults who want to
14 change their body because they want bigger
15 breasts or something like that.

16 And they are more competent
17 in making that decision.

18 Q Do you have a sense of how
19 often people come to regret having gastric
20 bypass surgery?

21 A Yes, I think it's very low,
22 very low. It's probably less than 5
23 percent, maybe 2 or 3 percent.

24 Because I see a lot of those
25 people, I follow people post gastric bypass.

1 DANIEL WEISS

2 Q Do you recommend gastric
3 bypass for any of your patients?

4 A Yes.

5 Q And if you came to learn that
6 the regret rate for gastric bypass was 30
7 percent, would that make you disinclined to
8 recommend gastric bypass surgery to your
9 patients?

10 A Yes. Yes, I would look and
11 see why is that? What surgical center is
12 that happening in? What procedure do they
13 have?

14 So, there are some older
15 procedures where there was more, a lot more
16 complications, and now, with the newer
17 procedures, there are less complications.

18 And you're treating a
19 physical problem in people who are severely
20 obese, who have often a multiple
21 comorbidities that resolve or substantially
22 improve promptly as they lose weight.

23 And they failed all these
24 other interventions that are less
25 aggressive.

1 DANIEL WEISS

2 But now we have medicines
3 that are seeming to work even better -- they
4 are working well, and that some people
5 respond well to those medicines, so well
6 that they don't need the surgery.

7 Q You were making a distinction
8 between being treated for a mental health
9 versus surgery, so let's talk about mental
10 health.

11 Do you think that people
12 suffering from depression should take
13 antidepressants?

14 A I think they should get
15 counseling, and consider the use of an
16 anti-depressant to help them if they choose
17 to do so, yes.

18 Q Have you ever recommended to
19 a patient that they go on an anti-depressant
20 medication?

21 A Oh, yes, and I have
22 prescribed it, sure. I treat depression.
23 It's -- depression is common in people with
24 diabetes. I see a lot of diabetes.

25 Q Are you aware that studies

1 DANIEL WEISS

2 have found that at least 16 percent of
3 people prescribed anti-depressants had a
4 negative experience, and only 54 percent
5 report a positive experience?

6 A I believe that --

7 ATTORNEY DROZ: Objection.

8 Q You still believe that it is
9 appropriate to prescribe anti-depressants,
10 despite the fact that only 54 percent report
11 having a positive experience with that
12 medication, is that right?

13 A Oh, so it depends -- so I'm
14 not familiar with that study you are citing.
15 One can never predict which anti-depressant
16 is going to work best for that individual.

17 And people who are suffering
18 with depression are then in a shared
19 decision-making process, are offered that
20 medication, which does not produce
21 irreversible changes on the body, and helps
22 them be more positive, have interest in
23 things, more motivation, sleep better and so
24 on.

25 And if they don't respond,

1 DANIEL WEISS

2 they can try an alternative one.

3 Some people choose, however,
4 they don't want medications, they just want
5 counseling and therapy.

6 Q So you would still prescribe
7 a treatment that has a meaningfully high
8 regret rate for a mental health disorder,
9 right?

10 ATTORNEY DROZ: Objection,
11 mischaracterizing it.

12 A Yeah, so again, I don't know
13 that particular study that you are referring
14 to.

15 When you are using
16 medication, you are not producing
17 irreversible changes on the body for the
18 mental health disorder, so they could stop
19 the pill.

20 And with surgical
21 interventions, removing breasts and cutting
22 off penises, and it's not quite comparable
23 to a pill that might give them an adverse
24 reaction.

25 It's just not -- it's kind of

1 DANIEL WEISS

2 ludicrous to compare the two of them, even
3 though they might both regret.

4 Q A number of times today you
5 have referred to the number of people who
6 are members of a Reddit website as evidence
7 of a large number of people who
8 detransition.

9 Do you agree?

10 A Yes, that's one piece of
11 evidence.

12 Q And does following a Reddit
13 site on the subject of detransitioning mean
14 that that person has personally accessed
15 gender affirming care and detransitioned and
16 desisted from that care?

17 A In many cases yes, but I
18 don't have data on that, I don't have
19 precise data on that.

20 Q Have you taken any steps to
21 verify anything about the people who follow
22 the Reddit site on detransitioning and
23 whether they did, in fact, receive gender
24 affirming care, or have stopped that care?

25 A No.

1 DANIEL WEISS

2 Q But it's your belief that the
3 majority of people who follow that Reddit
4 site in fact access gender affirming care
5 and then stopped accessing gender affirming
6 care, is that right?

7 ATTORNEY DROZ: Objection,
8 mischaracterizes.

9 A Had gender dysphoria and
10 desisted or detransitioned or regretted.

11 So I think it's probably a
12 diverse group of people who had gender
13 dysphoria who then accessed the site who no
14 longer are pursuing those medical
15 interventions.

16 Q You don't think the people
17 follow that site because, like you, they are
18 interested in the question of whether, in
19 fact, people desist from care?

20 A No. I don't follow it,
21 either. I just have access to it. I'm not
22 a follower of it.

23 ATTORNEY KORBERG: I'm
24 turning to a new topic now. Should
25 we change the tape?

1 DANIEL WEISS

2 THE VIDEOGRAPHER: Thank you,
3 I appreciate that.

4 The time is 5:30, we are
5 going off the record. This ends
6 media file 5.

7 (At this point in the proceedings
8 there was a recess, after which the
9 deposition continued as follows:)

10 THE VIDEOGRAPHER: The time
11 is 5:33. We are back on the record.
12 This begins media file 6.

13 Q Are you religious?

14 A A little bit.

15 ATTORNEY DROZ: Objection,
16 relevance. You can answer.

17 A A little bit.

18 Q Do you have any religious
19 beliefs regarding transgender people?

20 A No.

21 Q Do you have any religious
22 beliefs about gay and lesbian people?

23 A No.

24 Q I understand that you believe
25 that sex is unchangeable and binary, is that

1 DANIEL WEISS

2 right?

3 A Yes.

4 Q Is sex the same thing as
5 gender?

6 A I think it is.

7 And I should add again that
8 WPATH can't define gender, look in their
9 glossary, they can't define it. They use
10 all this circular language.

11 And I would also add my
12 religious views have not changed since 2003
13 through 2013 to now. So I was treating
14 adults with gender dysphoria, and my
15 religious views are the same.

16 Q And have your political
17 beliefs changed at all since --

18 A No.

19 Q -- from 2003 until today?

20 A No. I think you asked that
21 before, but they have not.

22 Q Do you think that men and
23 women have different capabilities because of
24 their biology?

25 A Of course.

1 DANIEL WEISS

2 Q Do you believe that men and
3 women are better suited to particular jobs
4 because of their biology?

5 A Of course.

6 Q And can you name some jobs
7 that men are better suited to because of
8 their biology?

9 A Construction work men are
10 better at, and climbing telephone poles men
11 might be better at.

12 Work that requires lots of
13 heavy lifting.

14 Q Are there some jobs that
15 women are better suited to because of their
16 biology?

17 ATTORNEY DROZ: Objection,
18 this relevance.

19 A I would say no.

20 Q Are there any non-physical
21 jobs that you any think men are better
22 suited to because of their biology?

23 A No.

24 Q In your report you refer to
25 being nonbinary in quotes. Why do you do

1 DANIEL WEISS

2 that?

3 A Where is that?

4 Q Paragraph 84 of your report,
5 you use the word nonbinary, and you put it
6 in quotes.

7 A Okay, I would like to see how
8 I refer to that.

9 Oh, yes, so I think because
10 it's not clear what that means.

11 I think they are referring to
12 a male who feels that they are neither, even
13 though they are male, they feel that they
14 are either, neither -- sorry, neither male
15 nor female.

16 That is, they are nonbinary,
17 that's the term that they use. They are not
18 either of those binary options, even though
19 in reality they are male.

20 So, WPATH used that term. I
21 happen to put that nonbinary in quotes, and
22 this is what I was stating before, they
23 might feel they identify as a eunuch, so we
24 are obliged to respect that and remove their
25 testes, if we follow WPATH guidelines, as

1 DANIEL WEISS

2 Dr. Connelly does.

3 Q So do you think that there is
4 any way in which someone who is nonbinary
5 should be respected for being nonbinary?

6 A No, I think the term to say
7 someone is nonbinary is nonsense.

8 They have some psychological
9 problem accepting their -- the reality of
10 their physical being, and they say they are
11 nonbinary, that's the term they might use.

12 But I think it's nonsense.

13 Q Okay. So someone who is
14 nonbinary, do you think they are suffering
15 from a delusion?

16 A No, I think they have a
17 psychological problem that they need help
18 with.

19 And we should not -- we
20 should not support that feeling or
21 conviction by physical intervention, by
22 surgical intervention, any more than we
23 should a young lady who has anorexia nervosa
24 who feels she's too fat, and then help her
25 lose weight when she's underweight.

1 DANIEL WEISS

2 That would be as similarly
3 absurd to intervene surgically in that
4 person.

5 I am just shocked that people
6 would consider supporting an intervention on
7 a child, because there is no lower age
8 limit, who doesn't like their testes who
9 says I'm nonbinary.

10 Q Okay. What about an adult
11 who's nonbinary?

12 A I think that person -- so
13 that person is not likely to regret it, and
14 I certainly wouldn't refer that person to a
15 surgeon, and I think they need therapy.

16 If they say I'm nonbinary and
17 I want my testes removed, I identify as a
18 eunuch, I had a person who wanted, a female
19 who had breasts and a vagina, normal
20 external genitalia, I believe, I didn't
21 examine her, she wanted a penis and she
22 wanted to keep her breasts.

23 Now, she was psychotic, and
24 she needed help for her psychosis. And
25 there is this analogy between that and

1 DANIEL WEISS

2 someone who has -- who says they identify as
3 a eunuch, and they are nonbinary.

4 Q It's your opinion that
5 someone who is nonbinary and wants to
6 physically appear in ways both like a male
7 and a female, that that person is psychotic,
8 is that correct?

9 A No, that patient I described
10 was psychotic.

11 But no, I don't know what the
12 psychiatric disorder would be in that person
13 who wants to appear both as a male and
14 female, who calls himself nonbinary, they
15 have some psychiatric disorder and it's
16 not -- if you want to call it gender
17 dysphoria, go right ahead, if that's the
18 name you want to call it, and they say they
19 identify as nonbinary, that person needs
20 psychiatric help.

21 You know, they may not seek
22 it, they may instead seek modification of
23 their body.

24 Q And the goal of that
25 psychiatric help would be to get them to

1 DANIEL WEISS

2 admit that they are whatever sex they were
3 assigned at birth?

4 A No, I did not say that.

5 The goal of that psychiatric
6 intervention is to relieve their psychic
7 distress that they might have, whatever
8 psychic distress that is present, and those
9 people have to have it.

10 They have to have depression,
11 anxiety, some thing is going on that makes
12 them call themselves nonbinary.

13 But the goal is not so-called
14 conversion therapy, which is a term used for
15 those who have a different sexual
16 orientation. It's not that.

17 The goal is to help make them
18 feel less dysphoric, make them feel more
19 positive about themselves and living in the
20 world.

21 Q What about someone who is
22 nonbinary and who does undergo some form of
23 gender affirming care and then has no more
24 psychic distress about their gender
25 presentation?

1 DANIEL WEISS

2 A Yes.

3 Q Would you say that they are
4 still mentally unwell and suffering from a
5 delusion if they continue to identify as
6 nonbinary?

7 A So, first, I didn't use the
8 word delusion, that's your word. They have
9 psychological disorders in general.

10 I mean, if they say they are
11 nonbinary, they have some psychological
12 disorder, and that needs to be addressed.

13 Now, if you are coming up
14 with a hypothetical example of someone who's
15 had some medical intervention, surgery,
16 hormones, and they say they are nonbinary,
17 and they are feeling fine about themselves,
18 no depression, anxiety. I would say that's
19 great.

20 But I'm not sure what your
21 question was.

22 Q Sure. Would you still say if
23 they are not experiencing any psychic
24 distress but they are still identifying as
25 nonbinary, is it still your belief that

1 DANIEL WEISS

2 person is mentally unwell in some way?

3 A If they say they are
4 nonbinary still, probably there is
5 psychological issues going on there that
6 haven't been addressed, yeah.

7 But if they are happy, they
8 are feeling great, it doesn't matter what I
9 say, and I don't care.

10 They shouldn't care if they
11 are -- if life is good, they are not
12 depressed, they are not anxious, they are
13 sleeping well, their energy is good, their
14 job is well, their social arrangements are
15 positive.

16 It's immaterial, that's
17 great, and I'm glad they are doing well.

18 Q When talking to patients to
19 whom you provide gender affirming care,
20 would you use their requested name if it
21 differed from the name?

22 A Oh, sure. There is no reason
23 to hurt people's feelings, insult them.

24 Q And would you refer to your
25 patients by their preferred pronouns?

1 DANIEL WEISS

2 A Absolutely.

3 Q And what about sort of
4 outside of their presence?

5 For example, if you were
6 discussing a patient with a nurse, would you
7 refer to them by their preferred pronouns?

8 A I would still try to, because
9 it's the right thing to do, and I don't want
10 to do it one way in one setting and not --
11 another way in the other setting, because I
12 don't want to offend the person.

13 Q And what about in the medical
14 records, would you try to use people's
15 preferred pronouns in their medical charts?

16 A Yes. I actually prefer not
17 to use pronouns in that setting, I just use
18 the first name.

19 Q So putting aside the issues
20 related to fertility and genital changes, do
21 all of the risks that you identified with
22 respect to puberty blockers exist when
23 blockers are used to treat precocious
24 puberty?

25 A Let me look in my list again.

1 DANIEL WEISS

2 Page 32.

3 One more time, that question?

4 Q Putting aside issues related
5 to fertility and genital changes that you
6 discussed, do all of the risks you
7 identified with puberty blockers that exist
8 when blockers --

9 ATTORNEY KORBERG: Withdrawn.

10 Q Putting aside the issues you
11 identified with regard to fertility and
12 genital changes, do all of the risks that
13 you identified with respect to blockers in a
14 gender affirming care context for minors
15 exist when blockers are used to treat
16 precocious puberty?

17 A So the data we have primarily
18 is in the setting of precocious puberty when
19 treating minors.

20 The only caveat I would say
21 is, besides infertility and genital changes,
22 there is orgasm, concern about inability to
23 achieve orgasm if they treat early.

24 And then the bone density,
25 which correlates to duration of treatment,

1 DANIEL WEISS

2 reductions in bone density.

3 Q Do you support banning
4 puberty blockers for precocious puberty?

5 A No.

6 Q Do you know anyone personally
7 outside of your patients who is transgender?

8 A No. In terms of like a
9 friend or aware of people, or in what
10 capacity?

11 Q Yeah, sure, let's start with
12 friends. Do you have any friends who are
13 transgender?

14 A No; I don't have very many
15 friends anyway.

16 Q Have you ever worked with
17 someone who is transgender?

18 A Yes. I don't -- but in a
19 professional capacity.

20 Q Do you have any personal
21 biases against transgender people?

22 A No.

23 Q Would you have any objection
24 to using the bathroom with someone who is
25 transgender?

1 DANIEL WEISS

2 A I myself, no. But I think,
3 you know, this is outside the scope of what
4 we are talking here.

5 But I think females, biologic
6 females might appropriately be concerned
7 about someone who says they are female, but
8 looks like a male or has -- exposes himself
9 and still has his external genitalia.

10 So I think I would be
11 sensitive to the females' concerns in that
12 regard.

13 But I have no problem.

14 Q Do you think that cys gender
15 men should be concerned about transgender
16 men using the same restroom?

17 A I think it's best that people
18 who retain their genitalia that they are
19 born with go into the bathroom that is
20 appropriate for their biologic sex, and I
21 think it's most respectful and caring for
22 all parties that way.

23 And if a person doesn't want
24 to do that who is trans, perhaps they can
25 use a bathroom that's unisex.

1 DANIEL WEISS

2 Q So you think it's most
3 appropriate for a transgender man with a
4 full beard who is physically presenting as a
5 man in every way to use the women's room, is
6 that right?

7 ATTORNEY DROZ: Objection,
8 enough. Relevance.

9 A In that setting, if he looks
10 like a man and he's using -- if he looks
11 like a man, then there is not going to be an
12 issue.

13 But if he looks like a woman
14 in some ways, he doesn't have the beard and
15 then he exposes himself, his external
16 genitalia, this is a biologic male in the
17 presence of women, that could cause anxiety
18 and concern, because of what you previously
19 stated before, about sexual assaults on
20 females is more common by males.

21 Biologic males, if they
22 retain their external genitalia, and they
23 say they are women, that could cause
24 distress among biologic females.

25 Q In the last year, what was

1 DANIEL WEISS

2 your approximate total income from all
3 sources?

4 A In the last -- 2022, you
5 mean?

6 Q Let's do 2022 first, and then
7 2023.

8 A 2022 --

9 ATTORNEY DROZ: I will just
10 object, the relevance.

11 A Probably -- I'm guessing
12 here, because I don't have my returns in
13 front of me, but probably about \$300,000;
14 roughly.

15 Q And how much of that income
16 comes from your clinical practice at
17 InterMountain?

18 A So I joined, to clarify, I
19 joined InterMountain in -- my first day of
20 work was the end of January of this year, so
21 I wasn't working, I was not employed with
22 InterMountain last year.

23 Q Okay, why don't we say then,
24 how much of that income came from your
25 clinical practice in Ohio?

1 DANIEL WEISS

2 A Let's see, I would say about
3 85 percent.

4 Q And what percentage of your
5 income has come from various agreements with
6 drug and device manufacturers to advise on,
7 present and promote certain treatments?

8 A Well, last year would have
9 been probably, if I am recalling correctly,
10 the other 15 percent would have been
11 promotional programs for pharmaceutical
12 companies.

13 Q Okay.
14 And what about, sorry, in
15 2022, did you have any other sources of
16 income?

17 A Not that I recall.
18 Not from employment. It
19 would have been dividends and that kind of
20 thing.

21 Q Sure.
22 So in 2023, what do you
23 expect your income from your clinical
24 practice at InterMountain to be?

25 A I am salaried, because I came

1 DANIEL WEISS

2 in as a new person, so it's lower, \$220,000.

3 Q How much do you expect this
4 year to receive from the various agreements
5 you have with drug and device manufacturers
6 to advise, present on and promote certain
7 treatments?

8 A Probably \$60,000.

9 Q And how much of your income
10 in 2023 is -- are you going to get from your
11 position as a senior fellow at Do No Harm?

12 A Whatever I -- what did I
13 previously say? Probably like that, maybe a
14 little more, I don't recall.

15 Q \$18,000?

16 A So it will be probably maybe
17 \$5,000 more or something. I am not doing
18 much work with Do No Harm now.

19 Q So roughly you expect about
20 \$20,000 from Do No Harm?

21 A Yes.

22 ATTORNEY DROZ: I think the
23 testimony was 12 to 15 before.

24 THE WITNESS: That sounds
25 right.

1 DANIEL WEISS

2 A So yeah, 20, roughly 20.

3 Q And how much income do you
4 expect this year from being an expert
5 witness in gender affirming care cases?

6 A Probably \$80,000.

7 Q And do you have any other
8 expected income for 2023?

9 A Expected income, you mean
10 other sources?

11 Q Yes, that we haven't talked
12 about here?

13 A No.

14 Q How does your total expected
15 income this year compare to three years ago?

16 A Well, last year it was -- it
17 should be similar to last year's. Three
18 years ago I think it was lower because I got
19 a raise when I was with my employer in Ohio.

20 But this year's should be
21 pretty similar to last year's, it seems
22 like, but we will see.

23 Q And next year, in 2024, do
24 you expect the amount of income that you
25 receive from Do No Harm to increase,

1 DANIEL WEISS

2 decrease or stay the same?

3 ATTORNEY DROZ: Objection,
4 speculation.

5 Q You can answer.

6 A Decrease.

7 Q Decrease?

8 A Yes.

9 Q Why is that?

10 A I don't think -- my role is
11 not important at this point with what they
12 are working on.

13 Q Do No Harm is no longer
14 focusing on gender affirming care bans for
15 minors?

16 A No, they are doing a lot of
17 areas of focus, some of which you touched
18 on.

19 But I suspect my role will be
20 less than -- and my income from them will be
21 less than this year, because I was doing a
22 lot more of those expert testimony
23 submissions, and there will probably be less
24 of that.

25 Q Do you think there is going

1 DANIEL WEISS

2 to be less of that because Do No Harm is
3 going to prioritize supporting state bans on
4 gender affirming care or because fewer
5 states are going to be passing bans on
6 gender affirming care for minors?

7 A Well, it's mere speculation,
8 but I don't think either of those is the
9 case. I think they are working on other
10 issues.

11 They, for example, are
12 working on affirmative action, I think they
13 have spoken on that, and the systemic racism
14 issues and things like that.

15 Q So it's your belief that on a
16 relative basis, Do No Harm is going to focus
17 on other issues more than gender affirming
18 care bans for minors, is that right?

19 A That's right, I suspect that.

20 Q What's the basis for you
21 suspecting that?

22 A If you go to their website
23 you see all the other areas they are
24 addressing.

25 Q And do you expect the income

1 DANIEL WEISS

2 that you received for being an expert
3 witness in cases regarding gender affirming
4 care cases to increase, decrease or stay the
5 same?

6 A Again, I don't know. I would
7 think it might stay the same or increase. I
8 doubt that it will decrease, because there
9 are a lot of bans that have been challenged,
10 and they might ask for my input.

11 ATTORNEY KORBERG: Okay, I
12 have no further questions. I
13 appreciate your time today.

14 THE VIDEOGRAPHER: Anything
15 else, Mr. Droz?

16 ATTORNEY DROZ: I don't think
17 I'm going to do a redirect.

18 THE VIDEOGRAPHER: This is
19 the videographer. The time is 5:56.
20 This ends media file 6, and this
21 concludes this deposition.

22 (Time noted: 5:56 p.m.)

23

24

25

DANIEL WEISS

I, the undersigned, a
Certified Shorthand Reporter of the
State of New York, do hereby
certify:

That the foregoing
proceedings were taken before me at
the time and place herein set forth;
that any witnesses in the foregoing
proceedings, prior to testifying,
were duly sworn; that a record of
the proceedings was made by me using
machine shorthand which was
thereafter transcribed under my
direction;

That the foregoing transcript
is a true record of the testimony
given.

Further, that if the
foregoing pertains to the original
transcript of a deposition in a
federal case before completion of
the proceedings, review of the
transcript [] was [x] was not
requested.

I further certify I am
neither financially interested in
the action nor a relative or
employee of any attorney or party to
this action.

IN WITNESS WHEREOF, I have
this date subscribed my name.

Dated: September 25, 2023



Stephen J. Moore
RPR, CRR

DANIEL WEISS

DECLARATION UNDER PENALTY OF PERJURY

Case Name: PAM POE v.

LABRADOR

Date of Deposition: September

22, 2023

I, DANIEL WEISS, hereby
certify under penalty of perjury
under the laws of the State of New
York that the foregoing is true and
correct.

Executed this _____ day of
_____, 2023, at
_____.

DANIEL WEISS

DANIEL WEISS
DEPOSITION ERRATA SHEET

Case Name: PAM POE v.
LABRADOR.

Name of Witness: DANIEL WEISS
Date of Deposition: September
22, 2023

Reason Codes: 1. To clarify
the record.

2. To conform to the facts.

3. To correct transcription
errors.

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DANIEL WEISS

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Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

DISCLAIMER: THE FOREGOING FEDERAL PROCEDURE RULES ARE PROVIDED FOR INFORMATIONAL PURPOSES ONLY.

THE ABOVE RULES ARE CURRENT AS OF APRIL 1, 2019. PLEASE REFER TO THE APPLICABLE FEDERAL RULES OF CIVIL PROCEDURE FOR UP-TO-DATE INFORMATION.

VERITEXT LEGAL SOLUTIONS

COMPANY CERTIFICATE AND DISCLOSURE STATEMENT

Veritext Legal Solutions represents that the foregoing transcript is a true, correct and complete transcript of the colloquies, questions and answers as submitted by the court reporter. Veritext Legal Solutions further represents that the attached exhibits, if any, are true, correct and complete documents as submitted by the court reporter and/or attorneys in relation to this deposition and that the documents were processed in accordance with our litigation support and production standards.

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Exhibit C

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**UNITED STATES DISTRICT COURT
DISTRICT OF IDAHO**

LAURDES MATSUMOTO, NORTHWEST
ABORTION ACCESS FUND, and
INDIGENOUS IDAHO ALLIANCE,

Plaintiffs,

v.

RAÚL LABRADOR, in his capacity as the
Attorney General for the State of Idaho,

Defendant.

Case No. 1:23-cv-00323-DKG

**DEFENDANT'S OPPOSITION
TO PLAINTIFFS' MOTION
FOR A TEMPORARY
RESTRAINING ORDER OR,
IN THE ALTERNATIVE, A
PRELIMINARY INJUNCTION**

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INTRODUCTION

This is a lawsuit over the constitutionality of Idaho Code § 18-623, which Plaintiffs call the “Abortion Travel Ban.” *See* Dkt. 12-1 at 2. But that is an egregious misnomer. The law does not ban anyone from traveling to another state, much less doing so to obtain an abortion that might be illegal in Idaho. The law prohibits not abortion travel, but rather abortion *trafficking*: recruiting, harboring, or transporting a pregnant minor for an abortion with *intent to conceal from the minor’s parents or guardian*. Idaho Code § 18-623(1). It is an Abortion *Trafficking* Ban, not an Abortion *Travel* Ban. Plaintiffs still challenge it: they say they have a First Amendment right to help other people’s children go to other states for abortions without their parents’ knowledge, much less consent. But the Constitution recognizes no such thing.

To the contrary, the Constitution recognizes the rights of parents to be involved in medical decisions about their children. Plaintiffs’ own allegations show that abortion is exactly that kind of decision. They allege that “[p]regnancy, childbirth and parenting significantly impact an individual’s physical and mental health, finances, and personal relationships” and that becoming a parent “is extremely personal and permanent.” Dkt. 1 ¶ 27. That is why “[a]n intimate decision of this magnitude,” *id.*, should be made with the support and wisdom of at least one of a child’s parents or guardians. “After all, there is the traditional presumption that a fit parent will act in the best interest of his or her child.” *Nelson v. Evans*, 170 Idaho 887, 896, 517 P.3d 816, 825 (Idaho 2022) (internal quotation omitted).

Yet Plaintiffs turn this presumption on its head by taking it upon themselves to determine whether a parent is fit and whether they should get to decide their children's decisions. Plaintiffs believe that they, not a pregnant minor's parents, get to decide what is in her best interests:

- that *they* have a right to hide a minor child from that child's parents if *they* believe that is appropriate;
- that *they* have a right to help transport a minor child across state lines for an abortion while concealing this transportation from the minor's parents;
- that *they* have a right to determine whether it is appropriate to notify a minor's parents about "an intimate decision of this magnitude."

Dkt. 1 ¶¶ 26–30, 32; *see also* Dkt. 12-9 ¶¶ 17–19; Dkt. 1 ¶¶ 26–30, 32, 47–51, 55; Dkt. 12-1 at 14, 21, 25–26; Dkt. 12-7 ¶¶ 43–45, 47–51, 53–54; Dkt. 12-8 ¶¶ 39–41, 50–54; Dkt. 12-9 ¶¶ 12–14, 18–19, 20–23, 26–27.

In any other context, Plaintiffs' statements about their plans would readily be recognized for what they are: the crime of child custody interference. That offense is when one "intentionally and without lawful authority ... takes, entices away, keeps or withholds any minor child from a parent or another person or institution having custody, joint custody, visitation, or other parental rights." *See* Idaho Code § 18-4506(1)(a). That is exactly what Plaintiffs want to do here. And if they do it for the additional purpose of helping a pregnant minor to obtain an abortion with an intent to conceal the abortion from the minor's parents, they also commit the crime of abortion trafficking.

In this light, Plaintiffs do not meet any of the requirements for a preliminary injunction. The law does not violate their freedom of speech, but rather regulates their conduct: helping other people's children cross state lines for an abortion with the intent to conceal the abortion from the minor's parents. That does not violate Plaintiffs' freedom of association either. Neither is the law vague, since the conduct it prohibits—recruiting, harboring, or transporting a minor—is the same conduct prohibited by other human trafficking statutes, including federal statutes that Plaintiffs' counsel enforced as U.S. Attorney. The balance of harms and public interest overwhelmingly favor the parents whom the Abortion Trafficking Ban protects, and whom Plaintiffs seek to prevent from knowing about major decisions affecting their children. Finally, Plaintiffs are not even injured with a threat of prosecution. They have not alleged any threat to actual protected speech, and the Attorney General has no authority to prosecute them until a county prosecutor either requests his assistance or refuses to enforce the law. That lack of prosecutorial authority is not just fatal to Plaintiffs' claims on the merits, but also to the Court's jurisdiction.

Plaintiffs' contention that the Constitution gives them the right to get minors to travel across state lines for an abortion without their parents' knowledge is truly shocking. That shocking contention does not entitle them to a preliminary injunction.

STANDARD OF DECISION

“A preliminary injunction is an extraordinary and drastic remedy, one that should not be granted unless the movant, by a clear showing, carries the burden of

persuasion.” *Fraihat v. U.S. Immigr. and Customs Enf’t*, 16 F.4th 613, 635 (9th Cir. 2021) (internal quotations omitted, emphasis removed). To obtain this extraordinary relief, Plaintiffs must show (1) that they are likely to succeed on the merits; (2) that they are likely to suffer irreparable harm without injunctive relief; (3) that the balance of equities tips in their favor; and (4) that an injunction is in the public interest. *Winter v. Nat. Res. Def. Couns., Inc.*, 555 U.S. 7, 20 (2008). “Likelihood of success on the merits is the most important factor.” *Fraihat*, 16 F.4th at 635 (internal quotations and citation omitted). A “possibility” of irreparable injury is not sufficient, rather plaintiffs seeking preliminary relief must “demonstrate that irreparable injury is *likely* in the absence of an injunction.” *Winter*, 555 U.S. at 20 (emphasis in original). And a court cannot grant a preliminary injunction if it lacks subject matter jurisdiction. *See Ex parte McCardle*, 74 U.S. 506, 514.

A temporary restraining order follows the same test as for a preliminary injunction, but “should be restricted to ... preserving the status quo” pending a full hearing. *Granny Goose Foods, Inc. v. Bhd. of Teamsters & Auto Truck Drivers Loc. No. 70 of Alameda Cnty*, 415 U.S. 423, 439 (1974). The Ninth Circuit holds that, for a challenge to state law, the status quo presumes that the legislation will go into effect as enacted. *See Golden Gate Rest. Ass’n v. City & Cnty. of San Francisco*, 512 F.3d 1112, 1116 (9th Cir. 2008). Thus, a temporary restraining order here would disturb, rather than preserve, the status quo.

ARGUMENT

I. Plaintiffs are not likely to succeed on the merits.

While Plaintiffs nominally complain about the Abortion Trafficking Ban, their true grievance is with Idaho’s abortion policy in general. Thus, they begin their brief with the assertion that “Idaho has some of the most oppressive criminal abortion statutes in the United States,” since “[e]very person who performs or attempts to perform an abortion ... commits the crime of criminal abortion.” Dkt. 12-1 at 1 (quoting Idaho Code § 18-622(1)). But no matter Plaintiffs’ views that these laws are “oppressive,” the Supreme Court of the United States in *Dobbs v. Jackson Women’s Health Organization*, 142 S. Ct. 2228 (2022), held that the U.S. Constitution does not impose any barriers on enacting them. And shortly thereafter, the Idaho Supreme Court held the Constitution of the State of Idaho also does not “protect abortion as a fundamental right,” and that Idaho’s criminal laws on abortion are constitutional. *Planned Parenthood Great Nw. v. State*, 171 Idaho 374, 522 P.3d 1132, 1148–49 (Idaho 2023). So, there is no question that Idaho can lawfully prohibit criminal abortion. And here too, despite Plaintiffs’ many grievances about Idaho’s laws, the question is not whether Idaho’s Abortion Trafficking law “is good policy,” but simply whether it is constitutional. *Id.* at 381, 522 P.3d at 1149. Plainly, it is.

None of Plaintiffs’ claims are likely to succeed. They sidestep over the important purposes of the Abortion Trafficking Ban in protecting parents’ rights. The law does not threaten their speech—instead, it prohibits only specified conduct that intentionally causes a pregnant minor’s abortion with an intent to conceal the

abortion from the minor’s parents. The law does not prohibit them from associating with anyone. Nor is it vague: the same three verbs that Plaintiffs challenge—recruit, harbor, and transport—are used in many human trafficking statutes, including the federal statutes that Plaintiffs’ counsel previously enforced and the statutes of various State Amici. The Court should deny a preliminary injunction.

A. The Abortion Trafficking Ban protects parents’ rights.

The Abortion Trafficking Ban is targeted legislation designed to protect a fundamental right secured by both the Idaho and the U.S. Constitutions—parents’ “fundamental right ‘to make decisions concerning the care, custody and control of their children.’” *Bartosz v. Jones*, 146 Idaho 449, 465, 197 P.3d 310, 326 (Idaho 2008) (Eismann, J., concurring) (quoting *Troxel v. Granville*, 530 U.S. 57, 66 (2000)). Thus, the Abortion Trafficking Ban does not punish those who take a pregnant minor across state lines for an abortion *unless* they do so with the specific intent to conceal it from her parents or guardian. Doing so is not constitutionally protected conduct.

1. Parents have a right to know about care for their children.

States have an important and compelling interest in protecting a parent’s right to make healthcare decisions for their children. For almost 80 years, U.S. Supreme Court precedent has stated that “[i]t is cardinal with us that the custody, care and nurture of the child reside first in the parents, whose primary function and freedom include preparation for obligations the state can neither supply nor hinder.” *Prince v. Massachusetts*, 321 U.S. 158, 166 (1944). “The law’s concept of the family rests on a presumption that parents possess what a child lacks in maturity, experience, and

capacity for judgment required for making life’s difficult decisions.” *Parham v. J.R.*, 442 U.S. 584, 602 (1979). “More important, historically, it has recognized that natural bonds of affection lead parents to act in the best interests of their children.” *Id.* “Most children, even in adolescence, simply are not able to make sound judgments concerning many decisions, including their need for medical care or treatment.” *Id.* at 603. “Parents can and must make those judgments.” *Id.* And so “parents have a right arising from the liberty interest in family association to be with their children while they are receiving medical attention.” *Wallis v. Spencer*, 202 F.3d 1126, 1142 (9th Cir. 2000).

Idaho law has recognized the same thing for over a century: “[t]he right of a parent to the custody, control, and society of his child is one of the highest known to the law.” *Martin v. Vincent*, 34 Idaho 432, 201 P. 492, 493 (Idaho 1921). Idaho law says that parents have a fundamental right to make child rearing decisions. *Nelson*, 170 Idaho at 894–95, 517 P.3d at 823–24 (citing *Troxel v. Granville*, 530 U.S. 57 (2000)). “[T]he interest of parents in the care, custody, and control of their children is perhaps the oldest of the fundamental liberty interests recognized by the Supreme Court of the United States.” *Id.* at 896, 517 P.3d at 825 (internal quotations omitted).

Because the Constitution protects these rights *from* governmental interference, legislatures necessarily have authority to enact laws to further these rights. As the Supreme Court of the United States has recognized, because “the parents’ claim to authority in their own household to direct the rearing of their children is basic in the structure of our society,” a state legislature may “properly

conclude that parents ... are entitled to the support of laws designed to aid discharge of that responsibility.” *Ginsberg v. State of N.Y.*, 390 U.S. 629, 639 (1968). That is just what the Abortion Trafficking Ban does.

2. The Abortion Trafficking Ban protects parents’ right to know.

The Abortion Trafficking Ban protects the fundamental rights of parents to give—and, in turn, their minor children to receive—help and advice to their minor children if they become pregnant. The law does so by making it an essential element of the offense, to be proved beyond a reasonable doubt, that it is done with “intent to conceal an abortion from the parents or guardian of a pregnant, unemancipated minor.” Idaho Code § 18-623(1). “Crimes in Idaho are categorized as either ‘general intent’ or ‘specific intent’ crimes. *State v. Stiffler*, 117 Idaho 405, 406, 788 P.2d 220, 221 (1990)[,]” and a “specific intent” crime is one that, like this statute, “refers to that state of mind which in part defines the crime and is an element thereof.” *State v. Guerra*, 169 Idaho 486, 503, 497 P.3d 1106, 1123 (Idaho 2021). Here, the specific intent required for Abortion Trafficking is the intent to conceal the abortion from the pregnant minor’s parents or guardian. Simply assisting a pregnant child in obtaining an abortion, without that specific intent, does not violate the statute.

Plaintiffs largely ignore this important element of the crime. They erroneously assert that the statute “made it unlawful to provide travel assistance within Idaho, including helping minors reach or cross Idaho’s borders.” Dkt. 1 at 3. And they omit the specific intent element of the Abortion Trafficking statute repeatedly throughout

Plaintiffs’ filings.¹ The State Amici make the same mistake, not once addressing the intent to conceal requirement of the statute in their brief. *See generally* Amicus Brief of the States in Support of Plaintiff’s Motion for a Temporary Restraining Order, Dkt. 20-1. But Plaintiffs plainly cannot prevail on a challenge to a state statute without acknowledging all of its essential elements.

Still, it is clear that Plaintiffs want to violate the specific intent requirement that they gloss over. Plaintiff Matsumoto, a member of the bar, “would like to provide temporary shelter for pregnant minors ... who are traveling to obtain ... abortion care ... *whether those minors’ parents know or do not know*” by “assisting them obtain transportation from Idaho to those states.” *See* Dkt. 12-1 at 4 (emphasis added). And Plaintiff NWAAF says that “[p]arents and guardians *may or may not have known or approved* of NWAAF’s support of these minors,” which support includes “provid[ing] food and lodging assistance” to minors seeking abortions. Dkt. 12-9 ¶¶ 17-19. Plaintiff Indigenous Idaho Alliance states that its mission and belief includes “providing financial, transportation, and logistical assistance to pregnant minors

¹ *See, e.g.*, Dkt. 1 ¶ 26 (stating that “the simple act of driving a minor to the Oregon border to get an abortion without the minor’s parent or guardian knowing” is illegal, but ignoring the specific intent element of the statute); *id.* ¶ 74 (stating that the statute “prevents Plaintiffs and pregnant minors from traveling within Idaho to reach a state where abortion is lawful,” but ignoring the specific intent requirement of the statute); *id.* ¶ 79 (stating that the statute “prevent[s] minors from accessing abortion care that is legal in Idaho’s neighbor states by criminalizing a trusted adult’s travel,” but ignoring the specific intent requirement of the statute); *id.* ¶ 106 (failing to recognize the specific intent requirement of the statute); *id.* ¶ 116 (failing to recognize the specific intent requirement of the statute); Dkt. 12-1 at 1 (stating that “Idaho criminalized conduct by adults who assist pregnant minors in receiving abortion care,” but ignoring the specific intent element of the statute).

within the region seeking legal abortion, *with or without the knowledge or consent of their parents or guardians.*” Dkt. 12-8 ¶ 61.; *see also* Dkt. 1 ¶¶ 26–30, 32, 47–51, 55; Dkt. 12-1 at 14, 21, 25–26; Dkt. 12-7 ¶¶ 43–45, 47–51, 53–54; Dkt. 12-8 ¶¶ 39–41, 50–54; Dkt. 12-9 ¶¶ 12–14, 18–19, 20–23, 26–27.

The Amici States note that their laws allow minors to obtain an abortion without parental consent. Dkt. 20-1 at 2–4. But that does not diminish in the least the State of Idaho’s choice to protect parents’ fundamental right over these important decisions. Indeed, even in the *Roe* era, the Supreme Court of the United States recognized that parental involvement in these decisions is critical. There are “potentially grave emotional and psychological consequences of the decision to abort,” which “has potentially traumatic and permanent consequences.” *H. L. v. Matheson*, 450 U.S. 398, 412–13 (1981). Consultation with parents is “particularly desirable with respect to the abortion decision—one that for some people raises profound moral and religious concerns.” *Bellotti v. Baird*, 443 U.S. 622, 640 (1979). As Justice Stewart so poignantly stated, “[t]here can be little doubt that the State furthers a constitutionally permissible end by encouraging an unmarried pregnant minor to seek the help and advice of her parents in making the very important decision whether or not to bear a child.” *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 91 (1976) (Stewart, J. concurring), *abrogated as to the right to abortion by Dobbs*, 142 S. Ct. 2228 (2022). “That is a grave decision, and a girl of tender years, under emotional stress, may be ill-equipped to make it without mature advice and emotional support.” *Id.*

Thus, now that the Supreme Court has recognized that no federal right to abortion exists, ensuring that a pregnant minor child receives the advice and support of her parents before making a decision to receive an abortion is all the more compelling. If anything, the laws of the Amici States—not Idaho—risk running afoul of the U.S. Constitution because they reject parental rights in this manner.

B. The Abortion Trafficking Ban does not punish speech.

1. The law criminalizes conduct, not speech.

Plaintiffs are not likely to succeed on the merits because their claims do not implicate the First Amendment’s free speech protections. “The first step of First Amendment analysis is to determine whether the regulation implicates protected expression.” *Recycle for Change v. City of Oakland*, 856 F.3d 666, 669 (9th. Cir. 2017). That is not the case here: the Abortion Trafficking Ban regulates conduct, not speech, and does not implicate protected expression.

All of the key terms of the Abortion Trafficking Ban relate to conduct, not speech. The conduct it prohibits is procuring an abortion or obtaining an abortion-inducing drug for a pregnant minor “by recruiting, harboring, or transporting the pregnant minor within this state[.]” *See* Idaho Code § 18-623(1). Procuring an abortion is not protected expression—rather, it is a crime, Idaho Code § 18-622, one that the Supreme Court of the United States and the Idaho Supreme Court have concluded the State may lawfully punish. *Dobbs*, 142 S. Ct. 2228; *Planned Parenthood Great Nw.*, 171 Idaho at 380–81, 522 P.3d at 1148–49. Nor does the First

Amendment protect “recruiting, harboring, or transporting” a minor for the purpose of that crime.

Plaintiffs say that their intended activities are “expressive conduct” because their assistance to the pregnant unemancipated minors “conveys a message of support for pregnant minors seeking to obtain lawful abortion care” and “conveys a clear message of support for abortion itself.” Dkt. 12-1 at 11–12. But that is true of all criminal conduct. Paying a hitman for a murder conveys a message of support for murder for hire. Propositioning a prostitute conveys a message of support for transactional sexual relationships. Possessing large quantities of methamphetamine conveys a message of support for the drug trade. Everything and anything conveys a message of support for something, but that does not make it protected under the First Amendment. And conduct lawfully criminalized by statute does not become speech simply because it necessarily “conveys a message.”

Thus, the Supreme Court of the United States has specifically rejected the argument that “the constitutional freedom for speech and press extends its immunity to speech or writing used as an integral part of conduct in violation of a valid criminal statute.” *Giboney v. Empire Storage & Ice. Co.*, 336 U.S. 490, 498 (1949). In that case, the speech at issue, picketing outside a business, was part of a “single and integrated course of conduct” “to compel Empire to agree to stop selling ice to nonunion peddlers” in violation of Missouri law. *Id.* Similarly, in the instant case, to the extent the Abortion Trafficking statute impacts speech, it only does so when that speech is part of a “single and integrated course of conduct” to procure an

abortion or obtain an abortion-inducing drug for a pregnant unemancipated minor child with the intent to conceal that abortion from the minor's parents or guardian.

Nor is there support for Plaintiffs' claims in *Holder v. Humanitarian Law Project*, 561 U.S. 1 (2010). The statute there, which prohibited the material support for terrorist organizations, "regulate[d] speech on the basis of its content," and whether the plaintiffs were able to speak to certain groups depended solely on "what they say." *Id.* at 27. In contrast, the Abortion Trafficking Ban does not prohibit speech of any kind. It does not stop Plaintiffs from sharing their views about abortion, or any other subject, to any person they want, including pregnant unemancipated minor children. But what they cannot do is take certain steps to procure an abortion or obtain an abortion-inducing drug for that pregnant minor with the intent to conceal it from the child's parents or guardian. The mere fact that speech may be used in recruiting, harboring, or transporting the child is immaterial: "[a]n illegal course of conduct is not protected by the first amendment merely because the conduct was in part carried out by language in contrast to direct action." *United States v. Gilbert*, 813 F.2d 1523, 1529 (9th Cir. 1987).

Plaintiffs say they need to take these actions as to *all* pregnant minors because *some* of them may be abused or neglected by their parents. Dkt. 12-1 at 1. But "the statist notion" that Plaintiffs have the unilateral right to substitute themselves for a child's parents "in *all* cases because *some* parents abuse and neglect children is repugnant to American tradition." *Parham*, 442 U.S. at 603. And if Plaintiffs have concerns about abuse and neglect, Idaho already has in effect a comprehensive

statutory scheme for protecting children from parents who abuse or neglect their children. *See* Child Protective Act, Title 16, Chapter 16, Idaho Code. This statutory scheme starts not with Plaintiffs determining for themselves whether parents are fit or not, but a report to the Idaho Department of Health and Welfare or local law enforcement. In fact, Plaintiffs, should they have a “reason to believe” that a pregnant minor they are trying to help “has been abused, abandoned, or neglected,” have a *duty* to report the matter, within 24 hours, to the proper law enforcement agency or the Idaho Department of Health and Welfare. Idaho Code § 16-1605(1). Failing to make the report is a misdemeanor. *See* Idaho Code § 16-1605(4).

Plaintiffs do not have a First Amendment interest in frustrating Idaho’s presumption of parental custody over children. “It is incumbent upon him who seeks to invade the home and remove a child from its protection, and from the custody of its natural guardians to show facts sufficient to justify his action[s] under the law.” *Martin*, 34 Idaho 432, 201 P. at 493. “Parents are not required in the first instance to take upon themselves the burden of proving their fitness to have the care of their children, or that they are properly exercising their parental control.” *Id.* That is why Idaho law makes it a crime, not a right, to interfere with a parent’s custody, which is what Plaintiffs seek to do here. Idaho Code § 18-4506(1)(a). Plaintiffs’ mere speculation that some parents might abuse their children is not sufficient to justify their argument that they should be allowed to remove all pregnant minors from the protection and custody of their parents regarding the decision as to whether to have an abortion or not.

The State Amici, quoting *Bigelow v. Virginia*, 421 U.S. 809, 824–25 (1975), argue that the State of Idaho “cannot ‘bar a citizen of another State from disseminating information about an activity that is legal in that State,’ even if it does so ‘under the guise of exercising internal police powers.’” Dkt. 20-1 at 5. But this is not a situation like in *Bigelow* involving an attempt to prosecute the mere advertisement of something that is legal in another state. 421 U.S. at 815 n.5. The Abortion Trafficking Ban does not criminalize the mere act of publicizing the fact that abortion is legal in another state, but instead punishes specific conduct furthering specific crimes with specific intent. And as long as the defendant commits “any essential element of the crime” within the State of Idaho, Idaho courts have jurisdiction over the crime, even if other elements of the crime are committed outside Idaho’s borders. *See State v. Villafuerte*, 160 Idaho 377, 379, 373 P.3d 695, 697 (2016) (citing Idaho Code §§ 18-202(1), 19-301(1), and 19-302). And just as the State of Idaho cannot criminalize abortion in the state of Washington, or any other state, those states cannot force Idaho to allow Plaintiffs, or any other person, to violate Idaho’s criminal laws.

2. Any minimal speech restriction passes constitutional scrutiny.

Even if the Abortion Trafficking Ban had some minimal effect on speech, it would easily be upheld under applicable First Amendment standards. Plaintiffs say the law is “subject to strict scrutiny,” but they fail to show the critical premise for applying that test: that the law regulates speech by its content. Dkt. 12-1 at 13. That premise is not met here.

“A content-based law is one that targets speech based on its communicative content or applies to particular speech because of the topic discussed or message expressed.” *Recycle for Change*, 856 F.3d at 670 (internal quotations and brackets omitted). The first step to determining “whether a law is content based is to consider whether a regulation of speech on its face draws distinctions based on the message a speaker conveys.” *Id.* (internal quotations omitted). But the Abortion Trafficking Ban does not reference speech at all, much less do so based on its content. Plaintiffs may express any message they like under the Abortion Trafficking Ban. To the extent the law even implicitly addresses speech, it addresses only its effects, not the message it expresses. Thus, the statute focuses on transitive action verbs—to “procure” or “obtain” an abortion or to “recruit,” “harbor,” or “transport” a pregnant minor—not on expressive verbs. The law does not discriminate on the basis of the content of any speech, but “on the basis of non-expressive, non-communicative conduct.” *Id.* at 672. Speakers may express any message they wish, so long as they do not cause a pregnant minor to obtain an abortion with the specific intent to conceal the fact from the minor’s parents.

That this may have “an incidental effect of some speakers or messages but not others” is immaterial because the law “serves purposes unrelated to the content of expression[.]” *Ward v. Rock Against Racism*, 491 U.S. 781, 791 (1989). Here, that purpose is the protection of the fundamental rights of parents to “make decisions concerning the care, custody and control of their children.” *Bartosz*, 146 Idaho at 465 (Eismann, J. concurring). And that purpose is unrelated to the content of a message

Plaintiffs, or any other person, may wish to express through their conduct. The law is therefore content-neutral.

So, at the very most, if any speech-related test must be applied to the Abortion Trafficking Ban, the Court should apply the “relatively lenient” standard from *United States v. O’Brien*, 391 U.S. 367, 376 (1968). *Texas v. Johnson*, 491 U.S. 397, 407 (1989). This test applies to statutes in which “speech and nonspeech elements are combined in the same course of conduct.” *Id.* (internal quotations omitted). Under this test, “a sufficiently important governmental interest in regulating the nonspeech element can justify incidental limitations on First Amendment freedoms.” *Id.* “Under *O’Brien*, a government regulation is sufficiently justified [1] if it is within the constitutional power of the Government; [2] if it furthers an important or substantial governmental interest; [3] if the governmental interest is unrelated to the suppression of free expression; and [4] if the incidental restriction on alleged First Amendment freedoms is no greater than is essential to the furtherance of that interest.” *Recycle for Change*, 856 F.3d at 674 (internal quotations omitted, brackets in original). The Abortion Trafficking Ban meets all of these elements.

First, there is no question that Idaho has the power to enact this law. As noted above, a state legislature may “properly conclude that parents ... are entitled to the support of laws designed to aid discharge” of their responsibility to care for their children. *Ginsberg*, 390 U.S. at 639.

Second, the Abortion Trafficking Ban furthers an important government interest. The law protects the fundamental right of parents to make medical

decisions for their children, and thus also protects the children themselves by helping ensure that they have the guidance of their parents. The fact that Plaintiffs are so eager to obtain and conceal abortions from children's parents shows the compelling need for a statute like this. Plaintiffs do not believe it is important for minors to have their parents' input in getting an abortion decision. And they believe that they have a right to help traffic children out of state for that purpose, regardless of whether their parents know. The State has a compelling interest in ensuring otherwise.

Third, the State's interest is unrelated to the restriction of free expression. Ensuring that any assistance for out-of-state abortions take place only with the knowledge of a child's parents has no relation to free speech.

Fourth, any incidental restriction on speech is no more than is necessary to protect parental rights. The Abortion Trafficking Ban satisfies this standard with its specific intent requirement concerning parental consent. Idaho Code § 18-623(1). That element goes directly to the interest served by the statute—helping ensure parental involvement in the pregnant minor's decision as to whether to have an abortion. The statute could have been written as a general intent crime, and simply required as an element of the crime that the parents or guardian did not affirmatively consent to the abortion. *Cf. Holder*, 561 U.S. at 17–18. Instead, the legislature narrowed the statute to require an intent to conceal the abortion from the pregnant minor's parents or guardian. That requirement quite arguably removes the conduct at issue entirely from First Amendment protections. *See id.* at 56–57 (Breyer, J.

dissenting). But at the very least, it amply satisfies the lenient *O'Brien* test—the most rigorous test that could apply to the law.

The Abortion Trafficking Ban thus does not infringe on free speech.

C. The Abortion Trafficking Ban does not limit association.

Neither does the Abortion Trafficking Ban violate Plaintiffs’ “First Amendment rights of association.” Dkt. 12-1 at 12. “The freedom of association protected by the First Amendment does not extend to joining with others for the purpose of depriving third parties of their lawful rights.” *State v. Manzanares*, 152 Idaho 410, 424, 272 P.3d 382, 396 (Idaho 2012) (quoting *Madsen v. Women’s Health Ctr.*, 512 U.S. 753, 776 (1994)). That is exactly what the statute prohibits by requiring proof the intent to conceal an abortion from the pregnant minor’s parents or guardian. Nothing about that offends the Constitution.

At bottom, the law does not prohibit Plaintiffs from associating with anyone, including minor children. What it prohibits is conduct related to such an association: procuring an abortion or obtaining an abortion inducing drug for a pregnant minor by recruiting, harboring, or transporting that minor with the intent to conceal the abortion from the minor’s parents or guardian. The Supreme Court of the United States in *Holder* summarily dismissed the notion that the statute there “prohibit[ed] being a member of one of the designated groups,” since what it in fact “prohibits is the act of giving material support.” 561 U.S. at 39–40. The Court should reach the same conclusion here.

D. The Abortion Trafficking Ban is not vague.

Finally, the Abortion Trafficking Ban does not fall afoul of constitutional vagueness principles. A statute is impermissibly vague if it “fails to provide a person of ordinary intelligence fair notice of what is prohibited, or is so standardless that it authorizes or encourages seriously discriminatory enforcement.” *Holder*, 561 U.S. at 18. While a more stringent test applies in the First Amendment context, Plaintiffs have not shown that the law restricts any protected speech. And even in the First Amendment context, “perfect clarity and precise guidance have never been required even of regulations that restrict expressive activity.” *Id.* at 19. (internal quotations omitted). As the Supreme Court noted in *Hill v. Colorado*, “while there is little doubt that imagination can conjure up hypothetical cases in which the meaning of these terms will be in nice question, because we are condemned to the use of words, we can never expect mathematical certainty from our language.” 530 U.S. 703, 733 (2000) (cleaned up).

Plaintiffs argue that the statute is unconstitutionally vague because it “does not contain or refer to a definitions section that would tell Plaintiffs when their conduct would constitute recruiting, harboring, or transporting.” Dkt. 12-1 at 15. But these are not unfamiliar terms used in isolation that only lawyers could understand. Rather, these terms are well within common understanding, which is why they are so commonly used in state and federal criminal trafficking statutes across the country:

Idaho law: In addition to the Abortion Trafficking Ban, Idaho’s general human trafficking statute criminalizes those same three verbs—“recruitment, harboring, transportation”—if in furtherance of subjecting a person “to involuntary servitude, peonage, debt bondage, or slavery.” Idaho Code § 18-8602(1)(a)(ii). If those verbs are vague when used to prevent abortion, they are also vague when used to prevent slavery.

Federal law: The U.S. criminal code likewise makes it a crime to “recruit[],... harbor[], [or] transport[] ... a person ... knowing ... that the person has not attained the age of 18 years and will be caused to engage in a commercial sex act.” 18 U.S.C. § 1591(a)(1). When Plaintiffs’ counsel served as United States Attorney for the District of Idaho, she evidently believed the same three words—recruit, harbor, and transport—were clear enough that she could prosecute not just violations of the law, but even attempts to interfere with its enforcement. *See United States. v. Swinson*, No. 1:12-CR-279-EJL, Dkt. 2 at 8 (D. Idaho. Oct. 26, 2012); Press Release, Washington Man Sentenced in Idaho Sex Trafficking Case, U.S. Attorney, Dist. of Idaho (Mar. 25, 2013), <https://tinyurl.com/bddbupa2>. How she now claims those verbs are unconstitutionally vague is a mystery.

Other states: Several other states, including some of the Amici States, use similar verbiage to criminalize human trafficking. *See, e.g.*, Wash. Rev. Code § 9A.40.100 (2017) (“A person is guilty of trafficking in the first degree when such person recruits, harbors, transports ... by any means another person”) (cleaned up); Ariz. Rev. Stat. Ann. § 13-1307 (2021) (“‘Traffic’ means to entice, recruit, harbor,

provide, transport or otherwise obtain another person.”); Colo. Rev. Stat. § 18-3-504 (2019) (“A person commits human trafficking of a minor for sexual servitude if the person knowingly sells, recruits, harbors, transports ... by any means, maintains, or makes available a minor for the purpose of commercial sexual activity.”).

Sex traffickers have repeatedly argued these terms are unconstitutionally vague. And courts have repeatedly held otherwise. *See, e.g., United States v. Snead*, 2022 WL 17975015 at *4 (4th Cir. 2022) (stating that each of the verbs “recruits, entices, harbors, transports, provides” has an ordinary meaning that would provide a person of ordinary intelligence fair notice of what conduct is prohibited”); *Alonso v. State*, 228 So. 3d 1093, 1101–02 (Ala. Crim. App. 2016) (upholding a statute that assigning criminal liability to an individual who “knowingly obtains, recruits, ... harbors, ... transports, provides, or maintains any minor for the purpose of causing a minor to engage in sexual servitude” and rejecting a vagueness challenge to its constitutionality); *State v. Scotia*, 146 Ariz. 159, 160 (Ariz. App. 1985) (collecting cases regarding the use of the term “transport” for drug transport statute); *State v. Bryant*, 953 So.2d 585, 587 (Fla. App. 2007) (reversing trial court finding of unconstitutional vagueness based on word “transport”). The fact that the statute concerns abortion does not magically transform a plain word into an unclear one. Plaintiffs’ vagueness challenge is thus wholly lacking in merit.

Plaintiffs also argue that the “statute fails to provide adequate notice regarding what culpability attaches to communication or the lack thereof with a minor’s parents and/or guardians.” Dkt. 12-1 at 16. But the many questions they

ask on this point do not move the needle. The elements of the statute do not depend upon any communication or lack of communication with the parents, but rather whether the defendant takes action to procure an abortion for a pregnant minor *with intent to conceal from the parents*. Idaho Code § 18-623(1). A prosecutor must prove that element of specific intent beyond a reasonable doubt. Thus, providing parents with notice and advance knowledge would likely prevent a prosecutor from bringing a case, while a prosecutor might be able to argue the specific intent requirement was met if a defendant provided no notice to the child's parents.

State Amici also raise other hypothetical arguments about what the statute may or may not cover. Dkt. 20-1 at 5. But this case involves challenges from the Plaintiffs, and as such the Court can only look at “the particular facts at issue,” since a “plaintiff who engages in some conduct that is clearly proscribed cannot complain of the vagueness of the law as applied to the conduct of others.” *See Holder*, 561 U.S. at 18–19; *see also* Dkt. 31 at 3 (“The Amici States ... may not initiate, create, extend, or enlarge the issues.”). And the Supreme Court of the United States has admonished that “while there is little doubt that imagination can conjure up hypothetical cases in which the meaning of these terms will be in nice question, because we are condemned to the use of words, we can never expect mathematical certainty from our language.” *Hill*, 530 U.S. at 733 (cleaned up). One can ask unending questions in an attempt to raise hypothetical situations in which the applicability of the statute might be in question. But the terms the Abortion Trafficking Ban employs have long been used by a variety of different trafficking statutes in a variety of different jurisdictions. So

Idaho Code § 18-623 provides more than ample notice to a person of ordinary intelligence of what it prohibits.

II. The balance of harms and public interest do not favor an injunction.

The balance of equities and the public interest weigh heavily in favor of the Attorney General and against issuing a temporary restraining order or preliminary injunction. The Plaintiffs are asserting the right to determine for themselves whether a parent is fit in order to decide whether it is okay to conceal information about a pregnant minor's abortion from the parents. Allowing the Plaintiffs to decide what is in the best interests of someone else's child and conceal that from the pregnant minor's parents actively undermines a parent's fundamental right and obligation to determine what is in the best interests of their children. Given this fundamental right of parents to direct the care and upbringing of their children and to be involved in the medical decisions of their minor children, the State of Idaho's policy in favor of protecting those rights is in the public interest. The constitutional rights of parents to determine what is in the best interests of their children heavily outweigh the desires of third parties to lead children into such consequential actions without their parents' knowledge or consent.

III. Plaintiffs have no irreparable injury.

Finally, the Court should deny Plaintiffs' motion for preliminary injunction for lack of an irreparable injury. At the outset, Plaintiffs have no irreparable injury because, for the reasons set forth in Section I.B, they allege only an effect on their intended conduct, not on any protected speech that would be otherwise chilled. As

Plaintiffs’ own cases acknowledge, they must “present more than allegations of a subjective chill” and must instead show “specific present objective harm or a threat of specific future harm.” *Bigelow*, 421 U.S. at 816–17 (internal quotations omitted). They have not made that showing here.

But in truth, and even more important, Plaintiffs have no injury at all, much less an irreparable one. And as will be set forth more fully in the Attorney General’s forthcoming motion to dismiss, that deficiency is fatal to jurisdiction—under both the Eleventh Amendment and Article III justiciability—just as it is to the merits.

In the pre-enforcement context here, both Eleventh Amendment immunity and Article III justiciability turn on whether there is a threat of prosecution. The *Ex parte Young* exception to the Attorney General’s Eleventh Amendment immunity applies only if he is “clothed with some duty in regard to the enforcement of the laws of the state, and ... threaten and are about to commence proceedings ... to enforce against parties affected [by] an unconstitutional act.” *Ex parte Young*, 209 U.S. 123, 155–56 (1908). And proving a justiciable controversy in the pre-enforcement context also requires a threat: for standing, “whether the prosecuting authorities have communicated a specific warning or threat to initiate proceedings,” *Twitter, Inc. v. Paxton*, 56 F.4th 1170, 1174, and for ripeness, a “specific and credible threat of adverse action.” *Lopez v. Candaele*, 630 F.3d 775, 781 (9th Cir. 2010). That essential threat is wholly absent here.

Aside from the fact that Plaintiffs do not allege the Attorney General has made any statement regarding the enforcement of the Abortion Trafficking Ban, Plaintiffs’

attempt to show injury falters based on a more fundamental proposition of law: the Attorney General *has no authority* to threaten criminal prosecutions of the Abortion Trafficking Ban at this time. Under Idaho statutory law, “the primary duty of enforcing all the penal provisions of any and all statutes of this state, in any court, is vested in the sheriff and prosecuting attorney of each of the several counties.” Idaho Code § 31-2227. Thus, while the Attorney General is Idaho’s “chief legal officer,” he is not its chief law enforcement officer, *Newman v. Lance*, 922 P.2d 395, 399 (Idaho 1996), and county prosecutors do not answer to him. Idaho Code § 31-2604. In fact, Idaho law previously allowed the Attorney General to “exercise supervisory powers over prosecuting attorneys in all matters pertaining to their duties,” *Newman*, 129 Idaho at 102, 922 P.2d at 399, but the Legislature struck that provision in 1998, limiting the Attorney General’s criminal enforcement authority to the ability to “assist the prosecuting attorney” in each respective county. *State v. Summer*, 139 Idaho 219, 224, 76 P.3d 963, 968 (Idaho 2003).

The Attorney General recently explained and clarified these principles in a formal opinion construing the limits on his own prosecutorial powers. Att’y Gen. Op. 23-1 (April 27, 2023). As he explained, he has prosecutorial authority only “if requested by county prosecutors and approved by a state district judge” or “if specifically conferred by the Legislature.” *Id.* at 2. That definitive construction of the limits of his own powers supersedes the Ninth Circuit’s interpretation of Idaho law in *Parenthood of Idaho, Inc. v. Wasden*, 376 F.3d 908 (9th Cir. 2004), which held that the Attorney General was a proper defendant to a challenge to the State’s

abortion laws.² And neither of the two conditions for the Attorney General’s prosecutorial authority—referral by a county prosecutor or a specific legislative grant—are met here.

First, no county prosecutor has referred any case under the Abortion Trafficking Ban to the Attorney General, and Plaintiffs do not allege otherwise. The Attorney General would not have referral authority to prosecute violations of this statute unless there were a specific case considered by a specific county prosecutor who asked the Attorney General for help. Plaintiffs do not allege that such a case exists. They want to violate the law, sure enough, but they do not allege any specific circumstances in which they intend to do so. Nor have they sued any of the county prosecutors who would have direct prosecutorial authority if they did violate the law. Instead, they have only sued the Attorney General, whose purely derivative authority has not yet been triggered.

Second, the limited legislative grant of prosecutorial authority to the Attorney General under the Abortion Trafficking Ban has not been triggered here. *See* Att’y Gen. Op. 23-1 at 2–3. That limited authority is still contingent on actions by county prosecutors: he “has the authority, at [his] sole discretion, to prosecute a person for a criminal violation of this section *if the prosecuting attorney authorized to prosecute* criminal violations of this section *refuses to prosecute* violations of any of the

² Judge Winmill ruled to the contrary in *Planned Parenthood v. Labrador*, but refused to consider the effect of the Att’y Gen. Op. 23-1 in construing the limits of his own authority. Case No. 1:23-CV-00142-BLW, Slip. Op., 2023 WL 5237613 (D. Idaho August 15, 2023), Judge Winmill’s decision is now on appeal to the Ninth Circuit.

provisions of this section by any person *without regard to the facts or circumstances.*” Idaho Code § 18-623 (emphasis added). Thus, the Attorney General does not have any prosecutorial authority unless a county prosecutor first refuses to exercise his or her authority. Plaintiffs have alleged no facts that indicate that *any* prosecutor in Idaho has so refused to enforce this section of code. Indeed, none have. The Attorney General thus lacks any prosecutorial authority under the Abortion Trafficking Ban at this time.

Because the Attorney General would have authority under this statute only based on actions of county prosecutors that have not yet occurred, he is not a proper defendant under *Ex parte Young* and Plaintiffs have not alleged a justiciable controversy against him under Article III. There is no “special relation” between the Attorney General and the law as required to overcome sovereign immunity, *Los Angeles Cnty. Bar Ass’n v. Eu*, 979 F.2d 697, 704 (9th Cir. 1992), much less “a ‘genuine threat of imminent prosecution’” by the Attorney General as required for ripeness. *San Diego Cnty. Gun Rts. Comm. v. Reno*, 98 F.3d 1121, 1126 (9th Cir. 1996) (citation omitted). The case is not fit for review because any individuals with whom the Plaintiffs intend to engage are not “identifiable” and the case presents no “concrete factual scenario” to which the law applies. *Thomas v. Anchorage Equal Rts. Comm’n*, 220 F.3d 1134, 1141 (9th Cir. 2000) (citation omitted); *Hodgers-Durgin v. de la Vina*, 199 F.3d 1037, 1044 (9th Cir. 1999). Plaintiffs have not shown any irreparable injury that warrants an injunction—in fact, they have not alleged any injury at all, and the Court lacks jurisdiction.

CONCLUSION

The Court should deny Plaintiffs’ motion for a temporary restraining order or preliminary injunction both on the merits and for lack of jurisdiction.

DATED: August 28, 2023

STATE OF IDAHO
OFFICE OF THE ATTORNEY GENERAL

By: /s/ Lincoln Davis Wilson
LINCOLN DAVIS WILSON
Chief, Civil Litigation and
Constitutional Defense

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on August 28, 2023, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system which sent a Notice of Electronic Filing to the following persons:

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Exhibit D

UNITED STATES DISTRICT COURT

DISTRICT OF IDAHO

SOUTHERN DIVISION

LOURDES MATSUMOTO, et al,	)	Case No. 1:23-CV-00323-DKG
	)	
Plaintiffs,	)	
	)	Boise, Idaho
vs.	)	September 14, 2023
	)	
RAUL LABRADOR, et al,	)	
	)	
Defendants.	)	
	)	
.	)	

VOLUME I OF I
MOTION HEARING
BEFORE THE HONORABLE DEBORA K. GRASHAM
UNITED STATES MAGISTRATE JUDGE

COURT RECORDER:

A. Tate
U.S. District Court

TRANSCRIPTION BY:

TAMARA A. WEBER, CSR
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Caldwell, Idaho 83606

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I N D E X

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1 (Proceedings begin.)

2 CLERK: All rise. The United States District Court for
3 the District of Idaho is now in session. The Honorable Debora
4 K. Grasham presiding.

5 COURT: Please be seated.

6 CLERK: The Court will now hear Case CIV23-233-S-DKG,
7 Lourdes Matsumoto versus Raul Labrador, et al. Counsel, please
8 state your appearances for the record beginning with counsel for
9 the plaintiff.

10 MS. OLSON: Yes. Thank you. Good afternoon, Your
11 Honor. Wendy Olson from Stole Rives, LLP, for the plaintiffs
12 along with my co-counsel Wendy Heipt and Kelly O'Neill who are
13 with the Lawyering Project and Jamila Johnson and Paige Suelzle
14 -- sorry, they're for Legal Voice. Jamila Johnson and Paige
15 Suelzle are with the Lawyering Project. Thank you, Your Honor.

16 COURT: Thank you.

17 MR. WILSON: Good afternoon, Your Honor. Lincoln
18 Wilson with the Idaho Attorney General's Office and here with my
19 Deputy Division Chief, James Craig, who will be presenting
20 argument today.

21 COURT: All right. Well, good afternoon, counsel. And
22 everybody, welcome. It's good to see you all here. I've been
23 (inaudible) your briefs so it's good to see some of the faces
24 that are behind these briefs.

25 All right. Counsel, as you know, this is the time set

1 for the hearing on plaintiffs' motion for temporary restraining
2 order or in the alternative for a preliminary injunction. It's
3 seeking to enjoin Defendant Labrador from enforcing Idaho Code
4 Section 18-623.

5 Counsel, I can assure you that I have spent a
6 considerable amount of time reviewing your briefs and your
7 submissions and I am familiar with your arguments presented here
8 today.

9 And so (inaudible) there's a lot to cover if we're
10 going to cover everything. My hope is that we don't have to
11 spend all day doing this and that we can cover what's most
12 important or specifically I'm going to be asking you to address
13 a couple of different issues that I see as particularly
14 important for the Court's consideration as I move forward.

15 Now, I know I've told or I've informed you that I'd
16 like to (inaudible) this argument to 30 minutes because I just
17 fear that this case could go on and on and on and we could keep
18 talking about it. Now, that said, I'm asking you questions.
19 I'll be giving you as much time as you need to answer those
20 questions but that is my hope to kind of get to the heart of the
21 matter and some of the key issues that are going to be presented
22 here today.

23 Now, as I said, the plaintiffs are here today
24 contesting the constitutionality of Idaho's criminal abortion
25 trafficking statute found in Idaho Code Section 18-623 which

1 went into effect on May 5, 2023.

2 Now, specifically the plaintiffs have asserted four
3 claims for relief in support of that argument that that statute
4 is unconstitutional. They claim that the statute is void for
5 vagueness under the due process clause of the 14th Amendment,
6 that this statute infringes on the fundamental right to both
7 inter and intrastate travel and then finally that the statute
8 violates the First Amendment and their right to freedom of
9 speech, expression and/or association.

10 The plaintiffs have filed a motion for the TRO or,
11 alternatively, for a preliminary injunction seeking to enjoin
12 just Defendant Labrador from enforcing the statute.

13 Now, as I mentioned, I had (inaudible) the submissions
14 in this case which are excellent and I want to commend both
15 parties for their excellent briefing on these very important
16 issues. I do want -- just in terms of the motion itself, the
17 plaintiffs have not addressed the travel inter or intrastate
18 arguments that they've asserted in their Complaint and rather
19 have focused on both the First Amendment and their due process
20 arguments.

21 Now, for purposes of today's hearing, you're free to
22 present the arguments that you think are most important for the
23 Court. There are a couple of key issues that should not be a
24 surprise to you that the Court is specifically interested in
25 hearing about from each of you.

1 The first relates to standing. Now, I see that the
2 plaintiffs have not (inaudible) Idaho's 44 elected prosecutors
3 in this case and I want the parties to specifically address the
4 effect, if any, of that decision on standing. And whether the
5 Court does issue a preliminary injunction, the Court's ability
6 to enjoin enforcement of the statute by (inaudible) prosecutors.
7 So standing is obviously something very essential to today's
8 argument.

9 And (inaudible) to the First Amendment and due process
10 arguments that have been presented, I want the parties to
11 address and answer the question very simply put does the statute
12 regulate speech, expression and association or is it just
13 conduct? That seems to be central to both of your arguments.
14 I'd like you to go into that and then specifically once you give
15 me your positions what I don't think is going to be a surprise
16 to this Court, I would like you to address the standard that
17 applies to the Court's consideration of the issue given your
18 stance on that. And then I'd also like the plaintiffs to talk
19 about whether or not the challenge is statute as applied or
20 facially. So that is as to the First Amendment.

21 As to the due process, the big argument there is
22 whether or not the statute is vague. And so, again, I'd like
23 the parties to specifically look at that. I may have specific
24 questions or examples that highlight the Court's questions in
25 that area and it will come up but I hope that we can keep this

1 not all day, this argument, even though I think they're very
2 interesting arguments and we could be here but hopefully we can
3 get right to the heart of the matter.

4 Ms. Olson, are you going to be arguing on behalf the
5 plaintiffs?

6 MS. OLSON: I am. Thank you, Your Honor.

7 COURT: Very well. Please proceed.

8 MS. OLSON: May it please the Court, as the Court
9 recognized, the plaintiffs here (inaudible).

10 COURT: Ms. Olson, hold on.

11 CLERK: I'm having difficulty with audio, Your Honor.

12 COURT: If you can remain just one second.

13 I'm sorry, Ms. Olson. Please proceed.

14 MS. OLSON: Thank you, Your Honor. And I think -- I
15 don't know if I need to start completely over again or if I
16 should start from where we left off.

17 COURT: You can go where -- I was following you. They
18 may not have heard you but --

19 MS. OLSON: Okay. All right. Well, Your Honor, I
20 wanted to take the opportunity to introduce the Court to the
21 plaintiffs in this case. The plaintiffs are organizations with
22 long histories of assisting pregnant persons seeking abortion
23 care, including minors, and an individual with a long history of
24 working with sexual violence survivors, including minors, and
25 with advocates who assist pregnant minors.

1 The plaintiff Lourdes Matsumoto who is here in the
2 courtroom is an attorney who works for a nonprofit that provides
3 emergency assistance, counseling and resources to victims of
4 domestic and sexual violence.

5 The Northwest Abortion Access Fund which has a
6 representation here today provides emotional, financial,
7 logistical, practical and informational assistance to pregnant
8 persons who may need or who may choose to obtain an abortion.
9 NWAAF is the only independent abortion fund in the Pacific
10 Northwest and covers the largest geographic area of any abortion
11 fund in the United States.

12 Its work includes booking and paying for bus tickets,
13 plane tickets and ride shares and providing volunteers to drive
14 patients to abortion appointments in states where abortion is
15 legal.

16 The Indigency Idaho Alliance is an Idaho nonprofit
17 organization that is centered around asserting the sovereignty
18 of indigenous people and there are representatives from the
19 Indigenous Idaho Alliance here today as well.

20 The Indigenous Idaho Alliance's work serves the five
21 tribes whose traditional, usual and accustomed lands encompass
22 territory within Idaho and whose traditional usual and accustom
23 lands are often recognized as transecting and incorporating land
24 within the United States/Canadian province -- provincial
25 boundaries of Washington, Idaho, Montana, Nevada, Utah, Wyoming,

1 California, British Columbia and Alberta.

2 They have coordinated the travel of pregnant people,
3 including minors, from locations across the region, including
4 Idaho, to and across state lines to access abortion where it is
5 lawful and they have provided a financial assistance. The
6 defendant, as he made clear in his opposition brief, sees these
7 people as criminals.

8 Your Honor, at the heart of plaintiffs' challenge is
9 their desire to engage in lawful and constitutional conduct and
10 to do so free from the threat of prosecution for engaging in
11 that lawful and constitutional conduct.

12 Your Honor, a fundamental and significant difference
13 between the parties and their understanding of this statute also
14 includes the understanding of where and whether abortion is
15 lawful reproductive health care and where it is a crime. The
16 plaintiffs well understand that abortion has been made a crime
17 in almost all instances by the State of Idaho. But it's also
18 undisputed, Your Honor, that abortion is lawful in Washington
19 and it is lawful in Oregon and it is lawful in the majority of
20 states in the country. And it's also undisputed that in
21 Washington and Oregon, minors, persons under the age of 18, can
22 obtain an abortion without a parent's consent.

23 Now, the Court asked about standing in this case and of
24 course standing has three components. Plaintiffs have to
25 demonstrate that they have suffered an injury in fact that is

1 concrete and particularized and actual and imminent. With
2 respect to that element of standing, we would submit the threat
3 of prosecution is precisely that. And then the second part of
4 that is the --

5 COURT: Ms. Olson, on that threat of prosecution, what
6 I hear the defendant saying is we haven't threatened anybody.
7 There's no specific threat out there and what I know they're
8 going to say is that we're not the ones to do it. It's going to
9 be the local prosecutors who are going to do it. And when and
10 only if they decide not to prosecute, not for looking at the
11 facts of the case but because they won't do it, then we'll have
12 the ability to step in and prosecute then. That's the threat of
13 prosecution but it's not an imminent threat. It's not something
14 that anyone has been threatened with at this point in time.

15 MS. OLSON: Well, Your Honor, I would submit that the
16 existence of the statute which has criminal penalties for
17 activities that our clients, the plaintiffs, have traditionally
18 engaged in where they're trying to engage in lawful conduct that
19 the statute itself and the notion that the -- you know, frankly
20 the defendant in this case was already given an opportunity to
21 say I'm not going to prosecute under that statute even while the
22 Court waited to hear this particular motion and he did not avail
23 himself of that.

24 And then, Your Honor, I think the question I
25 anticipated is the Court's real concern with standing is this

1 argument that they have made that the Attorney General is not
2 the appropriate defendant in this case. And I would submit to
3 Your Honor, first of all, that question has already been
4 addressed by the Ninth Circuit in the Wasden case from 2004 and
5 it was addressed by Judge Winmill I think just last month in the
6 decision that he issued with respect to the Planned Parenthood
7 versus Labrador case.

8 The fact that there is the ability for the defendant,
9 the Attorney General, to prosecute under this statute is
10 sufficient to find, first of all, the ex parte young exception
11 applies but also that there's that threat of prosecution.

12 There was -- and this Attorney General has made
13 statements that he would prosecute people who obtain abortions
14 in other states and I would submit, Your Honor, that's enough to
15 show that the threat is imminent and that this defendant is the
16 right defendant.

17 And I think the other question that the Court posed at
18 the outset was whether -- why aren't the other -- why aren't the
19 44 county prosecuting attorneys charged in this as well. Well,
20 there's several reasons for that. One, that's a lot more
21 defendants. That's a lot more expense in a lawsuit so that's 45
22 defendants instead of one. Second, Your Honor, the Attorney
23 General is the only one who can prosecute this case in any part
24 of the state. The individual district attorneys -- prosecuting
25 attorneys can only prosecute in their counties.

1 And I think, Your Honor, given the nature of the work
2 that plaintiffs do that they could be assisting a pregnant minor
3 or a pregnant person in any part of the state and any county of
4 the state, it would be difficult to predict where some event
5 that might trigger investigation and prosecution because it's
6 hard to know also what investigation and prosecution would be,
7 it would be hard to predict where that conduct would occur.

8 But it's the Attorney General who can do this at his
9 sole discretion so even if a county prosecutor said, "I don't
10 think this set of facts violates the statute," the Attorney
11 General could swoop in and say, "You know what? I have the
12 authority under the statute to do this," and he certainly hasn't
13 disavowed that at all, Your Honor.

14 And then just as a practical matter, Your Honor, I
15 would anticipate that the 44 county prosecuting attorneys in the
16 State of Idaho, if this Court were to enjoin enforcement of the
17 statute as to Attorney General Labrador, they would also, for
18 reasons it's unconstitutional, they being people who would
19 follow the law would also not prosecute under it.

20 COURT: And that's kind of -- this is a much later
21 question but let's just assume for that argument using that
22 right there, if the Court did issue an injunction as requested,
23 it's going to be just against the defendant, against Raul
24 Labrador. It will not be against the 44 prosecutors. So what
25 would prevent the prosecutors from enforcing this statute even

1 if the defendant is enjoined. And does that defeat basically
2 the ability for this Court to redress any harm that the
3 plaintiffs have alleged?

4 MS. OLSON: No, Your Honor, not at all. Again, for the
5 reason that if this Court were to enjoin Attorney General
6 Labrador, presumably the Court would enter an order that
7 explains its reasoning and the grounds that we have asked the
8 Court to do so on or that the statute is not constitutional and,
9 again, I would contemplate that those 44 prosecutors who have
10 followed that order from the federal court, otherwise it
11 wouldn't take much back to get into court with that particular
12 defendant so it's -- it is a remedy that addresses conduct that
13 the Attorney General could engage in at any part of the state
14 and I think it would have the effect of -- even though they
15 wouldn't technically be enjoined, it would be exceptionally
16 unlikely for someone else to prosecute and say, you know, it's
17 really constitutional when I do it. It was just when Attorney
18 General Labrador did it that it was unconstitutional.

19 COURT: No. And I follow that and I would hope that
20 any prosecutor in the state would follow valid decisions out of
21 any court but technical or not, I have no ability to enjoin any
22 of the 44 prosecutors, correct?

23 MS. OLSON: Understood, yes.

24 COURT: Okay. Very well.

25 MS. OLSON: That's not the relief that we requested

1 here --

2 COURT: All right.

3 MS. OLSON: -- Your Honor.

4 COURT: Thank you.

5 MS. OLSON: All right. And so, Your Honor, that's the
6 plaintiffs' position with respect to the questions that the
7 Court posed on standing. I think for a more detailed legal
8 analysis of why Attorney General Labrador is the correct
9 defendant, it's in our reply brief at the very end and it's in
10 detail in the Wasden case and in detail in Judge Winmill's
11 decision in Planned Parenthood versus Labrador.

12 So, Your Honor, sort of to go back to that place that I
13 was before I talked about standing, what the plaintiffs in this
14 case seek to do when they're engaged in the activity they want
15 to engage in is to provide assistance to pregnant people in
16 Idaho, including minors, who want to obtain a lawful abortion in
17 a place where it is lawful.

18 That assistance may take the form of providing
19 information about where abortion is lawful and it's abundantly
20 clear that providing information regarding lawful abortion is a
21 First Amendment right. In Bigler versus Virginia, the Supreme
22 Court overturned the conviction of a Virginia newspaper editor
23 for publishing advertisements about lawful abortion care in New
24 York. So that speech which is speech, not conduct, that speech
25 is protected by the First Amendment and it's a core component of

1 what plaintiffs do. And it's also a core component of what
2 18-623 attempts to criminalize.

3 So, Your Honor, I would submit that, for example,
4 recruiting. Recruiting is something that typically involves
5 talking to other people about an activity. Here, the activity
6 they would want to talk about is how to obtain lawful abortion.

7 When we talk about recruiting sort of generically, we
8 might talk about recruiting, you know, for a position on a
9 basketball team somewhere or a volleyball team somewhere. We
10 might talk about you're trying to bring somebody into our law
11 firm. That all involves direct speech, Your Honor. And that's
12 one of the activities that is prohibited under 623. We submit
13 that that's in violation of the First Amendment.

14 COURT: Ms. Olson, I understand that argument and that
15 is a straight forward argument but I see the defendants muddy
16 the water on that argument. They're saying, look, it's not just
17 providing information. It's providing information with the
18 intent to conceal an abortion from the parents or guardian of a
19 pregnant unemancipated minor which results in either an abortion
20 or obtaining the abortion-inducing drugs.

21 And so -- and they're saying, look, you can talk all
22 you want but really when you do it with that specific intent,
23 that's when we have the power to criminalize activities that
24 happen in our state. How do you respond to that?

25 MS. OLSON: Two things, Your Honor. When they talk

1 about with the intent to conceal, we would submit that that too
2 is vague under -- as it's written in the statute. And the way
3 they argue about it in their brief illustrates that it's a vague
4 term.

5 The phrase "intent to conceal," in and of itself, we
6 might try to figure out what that means but what they say it
7 means is that you didn't tell the parents. The parents don't
8 know. This statute is really about the parents' need to know
9 what their kid is doing.

10 There's two problems with that, Your Honor. So that's
11 different from the intent to conceal. I mean knowledge about
12 something is -- you're providing knowledge is different from
13 intending to conceal. And even in one of the examples the
14 defendants give in their brief, they talk about, well, you know,
15 maybe a prosecutor would have an argument that there was the
16 intent to conceal if you just didn't tell the parents.

17 But they didn't choose -- the legislature didn't choose
18 those words in the statute. They didn't say anything about
19 whether you have to tell or don't tell. They chose this phrase
20 "intent to conceal." But what they're telling us it means, at
21 least with respect to them prosecuting it, it means you didn't
22 tell the other person. They don't know about it. And that's
23 how they phrase their whole justification for this -- you know,
24 their parental rights compelling interest is the parent has the
25 right to know about the care of their kid.

1 The other reason, Your Honor, that you can't really --
2 that the speech is not relating to intent to conceal and is not
3 relating to the end result is the end result is not criminal
4 conduct. It's not one long crime. The end result is a lawful
5 abortion in a state where it is lawful. So I guess they're
6 criminalizing First Amendment speech because you didn't speak
7 enough to tell the parents that they need to know what their kid
8 is doing and then it's only part of the crime if -- that we call
9 the crime if the kid then goes and has the -- the minor has the
10 abortion.

11 So you can talk to people about something and you have
12 a First Amendment right I guess but if that person then goes and
13 gets an abortion, you really don't have a First Amendment right
14 to begin with.

15 So I think -- so I think it's -- I understand that
16 they're linking it up, Your Honor, but I don't think that's
17 really the way it would work and I don't think you can really
18 link speech with this, you know, vague specific intent and then
19 lawful conduct at the back end. There is -- there is no doubt
20 that this is lawful conduct at the back end. These are lawful
21 abortions.

22 COURT: And on that point, is that how you distinguish
23 the defendants' arguments that this is just like sex
24 trafficking? And so all these terms that have been used for
25 years and years and you yourself as U.S. Attorney enforced those

1 laws that that is the same. Are you saying, no, it's not
2 because at the end, it's not a crime that is being committed but
3 rather lawful conduct?

4 MS. OLSON: Absolutely, Your Honor. I spent, as the
5 Court knows, a long time prosecuting cases. Some of that
6 involved responsibility for sex trafficking statutes. There are
7 drug trafficking statutes. There's harboring a fugitive. And
8 the difference, Your Honor, is that in each of those instances,
9 these words are connected with what at the back end is clearly
10 other criminal conduct.

11 I mean you can have harboring a fugitive and when
12 you're harboring a fugitive and that person has committed a
13 crime, I mean you don't get to help people who commit crimes
14 hide out. But it's all about criminal activity.

15 When you have drug trafficking, when the drugs are
16 transported across state lines, it's the product that is illegal
17 and is being trafficked. Here, what they're saying -- I think,
18 you know, as we said in our brief, Your Honor, abortion
19 trafficking isn't a thing because abortion is lawful in the
20 places where these people are traveling to. It's not -- it's
21 not inherently criminal conduct.

22 In Idaho, as you know the Supreme Court said they
23 could, Idaho made it a crime. And in Washington and Oregon and
24 the majority of states, it's just not. And I think that's the
25 difference, Your Honor.

1 It's also, Your Honor, one of the problems when you
2 take words from one criminal statute and just drop them into
3 another criminal statute without thinking through the context
4 and why they would make sense in one criminal statute and why
5 they don't make sense in another criminal statute. Because,
6 Your Honor, the words "harboring," "recruiting" and
7 "transporting," that's not inherently criminal conduct.

8 I mean I'm going to drive to Portland, Oregon tomorrow
9 and take one of my daughter's dogs with us and we're going to
10 transport that dog across state lines. That transportation is,
11 you know, I don't think -- that is not inherently criminal
12 conduct, Your Honor. So it's not always that the terms that we
13 think might be everyday language, harboring, recruiting,
14 transporting, become ways to execute a crime.

15 The only ways they come to be executing a crime is if
16 the thing at the back end is criminal and that's why when you
17 have sex trafficking or human trafficking, that person is being
18 moved, harbored, recruited into something that is illegal and is
19 against their will. And you also have the human trafficking
20 sometimes they'll end -- ends up in labor trafficking or bring
21 somebody to work. You don't pay them. It's that kind of
22 activity but, again, abortion trafficking just isn't a thing,
23 Your Honor.

24 COURT: I understand that argument. Thank you, Ms.
25 Olson. One of the questions I had is to ask -- and I'm going to

1 ask each of the parties -- is what is their position on what is
2 the kind of speech that the statute prohibits? I understand the
3 providing of information. That is -- that is pure speech as
4 I -- just providing information. Truthful information. But the
5 statute doesn't just say recruiting. It says harboring and
6 transporting which involves some type of conduct. So even if
7 the statute only regulates conduct, does it still implicate the
8 First Amendment from your perspective?

9 MS. OLSON: It does, Your Honor. And for two reasons.
10 One, harboring and transporting may both involve expressive
11 conduct. It may also involve the First Amendment right to
12 association which is -- it's right there in the First Amendment
13 along with speech, same right. If an adult is driving a minor
14 in Idaho and, you know, they're clearly taking them in their
15 car, does that become transporting for purposes of 18-623? So
16 there's that associational right. With respect to harboring,
17 there would be an associational right.

18 If I have a pregnant minor in my home as a place for
19 them to stay perhaps before they travel to another state to have
20 a lawful abortion, does giving them that place to stay,
21 associating with them there, that's a First Amendment right.

22 And then I think, Your Honor, there's the expressive
23 conduct part of this and that's where the -- it's important to
24 know who the plaintiffs are and why I provided the Court that
25 description of the plaintiffs.

1 These are not people who once 18-623 was passed said,
2 you know, let's chin up a group and see if we can thwart the
3 State of Idaho. These are two organizations and an individual
4 who have long been involved in trying to help people access
5 lawful abortion including minors. And they're known for that
6 and when they provide that assistance, they are expressing
7 support for lawful abortion and access to lawful abortion.

8 COURT: I ask you what kind of speech it is because
9 there's different standards that the courts apply --

10 MS. OLSON: Right.

11 COURT: -- depending on the speech that's at issue. So
12 maybe you can address the standard that you think the Court
13 should be applying in this instance.

14 MS. OLSON: Well, Your Honor, I think the Court should
15 be applying strict scrutiny which would require then to show
16 that they have a compelling government interest that is narrowly
17 tailored to achieve that compelling government interest.

18 And the reason for that, Your Honor, is two-fold.
19 Certainly, Your Honor, pure speech, that is always strict
20 scrutiny and I think, Your Honor, probably the best discussion
21 of it that I found that sort of summarizes it well is in Holder
22 versus Humanitarian Law Project which we refer to in our brief.
23 It's 561 US 1 and there are some discussion there. The statute
24 was also challenged on vagueness and First Amendment grounds.

25 And there, there was a -- there was a speech part of

1 the whole thing and the Supreme Court said, look, people are
2 talking. That's speech so it's just not this intermediate
3 scrutiny that you get from O'Brien. And then later on when
4 they're discussing, you know, what standard applies, they get to
5 strict scrutiny. Now in that case, it's correct. The Court
6 said, you know, the government's compelling interest in
7 preventing terrorism, you know, justifies this particular
8 infringement on speech. It's narrowly tailored. It gets at
9 just those things because the speech is prohibited with groups
10 that are known to be terrorist groups. So that's I think, Your
11 Honor, why we look to strict scrutiny.

12 I would also say, Your Honor, the point I didn't touch
13 on yet on what kind of First Amendment violation there is or
14 infringement they were alleging, the statute also discriminates
15 by viewpoint and content. So only -- only if an adult, you
16 know, harbors or traffics -- excuse me, harbors or transports or
17 recruits a pregnant minor and then they end up getting abortion
18 care, we don't like that so we don't want you to express support
19 for abortion because the state disagrees with that. But it
20 doesn't prohibit any other sort of adult taking a pregnant minor
21 and harboring, transporting or recruiting, whatever those things
22 mean, across state lines to get prenatal care or to go to a
23 birthing center that's, you know, nicer in Ontario, Oregon, than
24 you have in Boise, Idaho or any other place. It's directly
25 aimed at this support for this speech about abortion care in

1 places where it's lawful.

2 And so for that reason, Your Honor, we think because
3 it's content based, viewpoint based, another reason the Court
4 has to provide -- has to apply strict scrutiny review, Your
5 Honor.

6 I think, Your Honor, hopefully we've covered the things
7 that the Court listed out at the beginning but I want to just
8 emphasize to the Court and it's in our brief -- you said you
9 looked at our briefs -- that the terms in the statute are --
10 violate the First Amendment and they're vague in part -- well,
11 in part because they were adopted sort of wholesale from some
12 other statute where it made sense. And then again to just
13 emphasize that here, we're talking about lawful conduct at the
14 back end and the state statute should not be able to get at that
15 kind of conduct by infringing on the First Amendment rights and
16 creating vagueness.

17 Your Honor, with respect to the state's asserted state
18 interest, there are a couple of things I want to touch on before
19 I cede the floor to Mr. Craig and would possible, if possible,
20 like to have some time for rebuttal, Your Honor.

21 The State's asserted compelling interest is that
22 parents have a right to know about care for their children. I
23 think that -- you know, that comes. That's one of the headings
24 out of their brief. And also, Your Honor, I think that's an
25 important interest and I think parents, there are case law --

1 there is case law that stands for the proposition that there are
2 certain things that the state can't interfere in when a parent
3 is trying to parent their child. And they rely on Troxel
4 versus Granville but that case didn't hold that parental rights
5 are unlimited. The (inaudible) there recognized that there are
6 situations where intervention in a family is warranted. And
7 courts really haven't extended that beyond visitation.

8 And again, Your Honor, the Court in Troxel was dealing
9 with a statute passed by the state that infringed on a parent's
10 right to provide care, custody and control of their child. So
11 the concern with the statute was that it infringed on those
12 parental rights. So it's those parental rights vis-a-vis state
13 action. That case doesn't stand for the proposition that the
14 state can pass statutes that give parents more rights than they
15 might otherwise have.

16 And Your Honor, also, with respect to how this parental
17 rights issue plays out in the State of Idaho, you know, as we
18 argued in our brief, it's a selective rationale. The same
19 legislature and the same session passed a statute that says,
20 "Guess what, parents, you don't have a right to provide gender
21 affirming care to your child." So that's -- apparently parents
22 need to know whether their child is going to cross state borders
23 to obtain lawful abortion care and they can maybe weigh in on
24 that.

25 But if it's trans -- if it's gender affirming care for

1 minors, sorry, parents, we know better than you do. And there
2 are plenty of places within Idaho Code that the legislature has
3 said minors do have the right to make certain medical decisions
4 for themselves. And we set those out on pages 13 and 14 of our
5 brief. Minors 14 or older can consent to medical treatment for
6 affordable, infectious, contagious or communicable diseases and
7 the consent of the parent -- parents or legal guardian of the
8 minor shall not be necessary. Minors 16 and older can request
9 drug treatment medical services.

10 COURT: Ms. Olson, I understand those line of cases as
11 minors have certain rights to do certain things even under Idaho
12 law. But we don't have a plaintiff that is a minor here
13 asserting to get those rights, to recognize those rights. I
14 understand that's part of the argument about why the state's
15 interest is maybe not as strong or in your view as valid as they
16 would otherwise do.

17 But in this instance, we're not having -- we don't have
18 a plaintiff that's saying, "Look, I'm 16 and I have a right to
19 get this information. I have a right to receive lawful
20 information, truthful information so that I can make choices
21 about my own care." That's not the case we have.

22 MS. OLSON: It's not, Your Honor. The Court is both
23 right on the law. There are absolutely -- minors absolutely
24 have those rights particularly with respect to free speech but
25 the plaintiffs here are not asserting any rights of the minors.

1 And the reason we bring this to the attention of the Court is
2 just to simply say this notion of parental rights that -- and
3 when they say that the parents have a right to know about care
4 for their children, again, first of all, that's not what the
5 statute says but it's also -- it's just not quite as complete
6 and absolute as they paint it to the Court in their argument,
7 Your Honor.

8 And so we would submit that because this asserted state
9 interest is not -- is narrowly tailored to the right they assert
10 which is to know if my kid's going to get an abortion, then it
11 means it failed strict scrutiny analysis, Your Honor.

12 And so, Your Honor, with all due respect to the
13 legislature and learned honored counsel on the other side, it's
14 plaintiffs' position that Idaho Code 18-623 is not about the
15 state's compelling interest in parents having a right to know
16 about care for their children. It's about the state seeking to
17 criminalize abortion care that is provided in states where it is
18 lawful.

19 And it is about a statute that infringes on the rights
20 of these plaintiffs to speak freely about that abortion care in
21 another state, to provide resources to people who seek abortion
22 care in another state, whose donors express their First
23 Amendment rights by providing funding to these organizations to
24 support lawful abortion.

25 And, Your Honor, because that infringes on plaintiffs'

1 First Amendment rights and because there is not a compelling
2 state interest that is narrowly tailored in this case, we would
3 ask the Court to enjoin its enforcement. And we'll rest on our
4 briefs, Your Honor, for the other three portions of the standard
5 for a preliminary injunction or TRO.

6 COURT: Thank you, Ms. Olson. All right. Mr. Craig.

7 MR. CRAIG: Thank you, Your Honor. It's a privilege to
8 represent the State of Idaho, the Attorney General and appear in
9 front of Your Honor, so thank you.

10 COURT: You're welcome.

11 MR. CRAIG: This case is not about abortion. This case
12 is about parental rights and who has the authority to make
13 decisions concerning the care, custody and control of minor
14 children.

15 I think the question presented in this case is really
16 quite simple. Does an uninterested third party have a
17 constitutional right to procure a medical procedure for a minor
18 with the intent to conceal that medical procedure from the
19 minor's parents or guardian?

20 If we are talking about any other medical procedure
21 other than abortion, we wouldn't be here to even talk about it
22 because the answer would be so clear. Can an uninterested third
23 party take a minor to procure a tonsillectomy for the minor with
24 the intent to conceal that tonsillectomy from the minor's
25 parents? Of course not. Can an uninterested third party take a

1 minor to one of the neighboring states where medical marijuana
2 is legal to obtain medical marijuana for a minor child with the
3 intent to conceal that provision or the obtaining of the medical
4 marijuana for the child from the parents? Of course not.
5 There's nothing about abortion that changes that context or that
6 standard.

7 The plaintiffs, as we've just heard, are trying to make
8 this case about abortion talking about how the State of Idaho is
9 trying to criminalize abortion in other states and in their
10 brief, they use the word "oppressive." They refer to Idaho's
11 abortion laws as the oppressive abortion laws. They argue that
12 this statute, Idaho Code 18-623, quote, criminalize conduct by
13 adults who assist pregnant minors in receiving abortion care.

14 But the statute does no such thing. Under Idaho Code
15 18-623, minors can still get an abortion in another state. The
16 plaintiffs can still help minors get an abortion in another
17 state.

18 In fact, in some circumstances, minors can even get an
19 abortion legally in the State of Idaho. What the plaintiffs
20 cannot do is procure an abortion for a minor or obtain an
21 abortion-inducing drug by recruiting, transporting or harboring
22 a minor with the intent to conceal that abortion from the
23 minor's parents.

24 COURT: One second, Mr. Craig. I want to make sure I'm
25 following you here. You said that the plaintiffs could help

1 minors get an abortion in another state but what they can't do
2 is -- basically cited the statute. I think what plaintiffs are
3 arguing is trying to figure out where assistance turns into
4 illegal or prohibited activity under 18-63 (sic) is not defined
5 and is just telling a minor you can go to Oregon where abortion
6 is provided legally and you can seek those services in Oregon.
7 Is providing that information, does that amount to recruiting
8 even if they have the intent to keep it from their parents?

9 MR. CRAIG: Well, that's where you can go through all
10 the elements of the statute. One, did they procure an abortion
11 for a minor child or did they obtain an abortion-inducing drug
12 for the minor child? If they're simply talking about an
13 abortion in another state, that it is legal in another state,
14 are they procuring the abortion for that child? No, they're
15 not. They're not obtaining the abortion for that child in
16 another state if you're just giving information about what is
17 legal in another state.

18 COURT: So okay. I'm trying to figure out where this
19 is because you're saying just providing information -- truthful
20 information about where minors may go to obtain an abortion
21 lawfully, that doesn't fall within 18-623. Okay.

22 MR. CRAIG: That's correct.

23 COURT: So we got that as a standard. Just providing
24 that information. So there must be something more. There's got
25 to be more than just providing truthful information. There's a

1 clinic in Ontario, Oregon where you can seek legal abortion
2 care. That's not enough. So what more? Now, again, let's just
3 presume that whoever's assisting that minor has the intent to
4 keep it from the parents. So what is the activity then that
5 then triggers 18-623?

6 MR. CRAIG: So I will go through some hypotheticals
7 that I think will meet that. But first, I think it's clear that
8 when we're talking about vagueness standard that, you know, the
9 Supreme Court has said we can always come up with hypotheticals
10 to muddy the water and make it unclear and all that. That's not
11 the standard for determining whether it's vague or not. But
12 what we'll assume, that the plaintiffs intend to conceal an
13 abortion from the minors. Now, that is bad --

14 COURT: From the parents.

15 MR. CRAIG: Or from the parents. Thank you. Now,
16 that's bad enough but if they're intending to conceal abortion
17 from the minor's parents and they, for example, transport the
18 minor to an abortion facility in Oregon or Washington or any of
19 the other places and pay for the abortion for example. I think
20 that would clearly violate the statute. They're procuring the
21 abortion by transporting the minor to the other state with the
22 intent to conceal it from the minor's parents.

23 COURT: And then tell me about the intent to conceal.
24 You heard Ms. Olson talk about -- and I saw in their briefing
25 that they take issue with those words. The statute says, "With

1 the intent to conceal an abortion from the parents." So -- and
2 I think the plaintiffs have raised a couple of questions about
3 when you were describing that in your brief how it wasn't just
4 intent to conceal. But is not telling the parents not enough?
5 Is it just not seeking the parents to be involved in it and just
6 kind of passively just not even asking the minor child, "Do your
7 parents know about this? Do we need to --" just providing that
8 without asking the question do your parents know, do we need to
9 do that, is that intent to conceal?

10 MR. CRAIG: So Idaho law requires there to be a union
11 of act and intent obviously for there to be a prosecution and a
12 criminal conviction and Idaho statutes -- case law when you're
13 talking about an intent, a specific intent, you look at the
14 totality of the circumstances and so you'd have to evaluate the
15 totality of the circumstances as to what their actions are.

16 Are they taking steps to affirmatively conceal it from
17 the parents? You know, for example, not allowing the minor
18 child to call the parents or, you know, transporting them
19 immediately without giving them an opportunity to consult with
20 their parents, some of those, that's what you would all consider
21 as part of the totality of the circumstances.

22 COURT: So there's got to be an affirmative action.
23 Something affirmative on the plaintiffs to not inform the
24 parents. Not just I'm not going to tell them, I'm not going to
25 ask about them but I'm going to affirmatively prevent that minor

1 or I'm not -- I'm affirmatively choosing not to inform the
2 parents.

3 MR. CRAIG: Again, you have to look at all of the
4 totality of the circumstances. I think that there could be
5 situations -- and again, we're getting into the hypotheticals
6 that the Supreme Court warned us against getting into the
7 hypotheticals.

8 COURT: Well, vagueness -- I mean the whole point about
9 vagueness is it's supposed to give people, you know, fair notice
10 of what they're going to be held criminally accountable to. So
11 if there's not a clear answer about what is intent to conceal or
12 if you guys have a different interpretation of what that means,
13 it's worth asking. It's what does that mean? I'm asking you
14 what does that statute intent to conceal mean? What is required
15 to hit that?

16 MR. CRAIG: Well, the intent to conceal, I mean I'm
17 just going to repeat the statute because it's plain. Means an
18 intent to conceal from the parents and so, again, you'd look at
19 the totality of the circumstances. Did they try to inform the
20 parents or not? Do they have a pattern in over and over and
21 over again of purposely not informing the parents? Did this
22 child have an opportunity to talk to the parents but the
23 plaintiff took that away from the child? Again, you look at the
24 totality of circumstances in all those things.

25 Now, to directly answer your question, is simply not

1 informing the parents by itself an intent to conceal, if that's
2 all you have, probably not. But it's very unlikely that in any
3 case that that's going to be all that you have.

4 COURT: Okay.

5 MR. CRAIG: So again, the plaintiffs are calling this
6 an abortion travel ban and they're talking about Idaho Code 623
7 criminalizing conduct but, as we just talked about, it doesn't
8 criminalize abortion. It doesn't criminalize the ability of a
9 minor to get an abortion. It doesn't criminalize the ability of
10 the plaintiffs to transport a minor somewhere to get an
11 abortion.

12 And so they're asking the Court to rule on a statute
13 that does not exist and they're asking the Court to declare
14 unconstitutional a statute that the legislature has not passed
15 because it does not prohibit a minor from getting an abortion.
16 It does not prohibit the plaintiffs from helping a minor get an
17 abortion.

18 COURT: Well, to an extent, right? So you just said it
19 doesn't prohibit the plaintiffs from helping a minor get an
20 abortion. Isn't exactly what this is supposed to be done?

21 MR. CRAIG: Only if they do it with the intent to
22 conceal that abortion from the parents.

23 COURT: So if the parents know about it, it's okay?

24 MR. CRAIG: Yes, because that would defeat -- well, for
25 two reasons. One, it would likely defeat the intent to conceal

1 from the parents and then, two, that's also an affirmative
2 defense to the statute as well.

3 COURT: And I think you just said that the statute
4 isn't making abortion illegal. I don't think that's what the
5 plaintiffs have argued. I think what they're arguing is exactly
6 the opposite. That you're criminalizing protected conduct that
7 is related to First Amendment speech and associational rights.
8 So let me ask you that question I started at the beginning,
9 Mr. Craig.

10 MR. CRAIG: Sure.

11 COURT: What kind of speech is at issue in this case?

12 MR. CRAIG: There is no speech at issue in this case
13 because the statute does not affect speech. It affects conduct.
14 You look at the five elements of the statute. The adult must
15 procure an abortion or obtain an abortion-inducing drug for a
16 pregnant unemancipated minor. That's conduct. Procuring an
17 abortion or obtaining an abortion inducing drug, that's conduct.

18 They then must do that by -- so the next part,
19 recruiting, harboring or transporting is kind of a subcomponent
20 of the procuring or obtaining abortion. They have to procure
21 the abortion by recruiting, harboring or transporting the
22 pregnant minor within the State of Idaho.

23 Again, recruiting, harboring and transporting is
24 conduct. It's conduct that's used in statute after statute by
25 the federal government, by the State of Idaho, by the state --

1 by the (inaudible) states, probably every state in the union
2 uses that language. Recruit, harbor or transport.

3 COURT: Well, two questions about that, Mr. Craig. So
4 recruiting, how do you recruit without speech?

5 MR. CRAIG: Well, there's a number of different ways
6 but case law also makes it clear that conduct is not governed by
7 First Amendment free speech standards just because you have to
8 use speech to engage in that conduct. That doesn't --

9 COURT: I get that. I know those line of cases but I'm
10 just trying to figure out how do you recruit someone without
11 speech?

12 MR. CRAIG: Well, again, it could be through speech.
13 It could be through your actions in terms of offering rides to
14 people to abortion clinics. That could be recruiting. It could
15 be paying for the abortion in other states. That could be
16 recruiting as well. So there's a number of different ways that
17 you can recruit without speech in addition to using your speech
18 and not under the First Amendment speech because of the case, it
19 says using speech for conduct is not speech. But you could also
20 talk to people. Hey, I can get you an abortion. Let's go get
21 you an abortion as well.

22 COURT: Mr. Craig, respond to the plaintiffs' argument
23 that because of the particular plaintiffs at issue in here, it's
24 not just speech. It's their associational rights. That they
25 have this interest as reflected in their members to associate

1 with these individuals to provide support for them in those
2 situations and to assist them in making those tough life
3 decisions. How do you respond to that aspect of their speech
4 argument?

5 MR. CRAIG: Well, under Idaho Code 18-623, they can
6 still associate with anyone they want to. They can still
7 associate with pregnant unemancipated minors. They can still
8 associate with members of their organizations. They can still
9 take pregnant unemancipated minors across state borders to get
10 an abortion in another state. So it doesn't prohibit any of
11 that association. What it prohibits -- and you're probably
12 going to get sick of me saying this. It prohibits them taking
13 those actions with an intent to conceal the abortion from the
14 parents.

15 Now, state -- U.S. Supreme Court case law and Idaho
16 Supreme Court case law is clear that the right of association
17 does not extend to joining with others to deprive third parties
18 of their rights. And in this case, as I stated in the
19 beginning, this case is not about abortion. This case is about
20 protecting the parental rights.

21 It is clear that in Idaho, in the U.S. Supreme Court
22 and in the Ninth Circuit, the parents have a fundamental right
23 to make decisions concerning the care, custody and control of
24 their children. And in fact, America legal tradition has a
25 presumption that the minor's parents are going to act in the

1 best interest of their child and that they're going to use the
2 wisdom that they have for their life experience and this unique
3 knowledge that they have as the child's parents to make a
4 decision in the best interests of the children.

5 COURT: Mr. Craig, I think that is a very important
6 interest for the state and for parents to be able to raise their
7 children and to raise them the way that they think and to be
8 involved with their families. Now, what the plaintiffs have
9 said is unfortunately not every minor has the ideal situation
10 and they're in places where they can't rely on their families.

11 The one question I wanted to push back on you,
12 Mr. Craig, is you keep telling me that 1863 (sic) is not about
13 abortion and while it doesn't prohibit abortion because it's
14 already prohibited in this state, the only thing it relates to
15 in terms of speech and conduct is if it results in an abortion.

16 It doesn't say parents are supposed to be provided with
17 information any time a child is seeking any type of medical --
18 medical intervention whatsoever. It's specific to abortion. It
19 doesn't -- and I agree with you. Parents have a right to know.
20 But that's not what this -- this statute doesn't say parents
21 have a right to know whenever their child is going to get any
22 kind of medical procedure. It says parents have a right to know
23 and we're singling out this one activity of abortion which is
24 legal in a different state but through the actions that
25 otherwise occur in Idaho to assist that minor in obtaining that

1 legal abortion.

2 So I understand that it's not prohibiting abortion but
3 it's all about abortion. It's all about activity related to
4 trying to prevent abortion in another state with a minor whose
5 parents don't know.

6 MR. CRAIG: With the plaintiffs acting with an intent
7 to conceal the abortion from the minors.

8 COURT: Right.

9 MR. CRAIG: So absolutely. Idaho Code 18-623 is
10 related to the abortion procedure. Absolutely. This case is
11 not about abortion though. This case is about parental rights.
12 The parental right to know when their kids, when their children
13 are undergoing a medical procedure, an abortion. The state
14 doesn't believe in most cases that abortion is an appropriate
15 medical procedure but that's what the plaintiffs are referring
16 to this, as a medical procedure.

17 So this is -- the statute absolutely applies to
18 abortion. This case is not about abortion though. This case is
19 about parental rights.

20 Now, the plaintiffs in their argument conceded that the
21 rights of parents in this case, the fundamental right of parents
22 to control the care, custody and control of their children is an
23 important interest. And so they have just conceded the first
24 element of the O'Brien standard. You were asking what standard
25 might apply. Well --

1 COURT: You're saying the O'Brien standard applies
2 because you're saying it's conduct, not speech, pure speech, so
3 we should apply the lesser standard.

4 MR. CRAIG: At most, the O'Brien standard should apply.
5 I actually think that this is not affected by the First
6 Amendment at all so you would apply rational basis. But at
7 most, you would apply the O'Brien standard with the important
8 interests. And the plaintiffs have conceded that that is an
9 important interest. That the first element has been met in
10 terms of that statute.

11 And so you simply have to look at, you know, the next
12 statute. I'll even argue the strict scrutiny standard that the
13 plaintiffs argue that it is narrowly tailored to further that
14 interest and it's narrowly tailored because of the specific
15 intent part of the statute.

16 The legislature could have written this as a general
17 intent crime. They could have written it as you can't help a
18 minor procuring abortion unless the parents consent to it or
19 without the parents' consent. That would have been a general
20 intent crime. They could have written it like that.

21 But instead, they narrowly tailored it. They narrowed
22 the statute by adding in the specific intent to conceal the
23 abortion from the minor's parents. That's a much tougher
24 standard for a prosecutor to meet in terms of the general intent
25 versus the specific intent.

1 And so they've narrowed it even further and so it meets
2 that narrow tailoring to further the government's important
3 interest of -- all right, I would even say compelling interest
4 of furthering parental rights in this case.

5 And you know, clearly, the government has the authority
6 to enforce these statutes, to impose the statutes. The U.S.
7 Supreme Court has stated that when we're talking about the
8 fundamental rights of some parents, state legislators have the
9 ability to pass laws to help protect those rights. They have
10 the ability to protect parental rights.

11 So the government has the authorized. It's an
12 important government interest and, again, I'll use the higher
13 standard of strict scrutiny and it's narrowly tailored to
14 further that important interest.

15 So even under the O'Brien standard or the lenient
16 standard that is the most the Court should apply, it meets that
17 for the First Amendment free speech.

18 COURT: Mr. Craig, I have a couple -- I just am looking
19 back at the statute and I made a note to myself that the statute
20 starts off with it's an adult --

21 MR. CRAIG: Correct.

22 COURT: -- who does this. So if the minor's
23 17-year-old boyfriend or best friend that's under 18 decides to
24 take that minor who's pregnant across state lines, provide
25 harboring, transport, support, all those things and purposely

1 doesn't want to tell mom and dad, they're not affected by this
2 statute.

3 MR. CRAIG: That's correct.

4 COURT: And then the other -- so I'm asking the
5 beginning of the end of no. 1. So at the end, there's this
6 sentence that I'm trying to get my head around. "As used in
7 this subsection, the terms 'procure' and 'obtain' shall not
8 include the providing of information regarding a health benefit
9 plan." I'm not entirely sure what that means but what I'm
10 concerned about is if the statute says that this does not --
11 providing of information for this purpose doesn't fall within
12 the statute, does that mean that everything else in providing
13 information does?

14 MR. CRAIG: I don't think so. I think by saying that
15 one thing is prohibited, it doesn't mean everything or one thing
16 is allowed that nothing else is allowed or prohibited. And I
17 think that that's actually a case that's not presented in this
18 situation. The plaintiffs aren't health care providers.
19 They're not planning on providing information about a health
20 care plan or anything like that. And so when you -- when the
21 Court's evaluating this case and the Court's asking about at the
22 beginning, is this a facial challenge or an as-applied challenge
23 and I think this is a good example. This is an as-applied
24 challenge.

25 Under the United States versus Salerno case, that

1 requires a facial challenge to show that there are no
2 circumstances in which the law's constitutional and the
3 plaintiffs haven't pled that. They've made no argument to that
4 so this is clearly an as-applied challenge and as applied to
5 their circumstances, that provision of the statute is
6 inapplicable because they're not a health care plan. They're
7 not talking about providing information about a health care
8 plan.

9 COURT: I'm sorry. If I miss -- I'm probably mis-
10 communicating this. I'm not suggesting that the plaintiffs are
11 claiming that they're a health benefit plan. I'm trying to look
12 at it from the vagueness perspective what all of this means and
13 what does "procure" and what does "obtain" and what does
14 "providing of information" mean? What is allowed? What isn't
15 allowed? Those are the words of the statute.

16 MR. CRAIG: Correct.

17 COURT: This is the one place where the statute tells
18 me what they think providing of information means or doesn't
19 mean and is allowed. And it tells me here that it shall not
20 include providing information regarding a health benefit plan.
21 It specifically for whatever reason called that out.

22 MR. CRAIG: Correct.

23 COURT: So that's not included. But does that mean
24 that any other information that's provided could constitute
25 procure and obtain which is pure speech? Providing of

1 information. That's why I'm asking.

2 MR. CRAIG: Right, right.

3 COURT: I'm not claiming that the plaintiffs are a
4 health benefit plan but I'm looking at the statute and trying to
5 grapple with is it vague? Are the terms defined? What did the
6 legislature mean?

7 MR. CRAIG: Yeah. So by itself, providing information
8 about an abortion with nothing else going along with it, would
9 not be procuring an abortion, no.

10 COURT: Okay. Very well.

11 MR. CRAIG: So the Court has also asked what is
12 essentially the burden of proof in this case and that was one of
13 the questions at the beginning is what -- what burden should be
14 applied in this case and, you know, the standard for preliminary
15 injunction is pretty clear. That the plaintiff has the
16 burden -- the quote from the (Inaudible) vs. U.S. Immigration
17 Customs Enforcement case is that a preliminary injunction is an
18 extraordinary and drastic remedy, one that should not be granted
19 unless the movant by a clear showing carries the burden of
20 persuasion. So they have this burden of showing by clear
21 showing that they are entitled to it.

22 And when you look at what we have here, they haven't
23 met that burden. They have not shown that this statute violates
24 their First Amendment free speech rights or their free
25 association rights. Even if this statute affects speech, we

1 have a fundamental right of the parents to control the care and
2 custody of their children. And the plaintiffs concede that that
3 is an important right and it is narrowly tailored to further
4 that right.

5 Now, when we're talking about the balance of equities
6 and public interest, I think that concession regarding the
7 importance of the parents' fundamental rights is critical
8 because the fundamental right of a parent is one of the oldest,
9 if not the oldest of the fundamental rights recognized by the
10 Supreme Court. It existed decades before Roe v. Wade was ever
11 decided and it still stands today after Roe v. Wade has been
12 overturned.

13 This is an extremely important fundamental right of a
14 parent and when we're talking about the plaintiffs who want to
15 interfere with the rights of a parent to know about the medical
16 procedures of their kids, the balance of equities has to tip in
17 favor of the parents. The parents are the ones who are presumed
18 to know -- to act in the best interests of the parents. There's
19 no presumption that the plaintiffs are going to act in the best
20 interests of somebody else's children.

21 And in fact, the law -- any such presumption would not
22 be viable. Plaintiffs don't know the situation of children,
23 their medical history, their mental health history, their
24 psychological history. All those things that a parent will know
25 that a parent will be able to apply.

1 Now, the plaintiffs will say, well, sure. That's fine.
2 But then some parents will actually abuse or neglect their kids
3 and for that reason, they should be able to act as an entrusted
4 adult. Well, Idaho statute already has a comprehensive scheme
5 for dealing with those cases and that starts with a phone call
6 to the Idaho Department of Health & Welfare or the local law
7 enforcement to report their reasonable belief about the abuse or
8 the neglect or the abandonment.

9 It doesn't involve the plaintiffs deciding whether a
10 parent is fit and then taking it upon themselves to conceal
11 information from the parents. That involves a trusted adult.
12 The Department of Health & Welfare, the police, the law
13 enforcement and, in appropriate circumstances, the courts
14 through a Child Protection Act.

15 So the balance of equities in this case has to fall in
16 favor of the parents and the parental rights in determining what
17 is the best interests of their children.

18 So you'd asked at the beginning about standing so if
19 the Court's okay, I'll move on to the standing argument.

20 COURT: That will be great. Thank you, sir.

21 MR. CRAIG: And the Court's specific question was
22 whether -- how they should be affected that the plaintiffs did
23 not name all 44 of the county prosecutors. And frankly, that's
24 fatal to their case, fatal to their standing in this case. And
25 that's simply because the Attorney General has no authority at

1 this time as it stands today to prosecute violations of this
2 statute. In fact, the Attorney General has specifically
3 disavowed his authority to prosecute without a referral from a
4 prosecuting attorney. And that goes both to standing and the
5 Attorney General's 11th Amendment immunity.

6 Now, the plaintiffs write in their reply brief, quote,
7 defendant Raul Labrador acknowledges in his opposition that he
8 intends to prosecute plaintiffs for exercising their First
9 Amendment rights to assist pregnant Idaho minors obtain lawful
10 abortion in neighboring states. That's the exact opposite of
11 what the Attorney General wrote in his brief.

12 On page 26 of his brief, the Attorney General wrote,
13 quote, the Attorney General has no authority to threaten
14 criminal prosecutions on the abortion trafficking ban. Now, if
15 that wasn't clear enough, on page 38, the Attorney General wrote
16 that, quote, he lacks any prosecutorial authority under the
17 abortion trafficking ban at this time.

18 COURT: And I see "at this time" which means the AG has
19 authority in limited circumstances to do these prosecutions so
20 he doesn't have no authority. He has some authority and isn't
21 that enough under the Wasden case and more recently Judge
22 Winmill of this court's decision saying that that's enough. And
23 in Judge Winmill's case, you didn't even have the language that
24 we have here in 623 that does give the Attorney General
25 authority to prosecute when the local prosecutor declines to do

1 so. So how is that not enough under either Wasden or Judge
2 Winmill's most recent decision?

3 MR. CRAIG: So the Wasden case uses language and Judge
4 Winmill quoted the exact same language so his decision is based
5 on that same language from Wasden that the Attorney General can
6 essentially -- and this is the language, quote, deputize himself
7 to prosecute cases. So the Ninth Circuit decision was based
8 upon the assumption that the Attorney General can deputize
9 himself or the governor can deputize him to go forward. The
10 Attorney General has specifically disavowed that authority and
11 said I have no authority to deputize myself. That's what the
12 Attorney General has said. That the only way he can come in and
13 prosecute these cases is with a referral from the prosecuting
14 attorney or in those limited circumstances in 18-623(4) where a
15 prosecuting attorney refuses to prosecute the violations without
16 regard to the facts or circumstances.

17 So that's not just looking at a case and saying, I
18 don't think this person has met the elements of the crime beyond
19 a reasonable doubt so I'm not going to go forward. That's a
20 prosecutor saying I'm never going to prosecute any violations of
21 this statute under any circumstances.

22 The plaintiffs have not alleged that those
23 circumstances are present here and there are none of those
24 circumstances. No prosecutor has referred one of these cases to
25 the Attorney General and there's no evidence that it has. And

1 so because of that, the Attorney General has no authority to
2 deputize himself to prosecute these cases.

3 And so at the time when Wasden was decided, the Ninth
4 Circuit believed that the Attorney General could deputize
5 himself. That's the language right in that statute. The
6 Attorney General has disavowed that authority and says I don't
7 have the authority to deputize myself and therefore the Attorney
8 General's not the proper defendant. He still enjoys the 11th
9 Amendment immunity in this case and the plaintiffs lack standing
10 in that situation.

11 COURT: So Mr. Craig, I appreciate the Attorney
12 General's opinion on his authority. This Court is governed by
13 the Ninth Circuit and the U.S. Supreme Court unless and until
14 that authority is overruled. And so I appreciate that but I am
15 bound to follow the law right now. And the law as I said is the
16 Wasden case and most recently is Judge Winmill's. I realize
17 that's up on appeal as well, sir.

18 MR. CRAIG: Correct.

19 COURT: And so of course I'm going to look at that but
20 I can tell you what is binding on this Court is the Ninth
21 Circuit and the U.S. Supreme Court decisions on that area.

22 MR. CRAIG: Right. And in the Ninth Circuit case in
23 Wasden, you did not have the situation where the Attorney
24 General specifically disavowed that authority so that's what
25 distinguishes this from Wasden. I'm not saying you're not bound

1 by Wasden or not saying that you're not bound by the Ninth
2 Circuit case. I'm saying that the situation is different now
3 because the Attorney General has specifically disavowed that
4 authority to deputize himself and that's what was critical to
5 the holding in the Wasden case.

6 COURT: I understand. Thank you, Mr. Craig.

7 MR. CRAIG: So to conclude, I just want to make a final
8 point about the plaintiffs' likelihood of success on the merits
9 and I think this also goes to the balance of equities.

10 So in this case, the plaintiffs challenged only Idaho
11 Code Section 18-623. But Idaho Code 18-623 is but one statute
12 in a suite of numerous statutes that Idaho has passed that's
13 designed to protect and uphold parental rights and make
14 decisions concerning the care, custody and control of their
15 children.

16 So if they have a constitutional right to violate the
17 parental rights like they're arguing that they do in this case
18 and if the Court issues the injunction that they're requesting
19 against Idaho Code 623, then the Court needs to ask the question
20 do they have a constitutional right to violate Idaho's other
21 statutes relating to parental rights that they have not
22 challenged but their actions also violate that they have talked
23 about.

24 You know, in our brief in opposition to the plaintiffs'
25 motion, we talked about child custody interference. Idaho Code

1 18-4506 and the plaintiffs acknowledge that in their reply brief
2 and say, well, but the Attorney General didn't talk about the
3 kidnapping statute. And the reason the Attorney General didn't
4 talk about the kidnapping statute they speculated was because
5 that required somebody to be held against their will.

6 Well, what the plaintiffs did not do is then, quote,
7 the second subsection of the kidnapping statute, subsection 2,
8 which makes it illegal to, quote, lead, take, entice away or
9 detain a child under the age of 16 years with intent to keep or
10 conceal it from its custodial parent, guardian or other person
11 having lawful care or control thereof.

12 So if they have the right to act with an intent to
13 conceal an abortion from the minor's parents in this case and to
14 transport the minor with the intent to conceal that abortion,
15 does that then call into question the constitutionality of the
16 kidnapping statute?

17 We have Idaho Code Section 18-1510, providing shelter
18 to a runaway child, which makes it illegal to, quote, knowingly
19 and intentionally provide housing or other accommodations to a
20 child 17 years of age or younger without -- without the
21 authority of, A, the custodial parent or guardian of the child,
22 B, the State of Idaho or a political subdivision thereof or, C,
23 the one having legal custody of the child.

24 The plaintiffs have already mentioned in their briefing
25 and in the Complaint and in their declarations an intent to

1 violate this. That they want to provide shelter to children
2 going to get an abortion without the knowledge of the parents.
3 That's a violation according to what they're saying in their
4 Complaint of providing shelter to a runaway child, 18,
5 section -- Section 18-1510. So if they have a constitutional
6 right to violate 18-623, do they have a constitutional right to
7 violate 18-1510.

8 And then we also have Idaho Code Section 16-1605,
9 subsection 1, which requires people to make a report to law
10 enforcement or the Department of Health & Welfare if they have a
11 reason to believe that a child has been abused, neglected or
12 abandoned.

13 Now, the plaintiffs say that many of the children that
14 they help, they have reason to believe that they were subjected
15 to abuse, neglect or abandonment but nowhere do we see in their
16 complaint or in their declarations or in their memos that they
17 have complied with their obligation to report that to the
18 Department of Health & Welfare or to local law enforcement.

19 So if they have the right to violate 18-623 as they're
20 talking about in this situation, do they have the right to
21 withhold that information from the Department of Health &
22 Welfare or from local law enforcement contrary to Idaho's Child
23 Protection Act.

24 So the plaintiffs described actions in their case
25 violate numerous Idaho statutes. Statutes which they have not

1 challenged in this case. So they're coming before this Court as
2 a court of equity asking the Court to grant them equitable
3 relief while indicating and providing information that they want
4 to violate numerous Idaho statutes that are not before this
5 Court.

6 This indicates that, one, they're not likely to succeed
7 on the merits and, two, I think the Court then has to question
8 whether they're coming to the Court with clean hands given their
9 stated intention to violate all these other statutes.

10 If the Court grants the plaintiffs their request for
11 relief, it calls into question the constitutionality of the run-
12 away statute, Idaho Code 18-1510; the kidnapping statute,
13 18-4501; the child custody interference statute, 18-4506, and
14 probably numerous other Idaho statutes.

15 COURT: Mr. Craig, you were coming down to the end here
16 and I think we've hit the 30-minute mark but I've given both
17 parties plenty of time because I want to make sure we get the
18 questions answered.

19 MR. CRAIG: Correct. Thank you.

20 COURT: I do have one follow-up question that I forgot
21 to ask. You're using the word "disavowed." I'm coming back
22 here to something you talked about. You talk about the Attorney
23 General has not disavowed his authority to self-deputize under
24 18-623. Has he disavowed his intent to prosecute under that
25 statute?

1 MR. CRAIG: So he has disavowed his authority to
2 prosecute at this time.

3 COURT: I understand that. That's not my question.

4 MR. CRAIG: Right. Oh, I understand that.

5 COURT: Yeah, yeah.

6 MR. CRAIG: So if a prosecutor appropriately refers the
7 case to the Attorney General which we have no allegations that
8 that's met in this case or if a prosecutor says that, you know,
9 he or she's not going to prosecute the statute under any
10 circumstances meeting that Idaho Code 623(4), then the Attorney
11 General in those limited circumstances could have the authority
12 to do it and he has not disavowed in those circumstances.

13 But the plaintiff has not pled that those circumstances
14 are present in this case. So as we stand here today or -- and
15 actually I think the Court has to look at at the time the
16 Complaint was filed, as we stand at the time that the Complaint
17 was filed, the Attorney General has no authority to prosecute
18 cases under 18-623.

19 COURT: I understand that argument but he also hasn't
20 disavowed at the time the Complaint was filed that he's not
21 going to prosecute if he was referred that case? Correct?

22 MR. CRAIG: That's correct, yes.

23 COURT: All right. Anything further, Mr. Craig?

24 MR. CRAIG: Thank you.

25 COURT: Thank you, sir. Ms. Olson.

1 MS. OLSON: Thank you, Your Honor. And at the outset,
2 I will apologize because it dawns on me there was one of your
3 questions that you posed at the outset that I didn't answer and
4 that was whether we were opposing the facial or as-applied
5 challenge. And Your Honor, I think it's pretty clear ours is a
6 facial challenge to the statute. We're alleging that the terms
7 are vague and that it infringes on First Amendment rights. And
8 there's no particular as-applied because there's not a specific
9 circumstance yet where the statute has sought to be enforced.
10 And it may be because the conduct is so chilled by the statute
11 that no one has -- that it has not been identified publicly yet,
12 Your Honor.

13 I want to sort of go in somewhat reverse order of
14 Mr. Craig's comments. And I would say first, Your Honor, this
15 opinion that the Attorney General wrote and I wrote the Court
16 it's not binding on this Court and we said that in our reply but
17 if he disavowed it with the stroke of a pen, he can also
18 undisavow it with the stroke of a pen. That would mean -- that
19 would make things solely within his discretion and I don't think
20 that -- one, I don't think he has the ability to overrule the
21 Ninth Circuit and, two, I think then it would be -- you know, he
22 could change it just as he did when he changed it to this
23 particular thing.

24 And then, Your Honor, with respect to all these other
25 statutes he discussed and of course no one's challenging those

1 other statutes but I'll say one thing about those that is
2 significantly different than the statute that plaintiffs
3 challenge is that those are sort of general applicability
4 statutes. And 18-623 is not. The only thing that 18-623
5 purports to criminalize is when the adult does these things that
6 may be speech, expressive conduct, and are vague and then the
7 person gets an abortion.

8 The rest of those statutes are, you know, we really
9 don't want people who aren't the kids' parents taking care of
10 them and there's some other parts of that but it's -- this is
11 specific to abortion so it gets us back to that argument, Your
12 Honor, about the viewpoint and content based.

13 And then, Your Honor, with respect to this argument
14 about this is also -- it's narrow because of this intent to
15 conceal element. Your Honor, what I would say to the Court
16 about that is, Your Honor, first of all, what the defendant said
17 in their brief is different from what Mr. Craig argued at the
18 outset and then different what he ended on which was, well, you
19 know, the parents need to know about this.

20 Those words truly are not in the statute but if to them
21 intent to conceal means not informing the parent, then those are
22 two different things and for sure that term is vague, Your
23 Honor.

24 And he gave this description of, you know, if the
25 person who -- the adult who recruits, harbors or transports

1 doesn't let the minor call their parents, well, that might be
2 intent to conceal. Well, Your Honor, that probably also would
3 be like kidnapping and we said in our brief that we're not --
4 we're not asserting that the kidnapping statute is no longer
5 enforced. In fact, the kidnapping statute is there. The
6 Attorney General is free to prosecute under that statute if he
7 finds facts that violate that. But the conduct that we're
8 talking about here and the free speech that we're talking about
9 here and the association that we're talking about here is not
10 kidnapping.

11 These are young people who come to people who express
12 that message of support for abortion who are looking for that
13 assistance and then the plaintiffs and others like them provide
14 that assistance and they help those young people get lawful
15 abortion care. And Idaho Code 18-623 takes direct aim at those
16 people because of the message of support that they provide,
17 because of the information that they provide, because of the
18 funding that they get from their donors for that precise
19 message.

20 Abortion is the only thing, the only subject matter of
21 this statute. It's not (inaudible) neutral. It is vague and we
22 would ask the Court to enjoin it. Thank you.

23 COURT: Thank you, counsel. This is -- it's clearly
24 very important issues that have been presented. I appreciate
25 the good argument of counsel.

1 Before we go, I do want to -- I want to address one
2 thing while I have the parties here. I see that the defendant
3 filed a motion to dismiss plaintiffs' Complaint earlier this
4 week on September 12, 2023, and that motion raises many of the
5 same issues that we have here but in greater detail. Namely
6 subject matter jurisdiction of this Court, standing and
7 sovereign immunity claims under the 11th Amendment among others.

8 I'd like to hear from the parties as to what their
9 positions are with respect to whether or not the Court should
10 take up both motions together at the same time or to go ahead
11 with the preliminary injunction and then obviously go through
12 the briefing schedule and address that at a later time.

13 So Ms. Olson, I know that this is taking probably
14 longer than your clients would already like but I don't know if
15 you've thought about that at all and what are the parties'
16 positions on that.

17 MS. OLSON: Yes, Your Honor. May I stay?

18 COURT: Yes, of course.

19 MS. OLSON: Those are sort of tight quarters. Your
20 Honor, our position is that the Court should hear -- it's heard
21 and decide the motion that is ripe before it. The state decided
22 to wait a substantial period of time before filing their motion
23 to dismiss. They kept saying they were going to do it. That is
24 a tactic, Your Honor, respectfully. That in fact does impose
25 greater harm on the plaintiffs in this case. So we would ask

1 the Court to decide this motion first and then we will -- I
2 think our response is due October 3 on the motion to dismiss?

3 COURT: Yes.

4 MS. OLSON: We will respond by that deadline and then
5 they can file their reply and then the Court can decide whether
6 it should dismiss the action or not and if the Court enjoins the
7 enforcement of the statute and then decides from looking at the
8 briefing on the motion to dismiss that in fact there is a reason
9 to dismiss the lawsuit, I assume that the Court would just, you
10 know, get rid of its injunction. But we would ask the Court to
11 make a decision on the motion that's currently before the Court.

12 COURT: Thank you, Ms. Olson.

13 MR. WILSON: Your Honor, our position would be that
14 since our motion to dismiss raises issues of the Court subject
15 matter jurisdiction, the Court would be constitutionally obliged
16 to decide that challenge to its jurisdiction before reaching the
17 preliminary injunction motion in connection with it.

18 I'm flattered that Ms. Olson thinks that we are making
19 tactical decisions. I wish we were but we're really just
20 overwhelmed with about nine preliminary injunction motions right
21 now and we actually filed one week before the deadline that we
22 had based on the waiver of service that she gave us for our
23 motion to dismiss. So we're actually ahead of schedule at this
24 point.

25 COURT: All right. I appreciate that from the parties.

1 Mr. Wilson, I understand that, sir, and I understand the
2 plaintiffs' argument. They are both valid arguments. The Court
3 is always worried about issues of jurisdiction. Obviously I
4 don't want to act outside the bounds of what I am otherwise set
5 to do.

6 This motion is now ripe and so the Court will take this
7 motion under advisement and issue a decision in due course.

8 Again, I truly want to thank counsel here today for
9 some excellent argument and briefing. The Court again has spent
10 an inordinate amount of time trying to get up to speed on these
11 arguments and good counsel always make for good arguments and
12 good cases and so we clearly have a good case here. So I want
13 to thank everyone that's been involved in this in presenting the
14 arguments here today.

15 So with that, the Court will be in recess. Thank you.

16 CLERK: All rise. The Court is adjourned.

17 (Proceedings concluded.)

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25

I, court-approved transcriber, certify that the foregoing is a correct transcript from the official electronic sound recording of the proceedings in the above-entitled matter.

/s/ Tamara A. Weber

9/29/23

Signature of Approved Transcriber

Date

Tamara A. Weber

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FOR THE DISTRICT OF IDAHO**

PAM POE, by and through her parents and next friends,
Penny and Peter Poe; **PENNY POE**; **PETER POE**; **JANE
DOE**, by and through her parents and next friends, Joan and
John Doe; **JOAN DOE**; **JOHN DOE**,

Plaintiffs,

v.

RAÚL LABRADOR, in his official capacity as Attorney
General of the State of Idaho; **JAN M. BENNETTS**, in her
official capacity as County Prosecuting Attorney for Ada,
Idaho; and the **INDIVIDUAL MEMBERS OF THE
IDAHO CODE COMMISSION**, in their official capacities,

Defendants.

Case No. 1:23-cv-00269-CWD

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1. I am submitting this rebuttal declaration to respond to some of the assertions made by Defendants and their experts. While the Defendants' expert declarations are filled with many statements that I believe are not supported by evidence, I do not attempt to address all of them but rather focus on some of the issues that seem most pertinent.

**DEFENDANTS AND THEIR EXPERTS' ASSERTIONS ABOUT RISKS OF
GENDER-AFFIRMING MEDICAL CARE**

Asserted risks of puberty blockers

2. Defendants' experts, *see, e.g.* Weiss ¶ 123. suggest that puberty blockers may negatively impact cognitive development. These medications have been used for decades for youth with central precocious puberty without any observed or measured negative impact on cognitive development. Wojniusz S et al. Cognitive, Emotional, and Psychosocial Functioning of Girls Treated with Pharmacological Puberty Blockage for Idiopathic Central Precocious Puberty. *Front Psychol.* 2016.
3. Defendants' experts' suggestion that the impact on cognitive development might be different with puberty blockers used for gender dysphoria compared to central precocious puberty is based on the mistaken assumption that youth treated with puberty blockers for gender dysphoria are left in a prolonged hypogonadal state. In practice, the timing of discontinuing pubertal suppression for patients who have been treated with puberty blockers for gender dysphoria is typically at ages when many of their peers are also starting puberty. Many youth begin puberty at age 13, 14 or even older. In the field of pediatric endocrinology there are no concerns about brain development in patients related to the age of pubertal onset. When delayed puberty is treated, the goals are to induce development of secondary sex characteristics or growth acceleration; concern about cognitive development is not a reason treatment is considered. Harrington H and Palmert MR. An Approach to the Patient With Delayed Puberty, *The Journal of Clinical Endocrinology & Metabolism*, Volume 107, Issue 6, June 2022, Pages 1739–1750. In my general endocrine clinic, many cisgender youth present after age 14, and not uncommonly at age 16 or 17, for evaluation of absent or delayed puberty. I have not had any concerns about cognition in these patients.

4. In addition, cognitive development during adolescence is a complex process relying on a number of different mechanisms, including the psychosocial environment. Chronic stress, particularly during adolescence, can impact cognitive development. Eiland L, Romeo RD. Stress and the developing adolescent brain. *Neuroscience*. 2013 Sep 26;249:162-71. Gender diverse youth who are denied the option of puberty blockers and thus are forced to undergo development of secondary sex characteristics can experience significant stress; the contribution of this to cognitive development cannot be ignored.
5. Defendants' experts also raise the risk of a negative impact on bone health with the use of puberty blockers. *See* Weiss ¶ 112. There is a risk of reduced bone density growth related to the use of puberty blockers, as I indicated in my opening declaration, whether used to treat gender dysphoria or central precocious puberty. This is something that is discussed with families prior to initiating treatment. Pubertal suppression can delay the peak accrual of bone mineralization that occurs during puberty. Research shows that bone mineral density increases when blockers are stopped and puberty resumes endogenously or with gender affirming hormone therapy. Schagen SEE, et al. Bone Development in Transgender Adolescents Treated With GnRH Analogues and Subsequent Gender-Affirming Hormones. *J Clin Endocrinol Metab*. 2020 Dec 1;105(12):e4252–63.; Vlot MC et al. Effect of pubertal suppression and cross-sex hormone therapy on bone turnover markers and bone mineral apparent density (BMAD) in transgender adolescents. *Bone*. 2017 Feb;95:11-19.
6. Defendants' expert Dr. Weiss points to a risk of idiopathic intracranial hypertension (IIH) for youth prescribed puberty blockers as a reason not to treat gender dysphoria with this medication. *See* Weiss ¶ 113. This is in relation to a warning issued by the Federal Drug Administration (FDA) in 2022 based on postmarketing surveillance data. This warning was based on 6 cases of IIH in youth treated with puberty blockers, 5 of whom were being treated for central precocious puberty and 1 treated for gender dysphoria. The nature of the postmarketing surveillance data collection did not allow for calculation of incidence. A recently published registry-based cohort study out of Sweden reported that of the 410 individuals with gender dysphoria treated with puberty blockers over the 10-year study period, no cases of IIH were identified. Karamanis G et al. Incidence of Idiopathic Intracranial Hypertension in Individuals With Gonadotropin-Releasing

Hormone Analogue Treatment for Gender Dysphoria in Sweden. *JAMA Pediatr.* 2023 Jul 1;177(7):726-727. I am not aware of any pediatric endocrinology practices that have ceased treatment with puberty blockers for central precocious puberty or any other condition based on this warning.

Asserted health risks of hormone therapy

7. The defendants' experts bring up concerns about health risks resulting from hormone therapy, such as heart disease, stroke, blood clots, and liver dysfunction. *See, e.g.* Weiss ¶¶ 133-149. However, these risks are the same when estrogen and testosterone are used to treat gender dysphoria as when they are used to treat delayed puberty or hypogonadism in cisgender adolescents. In other words, these risks for transgender girls receiving estrogen therapy are the same as these risks for cisgender girls receiving estrogen therapy, and these risks for transgender boys receiving testosterone therapy are the same as these risks for cisgender boys receiving testosterone therapy.¹ For cisgender or transgender youth receiving such treatments, it is important to monitor hormone levels to make sure they are in the appropriate range to avoid these adverse health consequences. These risks are well-managed (for cisgender and transgender patients) when care is provided and monitored by a physician. In my clinical experience with over 500 cisgender and gender diverse patients receiving hormone therapy, I have had no patients experience blood clots, heart disease, stroke or liver dysfunction. One patient taking testosterone developed higher red blood cell counts but these normalized with reduction in the testosterone dose.
8. One of the defendants' experts also makes the claim that testosterone therapy in birth-assigned females increases the risk of breast cancer; however, the references used, Weiss ¶ 139, are not represented accurately in the declaration. These studies report that

¹ Additionally, given that hormone prescribing protocols in published guidelines by the Endocrine Society simulate natural endogenous puberty, the health risk profile for transgender boys receiving testosterone therapy becomes more in line with that for cisgender boys who go through endogenous puberty, which means, for example, higher risks of heart attack than cisgender girls. Similarly, the health risk profile for transgender girls receiving estrogen therapy becomes more in line with that for cisgender girls who go through endogenous puberty, which means, for example, higher risks of breast cancer than cisgender boys.

transgender women treated with estrogen have a higher rate of breast cancer than cisgender men, but lower rate than cisgender women, and that transgender men treated with testosterone have a lower rate of breast cancer than cisgender women but a higher rate than cisgender men. Berliere M et al. Effects of Hormones on Breast Development and Breast Cancer Risk in Transgender Women. *Cancers* (Basel). 2022 Dec 30;15(1):245; Corso G et al. Risk and incidence of breast cancer in transgender individuals: a systematic review and meta-analysis. *Eur J Cancer Prev*. 2023 May 1;32(3):207-214. These findings are not surprising given that estrogen causes the development of breast tissue and cisgender men have very little breast tissue.

Asserted risks to fertility

9. Defendants' experts discuss the potential impact on fertility of gender-affirming medical care. While, as I discussed in my opening declaration, some treatments can impair fertility and this is thoroughly discussed with patients and their families, along with fertility preservation options, this outcome is not certain. There are many reports of transgender men who, after taking and stopping testosterone, are able to conceive children, with or without fertility treatment. Light AD et al. Transgender men who experienced pregnancy after female-to-male gender transitioning. *Obstet Gynecol*. 2014 Dec;124(6):1120-1127; Light AD et al. Family planning and contraception use in transgender men. *Contraception*. 2018 Oct;98(4):266-269; Stroumsa D et al. The Power and Limits of Classification - A 32-Year-Old Man with Abdominal Pain. *N Engl J Med*. 2019 May 16;380(20):1885-1888.² For this reason, in our informed consent process, we inform trans males that testosterone is not an effective contraception and they could become pregnant. Treatment can be tailored to minimize the risk to fertility where that is important to the family; for example, allowing some puberty to occur in transgender girls prior to starting puberty blockers so that they are able to preserve sperm, or temporarily stopping testosterone in transgender males to preserve eggs or try to get pregnant.

² Defendants suggest that the fact that I am not aware of any of my patients having conceived a child means they were unable to do so. Defs' brief. ¶ 20. My patients transition their care to adult medical providers by their early 20's, before they would be ready to start having families.

Asserted risk to sexual response

10. Dr. Cantor suggests that gender-affirming medical care will lead to “lifetime lack of orgasm and sexual function.” See Cantor ¶ 208. In actuality, sexual satisfaction is impacted by a multitude of factors, including psychological well-being. Studies have shown that as psychological well-being improves steadily during gender affirming treatment, so does sexual satisfaction. Young transgender adults who started their gender affirming care during adolescence had more sexual activity and satisfaction compared with individuals not accessing gender affirming care until adulthood. Bungener SL et al. Sexual Experiences of Young Transgender Persons During and After Gender-Affirmative Treatment. *Pediatrics*. 2020 Dec;146(6):e201914111. One study of transgender women having undergone vaginoplasty after pubertal suppression in adolescence reported that most were able to achieve orgasm. Bouman MB et al. Patient-Reported Esthetic and Functional Outcomes of Primary Total Laparoscopic Intestinal Vaginoplasty in Transgender Women With Penoscrotal Hypoplasia. *J Sex Med*. 2016 Sep;13(9):1438-1444. Another study found no difference between transgender women who were treated with puberty blockers early in puberty versus late in puberty in their ability to orgasm after gender affirming genital surgery. van der Meulen I et al. The Effect of Puberty Suppression on Sexual Functioning in Transwomen after Gender Affirmative Surgery, *The Journal of Sexual Medicine*, Volume 20, Issue Supplement_4, July 2023.
11. In my clinical experience with patients, gender affirming medical care improves sexual function and experiences due to the positive effect of physical effects on alignment with gender identity. Transgender men treated with testosterone do not experience any negative effects on sexual function, aside from possible vaginal dryness. Transgender women treated with estrogen can have diminished ability to achieve and sustain erections (which may be a desired effect), but treatment can be tailored to avoid that if desired.

Assertions regarding regret and detransition

12. Defendants and their experts devote significant time to suggesting that it is common for patients treated with gender-affirming medical care to detransition and regret treatment. There is no evidence to support this. One study of a large sample demonstrated that less

than 2% of people who transition ever detransition due to a shift in gender identity.

Turban JL *et al.* Factors Leading to "Detransition" Among Transgender and Gender Diverse People in the United States: A Mixed-Methods Analysis. *LGBT Health*. 2021 May-Jun;8(4):273-280. Regret related to gender-affirming hormone use is rare. Wiepjes CM *et al.* The Amsterdam Cohort of Gender Dysphoria Study (1972-2015): Trends in Prevalence, Treatment, and Regrets. *J Sex Med*. 2018 Apr;15(4):582-590. In my experience with hundreds of patients with gender dysphoria who have received puberty blockers and/or gender-affirming hormones, a number of patients have discontinued hormones because they were satisfied and happy with the physical changes they had experienced and did not feel the need to continue treatment. These patients did not come to identify with their sex assigned at birth or regret treatment. I am aware of just two patients who, after undergoing gender affirming medical care, have said they had a shift in their gender identity to their birth-assigned sex and neither have any regrets about their treatment.

13. Defendants' assertion, Defs' brief, ¶ 30, that I view detransitioners as "an inconvenient fact to be minimized" cannot be further from the truth. Defendants are aware of (and presented to me at my deposition) a paper I co-authored that details a multidisciplinary approach to adult patients who expressed desire to reverse their gender affirming surgery (0.3% in our institution). The study aimed to better understand factors impacting patient's experiences to aid in the development of protocols to support them. Patients in my clinic are all counseled about the possibility that their experience regarding their gender may shift and change and we encourage them to come to us for support if that occurs.
14. The possibility of regretting medical decisions is part of medicine. A review of the body of research on this topic found that the mean rate of medical decision regret across studies was 16.5%. Perez, MMB, *et al.* Extent and Predictors of Decision Regret About Health Care Decisions: A Systematic Review. *Medical Decision Making*. Aug. 2016:777. A review of the research on regret in the context of surgeries found that across studies the average rate of regret was 14.4%. Wilson, A, *et al.* Regret in Surgical Decision Making: A Systematic Review of Patient and Physician Perspectives. *World J. Surgery* (2017) 41L1454-1465.

DEFENDANTS AND THEIR EXPERTS' ASSERTIONS REGARDING THE EFFICACY OF GENDER-AFFIRMING MEDICAL CARE FOR ADOLESCENTS

15. Defendants and their experts assert that there is a lack of evidence of efficacy of gender-affirming medical care. First, they suggest that the research evidence we have demonstrating efficacy is not valuable because it is “low quality”. The defendants are referring to the Grading of Recommendations Assessment, Development and Evaluation (GRADE) approach to rating quality of evidence. This approach includes four levels of evidence quality, and is largely dependent on the type and methods of investigation. As such, observational studies including cross-sectional studies with comparison groups and longitudinal cohort studies—the types of studies done on gender-affirming medical care— are generally rated lower quality than randomized controlled clinical trials. Observational studies are critical to medical research and informing the practice of medicine, and the label of “low quality” under GRADE does not mean that the evidence is unreliable or of poor quality. Indeed, one recent study found that only 12% of health care interventions are supported by “high quality” evidence as defined by the GRADE standard, and more than half are supported by “low quality” or “very low quality” evidence. Howick J et al. Most healthcare interventions tested in Cochrane Reviews are not effective according to high quality evidence: a systematic review and meta-analysis. *J Clin Epidemiol.* 2022 Aug;148:160-169.
16. As I discussed in my opening declaration, Connelly ¶ 56, randomized controlled trials are not always feasible due to ethical concerns and methodological limitations. Ashley F et al, Randomized-controlled trials are methodologically inappropriate in adolescent transgender healthcare, *Int J Trans Health.* Well-designed observational studies are necessary and valuable, and can provide reliable evidence, sometimes more reliable than randomized controlled trials. This is not limited to research pertaining to gender affirming medical care.
17. Also as discussed in my opening declaration, in my clinical experience, I’ve seen the profoundly beneficial impact of gender affirming medical care on my patients. Defendants assert, Defs’ brief, at 26-27, that my statement that gender affirming medical care improves depression and anxiety in patients is contradicted by a study published by my clinical team. Cantu AL et al. Changes in Anxiety and Depression from Intake to

First Follow-Up Among Transgender Youth in a Pediatric Endocrinology Clinic. *Transgend Health*. 2020 Sep 2;5(3):196-200. This study looked at depression and anxiety screener data at the first follow up visit, which was typically just a few months after initiating hormone therapy (follow-up visits are recommended at 3-4 months after initial visit).³ We know from patients that physical changes occur very slowly, and often, patients do not notice physical differences until 3 to 6 months after initiating treatment; thus, we were not surprised that the improvements in depression and anxiety were not detected at the three month point. Over time, as patients see their bodies begin to match their gender, we consistently see significant improvement in patient mental health. In addition to seeing improvement in GAD-7 and PHQ-9 scores measuring anxiety and depression, we see reduction or elimination in suicidal ideation, improved family functioning and social relationships, and improved school engagement and performance. We get this information from the patients as well as their parents, who are often surprised to see such dramatic changes in their children's lives and well-being.

18. Defendants and their experts assert that clinical experience is not reliable evidence and appear to suggest that it should be disregarded. *See Cantor* ¶¶ 284 et seq. Yet Dr. Cantor seems to acknowledge that such evidence may be useful, as it “might be the only option available” if there aren’t systematic cohort studies available. While we would ideally always have more and stronger research to support all medical practices, as clinicians we must rely on the best evidence available to guide clinical care. Clinical practice guidelines like those of the Endocrine Society and the WPATH Standards of Care make recommendations based on the best evidence that exists. In all areas of medicine, sometimes treatment recommendations are made based on expert opinion from clinical experience. Gender affirming medical care for adolescents is supported by multiple cohort and retrospective studies; however, the experience of clinicians is also valuable.
19. Defendants and their experts suggest that lack of FDA approval of puberty blockers, testosterone, and estradiol for the treatment of gender dysphoria supports their position that these treatments are not effective. My opening declaration discusses the wide-spread

³ Our study was intended to continue to follow-up at additional time points, however our clinical operations shifted dramatically after this paper’s publication due to the COVID-19 pandemic. We plan to collect more long-term data on the patients included in that study.

use of medications off-label (without FDA approval for a particular indication). The defendants' suggestion that lack of FDA approval for an indication means the FDA does not support that use⁴ is erroneous. The lack of FDA approval does not mean disapproval of these medications for this indication; it says nothing at all about the FDA's views of the treatment. That is because the FDA does not opine on the safety or efficacy of a treatment for a particular indication unless a pharmaceutical company applies for approval for that indication. Making an application may not be financially reasonable or feasible if the treatment has already been approved for other conditions because, as the FDA states, "once the FDA approves a drug, healthcare providers generally may prescribe the drug for an unapproved use when they judge that it is medically appropriate for their patient." (<https://www.fda.gov/patients/learn-about-expanded-access-and-other-treatment-options/understanding-unapproved-use-approved-drugs-label>).

DEFENDANTS AND THEIR EXPERTS' ASSERTIONS REGARDING WPATH'S GUIDELINES REGARDING GENDER-AFFIRMING SURGERIES

20. Defendants' experts suggest that the fact that the WPATH Standards of Care 8 does not include a minimum age for genital surgery is equivalent to WPATH endorsing such surgeries at any age. *See* Cantor ¶ 249. This claim disregards the strong cautionary language included in the WPATH SOC 8 about assessing the patient's emotional and cognitive maturity to make each treatment decision and guidance about how to make that assessment. *See* WPATH SOC 8 at S61-62. The age at which an individual has the maturity and cognitive ability to develop realistic expectations for surgical outcomes and understand long-term consequences varies greatly from person to person, and is elucidated in the comprehensive mental health evaluation that is required prior to consideration of any surgical interventions.

⁴ See Defs' brief, at 9 (stating that "the FDA is not prepared to put its credibility and careful testing protocols behind the use" of puberty blockers, estrogen and testosterone to treat gender dysphoria).

I declare under penalty of perjury that the foregoing is true and correct.

Executed on October 13, 2023.

A handwritten signature in black ink that reads "Kara Connelly MD". The signature is written in a cursive, flowing style.

Kara Connelly, MD

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**UNITED STATES DISTRICT COURT
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PAM POE, by and through her parents and next friends,
Penny and Peter Poe; **PENNY POE**; **PETER POE**; **JANE
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John Doe; **JOAN DOE**; **JOHN DOE**,

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RAÚL LABRADOR, in his official capacity as Attorney
General of the State of Idaho; **JAN M. BENNETTS**, in her
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Case No. 1:23-cv-00269-CWD

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Attorneys for Plaintiffs

I, Christine Brady, PhD, hereby declare and state as follows:

1. I have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation.

2. I have actual knowledge of the matters stated herein.

3. My background and credentials are outlined in my initial declaration.

4. I reviewed the declarations of Drs. Cantor and Weiss. There are many assertions made in those declarations that I do not believe are supported by evidence. I do not attempt to address all of them here but, instead, respond to some of the central arguments made in those declarations. I reserve the right to supplement my opinions, if necessary, as the case proceeds.

DR. WEISS'S ASSERTION THAT GENDER DYSPHORIA IS A SYMPTOM OF OTHER MENTAL HEALTH DISORDERS IS UNSUPPORTED BY EVIDENCE

5. Dr. Weiss misunderstands gender dysphoria to be a symptom of other mental health issues such as trauma, abuse and depression (as opposed to a separate diagnosis), and claims that if those other issues are addressed, that will resolve the gender dysphoria.

Declaration of Daniel Weiss (Dkt. 56-3) ("Weiss Decl.") ¶ 21; Ex. B to the Declaration of Ritchie Eppink, Daniel Weiss Deposition Transcript ("Weiss Dep.") 213:1-215:8. By using quotation marks when referring to gender dysphoria (but not any other diagnoses), Dr. Weiss apparently disagrees with the DSM's recognition of gender dysphoria as a psychiatric diagnosis. His views are completely at odds with how gender dysphoria is understood by those working within the mental health field, including Dr. Cantor, who agrees that gender dysphoria is a mental health condition that should be treated. Declaration of James Cantor (Dkt. 56-4) ("Cantor Decl.") ¶109. Indeed, gender dysphoria (and precursor diagnoses such as "gender identity disorder") has been included in the DSM as a diagnosis since the publication of the DSM-III in 1980. Gender dysphoria, like all mental health conditions, can co-occur with other diagnosed conditions but

that does not mean that in those cases, gender dysphoria is a symptom of other conditions. Moreover, not all people with gender dysphoria have the other mental health conditions mentioned by Dr. Weiss. I have treated a number of adolescents with gender dysphoria who do not meet criteria for any other DSM diagnosis and have no history of trauma or abuse.

DEFENDANTS' EXPERTS' STATED CONCERNS ABOUT GENDER-AFFIRMING CARE ARE BASED ON A MISUNDERSTANDING OF HOW SUCH CARE IS PROVIDED IN ACCORDANCE WITH THE WPATH SOC

6. The State's experts assert a number of concerns about the treatment of adolescents with gender dysphoria that are premised on a profound misunderstanding of how care is provided in accordance with the recommendations of the World Professional Association for Transgender Health's Standards of Care for Transgender and Gender Diverse People ("WPATH SOC"). Specifically, they assert concerns regarding automatic acceptance of reported transgender identity, the misdiagnosis of gender dysphoria, and social influences causing adolescents to present at gender clinics. All of these stated concerns ignore or misunderstand the comprehensive psychosocial evaluation, which is a core recommendation of the WPATH SOC prior to considering any medical interventions for adolescents.

7. Dr. Cantor suggests that gender affirming healthcare providers support "transition-on-demand". Cantor Decl. ¶ 125. He seems to be asserting that when patients present to gender clinics, if they say they are transgender, doctors fail to engage in exploration of the patient's gender identity and other comorbidities. *See* Cantor Decl. p. 111 (heading) (suggesting doctors "assum[e] literal accuracy of self-report"). This is simply untrue. Under the WPATH SOC, a comprehensive psychosocial assessment is a critical component of care prior to considering medical interventions. WPATH SOC, p. S59-S61. And that includes not only assessing whether the patient meets the criteria for gender dysphoria, but also assessing other mental health issues affecting the patient. *Id.*, p. S62-S63. Additionally, information is obtained

not *just* from the youth but also from their parents. *Id.*, p. S60. This is not only to increase the reliability of the clinical data obtained, but to more fully understand the history of the child's experience related to their gender and any other mental health issues.

8. The State's experts also suggest that adolescents may be misdiagnosed with gender dysphoria when they have other mental health conditions that need to be addressed.¹ Again, this overlooks the comprehensive psychosocial evaluation that is provided prior to considering medical interventions. Differential diagnosis is a part of the process and alternative or additional mental health conditions may be identified. In my own clinical experience, I've had a number of patients who have presented expressing issues related to their gender identity where, after evaluation and exploration, it became clear that the patient did not have gender dysphoria and there were other issues that required attention and treatment. In other cases, patients have gender dysphoria in addition to other mental health issues that need to be addressed. It is not unique to gender dysphoria that individuals can carry multiple mental health

¹ Dr. Cantor suggests a specific concern about gender dysphoria diagnoses being misdiagnosed as borderline personality disorder (BPD). Cantor Decl. ¶ 160. He highlighted two of nine criteria of BPD that he believes could be diagnostically confused with gender dysphoria, starting with "recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior" and "identity disturbance: markedly and persistently unstable self-image or sense of self." While suicidal thoughts and self-harm behaviors are diagnostic criteria for many mental health disorders including various forms of depression, bipolar disorder, schizophrenia, anxiety and PTSD, they are not part of the diagnostic criteria for gender dysphoria and the presence of those symptoms would not impact or influence the diagnosis of gender dysphoria. As for the "identity disturbance" criterion, as stated in the diagnostic criteria for BPD, the identity must be "persistently unstable." In the case of gender dysphoria, symptoms must be stably present for a duration of at least six months and in most cases presenting to our Gender Clinic, have been stable for several years. Goldhammer and colleagues (2019) examined the relationship between BPD and gender dysphoria and concluded that "gender minority identity is rarely a sign of identity diffusion." Hilary Goldhammer et al., *Distinguishing and Addressing Gender Minority Stress and Borderline Personality Symptoms*, 27 HARV REV PSYCHIATRY 317-325, 323 (2019). Finally, in order to be diagnosed with BPD, an individual must display 5 or more of the nine criteria. Having these two symptoms alone would not meet criteria for BPD and completely different symptoms must be had in order to be diagnosed with gender dysphoria.

diagnoses. And the suggestion by the State’s experts that a gender dysphoria diagnosis and treatment with gender-affirming medication means that any other mental health conditions a patient has will not be addressed, *see* Cantor Decl. ¶¶ 158, 237, is without basis. I provide psychotherapy for comorbidities to many patients who are receiving puberty blockers or hormone therapy, and this is common in gender clinics across the country.

9. The State’s experts assert that many adolescents present for care at gender clinics because they are influenced by social media and their peers. Cantor Decl. ¶ 136; Weiss Decl. ¶ 30. It is hard to imagine this happening given that in my clinical experience, most patients have experienced gender incongruity and dysphoria for several years prior to presenting to clinic. In any case, should social influence lead someone to present to a medical provider asserting a transgender identity and seek gender-affirming medical care, like all patients they would receive a comprehensive psychosocial evaluation prior to considering any medical interventions, which would examine the history of their gender identity and possible external drivers of identity. I am confident that such evaluations would identify peer and social media influence if that were a factor and no medical interventions would be provided if the patient did not meet the criteria for gender dysphoria.

THE STATE’S EXPERTS INAPPROPRIATELY RELY ON THE DESISTANCE STUDIES OF PREPUBERTAL CHILDREN TO SUPPORT BANNING GENDER-AFFIRMING MEDICAL CARE FOR ADOLESCENTS WITH GENDER DYSPHORIA

10. The State presents data on pre-pubertal gender nonconforming children to suggest that most youth affected by the Idaho law will “cease to want to be the other gender.” Cantor Decl. ¶ 116. There are several reasons why such a conclusion cannot be made from this data. First, the studies included in Dr. Cantor’s meta-analysis date from 1972 – 2021 (with all but 1 of the 11 studies done during prior to the DSM-5). Cantor Decl. Table 2, pp. 50-51. As outlined in my opening declaration, prior to DSM-5, the diagnostic criteria did not require that a child

identify with a different sex – in other words, a child could be diagnosed with the precursor diagnosis of gender identity disorder solely on the basis of gender atypical behavior. As Dr. Cantor acknowledges in his report, many of the studies were not limited to transgender children, but rather included gay, uncertain, and crossdressing children; several of the studies—as indicated by their titles—assessed “effeminate behavior in boys”. *Id.* Therefore, the studies do not provide data on desistance of children who have gender dysphoria.

11. Second, the studies looked only at prepubertal children and say nothing about the likelihood of desistance among adolescents—youth who have started puberty, who Dr. Cantor recognizes are less likely to desist. Cantor Decl. ¶ 245 (desistance less likely to occur after age 12). It is important to note that medical interventions are not offered to pre-pubertal youth. Thus, the rates of desistance among prepubertal children would not support an argument to prohibit medical care for adolescents.

DR. CANTOR’S OPINION THAT GENDER-AFFIRMING MEDICAL CARE SHOULD BE POSTPONED UNTIL ADULTHOOD WOULD RESULT IN SERIOUS SUFFERING

12. Dr. Cantor states “Accepting that gender identity can change, even if only *involuntarily*, calls for the very policy Dr. Brady rejects: Hold off medicalization until adulthood.” Cantor Decl. ¶ 267. As an initial matter, Dr. Cantor overstates the likelihood of gender identity changing among adolescents—the group affected by the Idaho law—by relying inappropriately on the desistance studies of prepubertal children. In my clinical experience, while I have had patients who, over time, use different gender diverse identity labels for themselves, e.g., shifting from identifying as transgender female to non-binary, shifts from gender diverse to cisgender have been extremely rare (6 out of over 900 patients). The fact that there may be some adolescents who have a shift in their gender identity to cisgender is not a basis to withhold treatment from those who need and would benefit from it. The fact that a

patient's gender identity changed to cisgender does not equate with regretting treatment or negative consequences of treatment. That was my clinical experience with my two patients who shifted to a cisgender identity after having received pubertal suppression. And research shows that people whose gender identity evolved to cisgender have nonetheless found that the treatment helpful for them at the time.² Moreover, almost all if not all medical treatments have some patients who ultimately regret receiving them, but that is not a reason to deny treatment to those who need and benefit from it.

13. The State's experts suggest that gender dysphoria can be treated with psychotherapy alone. *See, e.g.,* Weiss Dep. 186:10-187:2. While psychotherapy can be important to treat comorbidities—which is something I do regularly with patients—it does not address the distress of gender dysphoria. For my patients who have had to delay accessing medical treatment (e.g., because their parents did not consent to treatment), their gender dysphoria was not alleviated despite regular therapy and often their mental health severely decompensated until they were able to begin medical treatment.

14. Dr. Cantor suggests that a study by Costa (2015) demonstrates the effectiveness of psychotherapy alone, and that I misinterpreted the findings of that study. Cantor Decl. ¶ 290; *see* R. Costa et al, Psychological support, puberty suppression, and psychosocial functioning in adolescents with gender dysphoria, 12 J. SEXUAL MEDICINE 2206-2214 (2015). That is not so. Costa found that psychosocial support alone for 6 months significantly improved psychosocial functioning in a group of adolescents with GD who were deemed “delayed eligible” for puberty blockers, but then no further significant improvements were observed (plateau) over the next 12

² *See, e.g.,* Lisa Littman, *Individuals treated for gender dysphoria with medical and/or surgical transition who subsequently detransitioned: A survey of 100 detransitioners*. 50 ARCHIVES SEXUAL BEHAV. 3353-3369, 3363 (2021).

months of psychological support and their psychosocial functioning scores continue to be lower than those of healthy peers. *Id.* at 2211. In contrast, for adolescents with GD who were deemed “immediately eligible” for blockers, 6 months of psychosocial support alone did not significantly improve their psychosocial functioning but after 12 months of pubertal suppression, their psychosocial functioning significantly improved and their scores matched those of healthy peers. *Id.* The “delayed eligible” group included those individuals who needed more time to make a decision or where “clinicians needed more time to make the decision of starting GnRHa because of possible comorbid psychiatric problems and/or psychological difficulties.” *Id.* at 2208-09. This study unsurprisingly reaffirms that psychological support can be helpful to improve psychosocial functioning, particularly in individuals with other psychiatric issues. *Id.* at 2212. It also shows that pubertal suppression provided benefits that did not come with psychotherapy alone. *Id.* at 2212-13. Also, of note, the delayed eligible group all elected to receive pubertal blockers on average 6 months after the study concluded. *Id.* at 2209.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on: 10/13/2023


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**UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO**

PAM POE, by and through her parents and next friends,
Penny and Peter Poe; **PENNY POE**; **PETER POE**; **JANE
DOE**, by and through her parents and next friends, Joan and
John Doe; **JOAN DOE**; **JOHN DOE**,
Plaintiffs,

v.

RAÚL LABRADOR, in his official capacity as Attorney
General of the State of Idaho; **JAN M. BENNETTS**, in her
official capacity as County Prosecuting Attorney for Ada,
Idaho; and the **INDIVIDUAL MEMBERS OF THE
IDAHO CODE COMMISSION**, in their official capacities,
Defendants.

Case No. 1:23-cv-00269-CWD

EXPERT REBUTTAL DECLARATION OF JACK TURBAN, MD, MHS

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I, JACK TURBAN, MD, MHS hereby declare as follows:

1. I have been retained by counsel for Plaintiffs as an expert witness in connection with the above-captioned litigation.
2. I have actual knowledge of the matters stated herein.
3. In preparing this declaration, I reviewed the State's combined memorandum of law in opposition to motion for preliminary injunction and in support of motion to dismiss and the expert declarations by Drs. James Cantor and Daniel Weiss. The materials I have relied upon in preparing this declaration are the same types of materials that experts in my field of study regularly rely upon when forming opinions on the subject. I may wish to supplement these opinions or the bases for them as a result of new scientific research or publications or other developments in my area of expertise.

BACKGROUND AND QUALIFICATIONS

4. My curriculum vitae is attached as Exhibit A to this declaration. I am currently an Assistant Professor of Child & Adolescent Psychiatry at the University of California, San Francisco (UCSF) School of Medicine, where I am also Affiliate Faculty at the Philip R. Lee Institute for Health Policy Studies. As a member of the faculty at UCSF, I serve as director of the Gender Psychiatry Program in the Division of Child & Adolescent Psychiatry. I also serve as an attending psychiatrist in the adult LGBT psychiatry clinic and in the eating disorders program. In my career, I have cared for at least 100 adolescents with gender dysphoria. In addition to my clinical work, I conduct research focusing on the determinants of mental health among transgender youth and teach medical students, psychology trainees, psychiatry residents, and child and adolescent psychiatry fellows.

5. I received my undergraduate degree in neuroscience from Harvard College. I received both my MD and Master of Health Science (MHS) degrees from Yale University School

of Medicine. I completed residency training in general psychiatry in the combined Massachusetts General Hospital / McLean Hospital residency training program (Harvard Medical School) and fellowship training in child and adolescent psychiatry at Stanford University. I am board certified in psychiatry by The American Board of Psychiatry and Neurology.

6. My research focuses on the mental health of transgender youth and youth experiencing gender dysphoria. While at Yale, I was awarded the Ferris Prize for my thesis entitled “Evolving Treatment Paradigms for Transgender Youth.” In 2017, I received the United States Preventative Health Services Award for Excellence in Public Health based on my work related to the mental health of transgender youth. I have lectured on the mental health of transgender youth at Yale School of Medicine, UCSF, Stanford University, and The Massachusetts General Hospital (a teaching hospital of Harvard Medical School). I have given invited grand rounds presentations at academic institutions around the country and have presented nationally and internationally on topics related to the mental health of transgender people and people experiencing gender dysphoria.

7. I have served as a manuscript reviewer for numerous professional publications, including *The Journal of The American Medical Association (JAMA)*, *JAMA Pediatrics*, *JAMA Psychiatry*, *The Journal of The American Academy of Child & Adolescent Psychiatry*, *Pediatrics*, *The Journal of Adolescent Health*, and *The American Journal of Public Health*. I received commendation as a top peer reviewer from *Annals of Internal Medicine*, the academic journal of the American College of Physicians. I am an academic editor for the journal *PLoS One* and a contributing editor for *The Journal of The American Academy of Child & Adolescent Psychiatry*. I have served as lead author for textbook chapters on the mental health of transgender youth, including for *Lewis’s Child & Adolescent Psychiatry: A Comprehensive Textbook* and the textbook

of The International Academy for Child & Adolescent Psychiatry and Allied Professionals. I am co-editor of the textbook *Pediatric Gender Identity: Gender-Affirming Care for Transgender and Gender Diverse Youth*.

8. I have published extensively on the topic of transgender youth, including nine articles in peer-reviewed journals within the past two years.

9. In the last four years, I have been retained as an expert and provided testimony at trial or by deposition in the following cases: *Brandt et al. v. Rutledge, et al.*, No. 21-CV-450 (D. Ark.) (deposition and trial testimony); *K.C. v. Medical Licensing Board of Indiana*, No. 1:23-cv-00595-JPH-KMB (S.D. Ind.) (deposition).

10. I am being compensated at an hourly rate of \$400 per hour for preparation of expert declarations and reports and time spent preparing for or giving deposition or trial testimony. My compensation does not depend on the outcome of this litigation, the opinions I express, or the testimony I provide.

THERE IS NO BASIS FOR THE STATE’S EXPERTS’ ASSERTIONS THAT THERE IS NO RELIABLE RESEARCH SHOWING THE EFFICACY AND EFFECTIVENESS OF GENDER-AFFIRMING MEDICAL CARE FOR ADOLESCENTS

11. There are over a dozen studies evaluating the efficacy and effectiveness¹ of puberty blockers and gender-affirming hormones for the treatment of adolescents with gender dysphoria.²

¹ Efficacy refers to studies looking at an intervention under “ideal circumstances” (*e.g.*, in a research clinic), whereas effectiveness studies look at the impact of an intervention under “real world” conditions (*i.e.*, in the general community practice setting).

² Such studies include: De Vries, A. L., Steensma, T. D., Doreleijers, T. A., & Cohen-Kettenis, P. T. (2011). Puberty suppression in adolescents with gender identity disorder: A prospective follow-up study. *The Journal of Sexual Medicine*, 8(8), 2276-2283; De Vries, A. L., McGuire, J. K., Steensma, T. D., Wagenaar, E. C., Doreleijers, T. A., & Cohen-Kettenis, P. T. (2014). Young adult psychological outcome after puberty suppression and gender reassignment. *Pediatrics*, 134(4), 696-704; Costa, R., Dunsford, M., Skagerberg, E., Holt, V., Carmichael, P., & Colizzi, M. (2015). Psychological support, puberty suppression, and psychosocial functioning in adolescents with gender dysphoria. *The Journal of Sexual Medicine*, 12(11), 2206-2214; Allen, L. R., Watson, L.

These studies can be roughly delineated into two categories: uncontrolled longitudinal studies and controlled cross-sectional studies. Uncontrolled longitudinal studies (e.g., Chen et al. *New England Journal of Medicine* 2023³ and deVries et al. *Journal of Sexual Medicine* 2011⁴) have examined mental health before and after gender-affirming medical interventions and found that mental health is improved after treatment. Controlled cross-sectional studies (e.g., van der Miesen

B., Egan, A. M., & Moser, C. N. (2019). Well-being and suicidality among transgender youth after gender-affirming hormones. *Clinical Practice in Pediatric Psychology*, 7(3), 302-311; Kaltiala, R., Heino, E., Työläjärvä, M., & Suomalainen, L. (2020). Adolescent development and psychosocial functioning after starting cross-sex hormones for gender dysphoria. *Nordic Journal of Psychiatry*, 74(3), 213-219; de Lara, D. L., Rodríguez, O. P., Flores, I. C., Masa, J. L. P., Campos-Muñoz, L., Hernández, M. C., & Amador, J. T. R. (2020). Psychosocial assessment in transgender adolescents. *Anales de Pediatría (English Edition)*, 93(1), 41-48; van der Miesen, A. I., Steensma, T. D., de Vries, A. L., Bos, H., & Popma, A. (2020). Psychological functioning in transgender adolescents before and after gender-affirmative care compared with cisgender general population peers. *Journal of Adolescent Health*, 66(6), 699-704; Kuper, L. E., Stewart, S., Preston, S., Lau, M., & Lopez, X. (2020). Body dissatisfaction and mental health outcomes of youth on gender-affirming hormone therapy. *Pediatrics*, 145(4), e20193006; Turban, J. L., King, D., Carswell, J. M., & Keuroghlian, A. S. (2020). Pubertal suppression for transgender youth and risk of suicidal ideation. *Pediatrics*, 145(2), e20191725; Green, A. E., DeChants, J. P., Price, M. N., & Davis, C. K. (2021). Association of gender-affirming hormone therapy with depression, thoughts of suicide, and attempted suicide among transgender and nonbinary youth. *Journal of Adolescent Health*, 70(4), 643-649; Turban, J. L., King, D., Kobe, J., Reisner, S. L., & Keuroghlian, A. S. (2022). Access to gender-affirming hormones during adolescence and mental health outcomes among transgender adults. *PLoS One*, 17(1), e0261039; Tordoff, D. M., Wanta, J. W., Collin, A., Stephney, C., Inwards-Breland, D. J., Ahrens, K. (2022). Mental Health Outcomes in Transgender and Nonbinary Youths Receiving Gender-Affirming Care. *JAMA Network Open*, 5(2), e220978; Chen, D., Berona, J., Chan, Y. M., Ehrensaft, D., Garofalo, R., Hidalgo, M. A., Rosenthal, S. M., Tishelman, A. C., & Olson-Kennedy, J. (2023). Psychosocial functioning in transgender youth after 2 years of hormones. *New England Journal of Medicine*, 388(3), 240-250.

³ Chen, D., Berona, J., Chan, Y. M., Ehrensaft, D., Garofalo, R., Hidalgo, M. A., Rosenthal, S. M., Tishelman, A.C., & Olson-Kennedy, J. (2023). Psychosocial functioning in transgender youth after 2 years of hormones. *New England Journal of Medicine*, 388(3), 240-250.

⁴ De Vries, A. L., Steensma, T. D., Doreleijers, T. A., & Cohen-Kettenis, P. T. (2011). Puberty suppression in adolescents with gender identity disorder: A prospective follow-up study. *The Journal of Sexual Medicine*, 8(8), 2276-2283.

et al. *Journal of Adolescent Health*⁵ and Turban et al. *PLoS One*⁶) have compared those who accessed gender-affirming medical care to those who desired but did not access this treatment and found that those who accessed treatment had better mental health outcomes. These two types of study designs offer complementary information that make experts in this field confident regarding the mental health benefits of these treatments. These studies are additionally supplemented by decades of clinical experience from experts around the world who care for adolescents with gender dysphoria.

12. The State’s experts devote many pages to quarreling with individual studies’ methodologies. All studies in medicine have strengths and weaknesses, and one must examine the body of literature as a whole to draw conclusions. Examining the body of literature regarding gender-affirming medical care for adolescent gender dysphoria as a whole provides a rich scientific perspective, linking these treatments to clear mental health benefits.

13. The State’s experts often discuss the concept of “confounding” variables—the notion that certain *other variables* that are related to gender-affirming care and mental health outcomes may be the true reason for observed mental health benefits. The question of “confounding effect” has been examined in several ways. For instance, a 2022 paper from my research group that assessed the relationship between treatment with gender-affirming medical interventions and improved mental health statistically adjusted for a range of potentially confounding variables including age, gender identity, sex assigned at birth, sexual orientation,

⁵ van der Miesen, A. I., Steensma, T. D., de Vries, A. L., Bos, H., & Popma, A. (2020). Psychological functioning in transgender adolescents before and after gender-affirmative care compared with cisgender general population peers. *Journal of Adolescent Health*, 66(6), 699-704.

⁶ Turban, J. L., King, D., Kobe, J., Reisner, S. L., & Keuroghlian, A. S. (2022). Access to gender-affirming hormones during adolescence and mental health outcomes among transgender adults. *PLoS One*, 17(1), e0261039

race/ethnicity, level of family support for gender identity, relationship status, level of education, employment status, household income, having ever received pubertal suppression, having ever been exposed to gender identity conversion efforts, and having experienced any harassment based on gender identity in school.⁷ Even after adjusting for these potential confounding factors, the study found that treatment with gender-affirming medical care during adolescence was associated with lower odds of adverse mental health outcomes.

14. A potential confounder that the State's experts raise in particular is whether or not participants received supportive psychotherapy in addition to gender-affirming medical care. Of note, there is no evidence-based psychotherapy that treats gender dysphoria itself, so such therapy is generally aimed at supporting the patient in general with their mental health. Some studies assessing gender-affirming medical care in adolescents have taken psychotherapy into account and found that benefits seen were not explained by the psychotherapy. Costa et al.⁸ examined two cohorts of adolescents with gender dysphoria. Both cohorts received six months of supportive psychotherapy for the initial six months of the study. For the next twelve months, one group continued to receive supportive psychotherapy alone (the "delayed eligible" group), while the other received supportive psychotherapy *and* pubertal suppression (the "immediately eligible" group). The delayed eligible group had statistically significant improvement in global functioning after six months of psychotherapy alone. Of note, this supportive psychotherapy was aimed at improving mental health generally, not gender dysphoria specifically. The delayed eligible group

⁷ Turban, J. L., King, D., Kobe, J., Reisner, S. L., & Keuroghlian, A. S. (2022). Access to gender-affirming hormones during adolescence and mental health outcomes among transgender adults. *PLoS One*, 17(1), e0261039.

⁸ Costa R, Dunsford M, Skagerberg E, Holt V, Carmichael P, Colizzi M (2015). Psychological support, puberty suppression, and psychosocial functioning in adolescents with gender dysphoria. *The Journal of Sexual Medicine*, 12(11), 2206-2214.

likely had worse mental health at baseline and thus was more likely to have their mental health improve with therapy. The “immediately eligible” group, which was deemed eligible for puberty blockers likely in part because their other mental health conditions besides gender dysphoria were reasonably well-controlled, did not see an improvement with therapy over these first six months. For the next twelve months of the study, the delayed eligible group that continued to receive psychotherapy alone saw no further improvement in their mental health. However, the immediately eligible group that received pubertal suppression in addition to psychotherapy saw statistically significant improvement in their global mental health functioning. This shows that pubertal suppression alleviated psychological distress that supportive psychotherapy alone could not—presumably gender dysphoria-related distress, given the mechanism of the medication. A study by Tordoff et al. similarly examined psychotherapy as a potentially confounding variable and their results showed that mental health improvements seen were not from psychotherapy alone.⁹ Another study by Achille et al.¹⁰ ran regression analyses in order to separate out the impacts of gender-affirming medical interventions from the impact of counseling and psychiatric medications. Though the sample size made it statistically difficult to detect differences, pubertal suppression was associated with better scores on the Center for Epidemiology Studies Depression Scale for participants assigned male at birth, which was a statistically significant finding.¹¹

⁹ Tordoff, D. M., Wanta, J. W., Collin, A., Stepney, C., Inwards-Breland, D. J., & Ahrens, K. (2022). Mental health outcomes in transgender and nonbinary youths receiving gender-affirming care. *JAMA Network Open*, 5(2), e220978.

¹⁰ Achille, C., Taggart, T., Eaton, N. R., Osipoff, J., Tafuri, K., Lane, A., & Wilson, T. A. (2020). Longitudinal impact of gender-affirming endocrine intervention on the mental health and well-being of transgender youths: preliminary results. *International Journal of Pediatric Endocrinology*, 2020(8). doi: 10.1186/s13633-020-00078-2.

¹¹ It is important to note that in statistics, a statistically significant finding tells you that a finding is likely to represent a true effect and the finding was not due to random chance. In contrast, the lack of a statistically significant finding does not tell you one way or another if there is an effect. I would caution against over-interpreting non-statistically significant findings. Lack of a

15. As discussed above, Dr. Cantor is likely correct (Cantor, ¶ 196) that the pubertal suppression plus therapy group in Costa was different from the therapy alone group in that the latter group had other mental health concerns. However, this would mean that this group would be even more likely to respond well to psychotherapy than the therapy plus pubertal suppression group—as the study found in the first six months of psychotherapy alone; the pubertal suppression plus therapy had improvement over the latter course of the study when pubertal suppression was added, whereas the therapy alone group did not.¹² Again, this speaks to the mental health benefits of pubertal suppression for gender dysphoria, separate from the impact of supportive psychotherapy.

16. Of note, Dr. Cantor asserts that Carmichael et al. 2021¹³ supersedes the results of Costa et al. 2015 because “neither group actually had experienced any significant improvement at all.” (Cantor, ¶196). He failed to recognize that the Carmichael study did find that global functioning scores improved; however, for reasons not clearly outlined in the Carmichael study,

statistically significant finding does not mean that no effect exists; it simply means the analysis in question does not tell the researchers one way or another if an effect exists.

¹² Dr. Cantor also references a letter to the editor about the Costa study that mentions the “dropout” rate being high (Cantor, ¶ 196). However, the dropout rate is nearly identical in the two groups, and there is no clear reason to think that the dropout rates would have thus impacted the results. If one had seen, for instance, that the dropout rate was much higher in the pubertal suppression group, one may think that people were leaving the study due to adverse effects of treatment; however, this was not seen in the study—the dropout rates were nearly identical in both groups. Biggs, M. (2019). A letter to the editor regarding the original article by Costa et al: Psychological support, puberty suppression, and psychosocial functioning in adolescents with gender dysphoria. *Journal of Sexual Medicine*, 16(12), 2043.

¹³ Carmichael, P., Butler, G., Masic, U., Cole, T. J., De Stavola, B. L., Davidson, S., Skageberg, E. M., Khadr, S., Viner, R. M. (2021). Short-term outcomes of pubertal suppression in a selected cohort of 12 to 15 year old young people with persistent gender dysphoria in the UK. *PLoS One*, 16(2), e0243894.

the authors did not run statistical analyses on this measure, as they did in the Costa 2015 publication.¹⁴

17. Dr. Cantor raises the possibility that the studies finding benefits of gender-affirming medical care for adolescents reflect reverse causation (*i.e.*, the notion that improved mental health causes one to access gender-affirming medical care rather than the reverse, that gender-affirming medical care leads to better mental health). (*See* Cantor, ¶ 61). This issue has been examined in the literature. For example, in a recent major publication in *The New England Journal of Medicine*, Chen et al. used a technique called parallel process modeling and found that improvements in mental health tracked along with improvements in appearance congruence over time (a measure of the degree to which study participants' bodies aligned with their gender identities), suggesting that gender-affirming medical care was the cause of the improvements in mental health, and arguing against the notion of reverse causation.¹⁵

18. The State's experts spend a great deal of time focusing on the lack of randomized controlled trial ("RCT") studies in this area. First, controlled cross-sectional studies and uncontrolled longitudinal cohort studies are well-accepted in medical research and often relied upon in medicine. It is true that randomized controlled trials provide valuable information and strong evidence of causation that other studies do not. But such studies are not always feasible or ethical in medicine, and many treatments are provided without the benefit of randomized

¹⁴ The discussion in the Carmichael study goes on to say, "Participant experience of treatment as reported in interviews was positive for the majority, particularly relating to feeling happier, feeling more comfortable, better relationships with family and peers and positive changes in gender role" and that their lack of statistically significant findings for other measures that were statistically analyzed "may relate simply to sample size."

¹⁵ Chen, D., Berona, J., Chan, Y. M., Ehrensaft, D., Garofalo, R., Hidalgo, M. A., Rosenthal, S. M., Tishelman, A.C., & Olson-Kennedy, J. (2023). Psychosocial functioning in transgender youth after 2 years of hormones. *New England Journal of Medicine*, 388(3), 240-250.

controlled trials. Randomized controlled trials are not feasible in the realm of gender-affirming medical care for adolescent gender dysphoria in particular. Because of the existing body of literature linking gender-affirming medical care to improved mental health outcomes for adolescents with gender dysphoria, it would be extraordinarily difficult to recruit people to participate in studies, knowing they could be randomized to receive no treatment. Particularly for vulnerable and pediatric populations, is not considered ethical to randomize patients to placebo treatments when there is substantial evidence that active treatment confers important benefits. Thus, a randomized controlled trial of gender-affirming medical care for adolescent gender dysphoria would be unlikely to be approved by an Institutional Review Board (IRB), the ethical boards at universities that decide if research is allowed to proceed).¹⁶

19. The State's experts also claim that data based on self-report and surveys are not valid or reliable evidence. Their claims represent a broad misunderstanding of psychiatry. Clinical psychiatry and clinical psychiatric research almost always involve patient reports of their symptoms. Because psychiatric conditions (*e.g.*, generalized anxiety disorder, major depressive disorder, schizophrenia, obsessive compulsive disorder, and gender dysphoria, among many others) do not have laboratory tests, diagnosis is made largely based on patient reports of their symptoms. At times these may be supplemented by reports from parents and clinician observations, particularly for establishing a diagnosis; however, they are not considered standard

¹⁶ Of note, an RCT was recently conducted in Australia among adults with gender dysphoria to examine the impact of testosterone therapy. Nolan, B. J., Zwickl, S., Locke, P., Zajac, J. D., & Cheung, A. S. (2023). Early Access to Testosterone Therapy in Transgender and Gender-Diverse Adults Seeking Masculinization: A Randomized Clinical Trial. *JAMA Network Open*, 6(9), e2331919. The RCT found that those randomized to immediate testosterone therapy had better mental health outcomes than those randomized to the clinic's regular waitlist. Given that they are a vulnerable group that generally warrants stricter protection under IRB review, it is unlikely that such an RCT would be approved for minors.

or necessary in clinical trials that track symptoms over time or compare the mental health of those receiving treatment to those not receiving treatment. The studies cited in this declaration utilize commonly used and validated self-report psychometric measures including the Kessler-6 measure of past-month severe psychological distress,¹⁷ Beck Depression Inventory II,¹⁸ and self-report measures from the National Institutes of Health Toolbox Emotion Battery.¹⁹ These self-report instruments are standard in psychiatric research.

20. Survey methodologies are widely used in psychiatric research. Of note, the State's experts repeatedly cite survey research in their own reports (*e.g.*, Littman 2018,²⁰ Diaz 2023,²¹ Littman 2021²²). It is worth highlighting that there exist both high-quality and low-quality survey

¹⁷ Kessler, R. C., Green, J. G., Gruber, M. J., Sampson, N. A., Bromet, E., Cuitan, M., Furukawa, T.A., Gureje, O., Hinkov, H., Hu, C., Lara, C., Lee, S., Mneimneh, Z., Myer, L., Oakley-Browne, M., Posada-Villa, J., Sagar, R., Viana, M. C., & Zaslavsky, A. M. (2010). Screening for serious mental illness in the general population with the K6 screening scale: results from the WHO World Mental Health (WMH) survey initiative. *International Journal of Methods in Psychiatric Research*, 19(S1), 4-22.

¹⁸ Beck, A. T., Steer, R. A., & Brown, G. (1996). Beck depression inventory–II. *Psychological Assessment*.

¹⁹ Slotkin, J., Nowinski, C., Hays, R., Beaumont, J., Griffith, J., Magasi, S., & Gershon, R. (2012). NIH Toolbox scoring and interpretation guide. *Washington (DC): National Institutes of Health*, 6-7.

²⁰ Littman, L. (2018). Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria. *PLoS One*, 13(8), e0202330.

²¹ Diaz, S. & Bailey, J. M. (2023). Rapid Onset Gender Dysphoria: Parent Reports on 1655 Possible Cases. *Archives of Sexual Behavior*, 52(3), 1031-1043. This article was later retracted by the journal. Diaz, S. & Bailey, J. M. (2023). Retraction Note: Rapid Onset Gender Dysphoria: Parent Reports on 1655 Possible Cases. *Archives of Sexual Behavior*, doi: 10.1007/s10508-023-02635-1.

²² Littman, L. (2021). Individuals treated for gender dysphoria with medical and/or surgical transition who subsequently detransitioned: A survey of 100 detransitioners. *Archives of Sexual Behavior*, 50(8), 3353-3369.

methodologies. For example, Littman 2018 has been criticized for asking leading questions to a group that is ideologically focused, making it easy for participants to bias results and analyses.²³ In contrast, the 2015 US Transgender Survey had over 180 questions across 32 sections.²⁴ If participants were to attempt to bias the results in a certain direction, they would have needed to answer questions at distant parts of the survey in a particular fashion, based on what study design they believed researchers would use. Our group's analyses also utilized regression analyses that adjusted for a range of potentially confounding variables, further adding to the complexity of the analyses. Of note, the analysis plans for our group's studies were designed only after the 2015 USTS was already administered.

21. The State's experts' opinions concerning the evidence related to gender-affirming medical care and its impact on suicidality demonstrate a lack of understanding of suicidality research. Dr. Weiss and Dr. Cantor focus on a lack of data showing elevated rates of completed suicides among youth with gender dysphoria, at least as compared to youth with other mental health disorders. (Weiss, ¶ 89; Cantor, ¶¶ 147–53). It is true that there is a paucity of literature in this regard. Such research is often conducted by examination of death records, and because gender identity is rarely recorded on such records, this research has been difficult to conduct. However, there have been studies showing lower odds of suicidal ideation among those who receive treatment.²⁵ The suggestion that there is not really an elevated risk of suicide because the data we

²³ Littman, L. (2018). Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria. *PLoS One*, 13(8), e0202330; Littman, L. (2019). Correction: Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria. *PLoS One*, 14(3), e0214157.

²⁴ James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). The Report of the 2015 U.S. Transgender Survey. Washington, DC: National Center for Transgender Equality.

²⁵ See for example Turban, J. L., King, D., Carswell, J. M., & Keuroghlian, A. S. (2020). Pubertal suppression for transgender youth and risk of suicidal ideation. *Pediatrics*, 145(2), e20191725 in the realm of cross-sectional studies and Allen, L. R., Watson, L. B., Egan, A. M., & Moser, C. N.

have is about suicidal ideation and not completed suicides demonstrates a profound lack of understanding of suicidality. Moreover, suicidal ideation is an indicator of severe psychological distress, rising to the level of the individual not wanting to live. Whether or not it ultimately results in a completed suicide, suicidal ideation is a serious negative outcome to be prevented. Reducing suicidal ideation is an important goal of mental health treatment, and it is vital for patients to have access to interventions that that reduce suicidal ideation.

22. The State's experts highlight that rates of suicidality are elevated among transgender people after gender-affirming care and Dr. Weiss even suggests that gender-affirming medical care "may increase the risk of suicide." (Weiss, ¶ 90). For example, he highlights a study by Dhejne et al. published in 2011²⁶ that found that those who had gender-affirming surgery had a 19-fold increased odds of suicidality when compared to the general population. Such statistics are not evidence that gender-affirming care is ineffective or that it increases suicide risk. The discussion from that very study explains:

"It is therefore important to note that the current study is only informative with respect to transsexual persons health after sex reassignment; no inferences can be drawn as to the effectiveness of sex reassignment as a treatment for transsexualism. In other words, the results should not be interpreted such as sex reassignment *per se* increases morbidity and mortality. Things might have been even worse without sex reassignment. As an analogy, similar studies have found increased somatic morbidity, suicide rate, and overall mortality for patients treated for bipolar disorder and schizophrenia. This is important information, but it does not follow that mood stabilizing treatment or antipsychotic treatment is the culprit."

(2019). Well-being and suicidality among transgender youth after gender-affirming hormones. *Clinical Practice in Pediatric Psychology*, 7(3), 302-311 in the realm of longitudinal studies.

²⁶ Dhejne, C., Lichtenstein, P., Boman, M., Johansson, A. L., Långström, N., & Landén, M. (2011). Long-term follow-up of transsexual persons undergoing sex reassignment surgery: Cohort study in Sweden. *PLoS One*, 6(2), e16885.

In other words, though gender-affirming care improves mental health, it does not eliminate other factors like societal experiences of transphobia that adversely impact mental health. To evaluate if gender-affirming medical care is helpful to mental health using a control group, the control group would need to be transgender people who desired but did not access the treatment, not the general population. Almazan & Keuroghlian used that appropriate control group in a study published in *JAMA Surgery* in 2021²⁷ and found that access to gender-affirming surgery was associated with lower odds of past-year suicidal ideation. They further conducted post-hoc analyses that argued against the possibility of reverse causation (*i.e.*, they showed that people who received surgery had better mental health after the treatment, rather than having better mental health at baseline prior to having the surgery).

THE STATE’S EXPERTS’ CLAIM THAT IDAHO’S BAN ON GENDER-AFFIRMING MEDICAL CARE FOR ADOLESCENT GENDER DYSPHORIA IS CONSISTENT WITH INTERNATIONAL CONSENSUS IS NOT ACCURATE

23. The State’s experts rely on reports from some European countries and imply that Idaho’s ban on gender-affirming medical care is in line with “international consensus.” (*See* for example Cantor, ¶¶ 17-33).²⁸ This is not accurate. *None* of these countries have banned—let alone

²⁷ Almazan, A. N., & Keuroghlian, A. S. (2021). Association between gender-affirming surgeries and mental health outcomes. *JAMA Surgery*, 156(7), 611-618.

²⁸ For example, Cass, H. (2022, February). The Cass Review: Independent review of gender identity services for children and young people Interim report. National Health Service (NHS), UK (England); COHERE Finland (Council for Choices in Health Care in Finland) (2020, June 16). Medical treatment methods for dysphoria associated with variations in gender identity in minors—Summary of a recommendation. [Translated], *available at* [https://palveluvalikoima.fi/documents/1237350/22895008/Summary_minors_en+\(1\).pdf/fa2054c5-8c35-8492-59d6-b3de1c00de49/Summary_minors_en+\(1\).pdf?t=1631773838474](https://palveluvalikoima.fi/documents/1237350/22895008/Summary_minors_en+(1).pdf/fa2054c5-8c35-8492-59d6-b3de1c00de49/Summary_minors_en+(1).pdf?t=1631773838474) (Finland); Swedish Socialstyrelsen. (2022, February 22). Uppdaterade rekommendationer för hormonbehandling vid könsdysfori hos unga. [Updated recommendations for hormone therapy for gender dysphoria in young people.], *available at* <https://www.socialstyrelsen.se/om-socialstyrelsen/pressrum/press/uppdateraderekommendationer-for-hormonbehandling-vid-konsdysfori-hos-unga/> (Sweden); Swedish Socialstyrelsen. (2022, December). Care of children and adolescents with gender dysphoria. Summary of national guidelines, *available at*

criminalized—gender-affirming medical care for adolescents with gender dysphoria as Idaho does. Rather, the government health authorities in the select countries referenced have made changes to the way in which gender-affirming care is being delivered (*e.g.*, moving care to research settings where more data can be collected).²⁹ Rather than put it in line with “international consensus,” Idaho’s ban on gender-affirming medical care for adolescent gender dysphoria puts the law squarely outside of mainstream medical views and policies around the world.

24. The State’s experts focus on the European reports’ assessment of the body of research on gender-affirming care for minors. Of note, most of these reports were not peer-reviewed and were published by government entities.³⁰ These types of government reports are not the types of research that experts rely upon when forming conclusions about research. Moreover, they do not include all of the relevant literature. The State’s experts attempt to bolster the importance of these reports by calling them “systematic reviews.” But all a “systematic review” means is that the authors of the reports pre-defined the search terms they used when conducting literature reviews in various databases.³¹ Merely pre-defining search terms does not guarantee that

<https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/kunskapsstod/2023-1-8330.pdf> (Sweden); French Academy of Medicine. (2022) Medicine and gender transidentity in children and adolescents, *available at* <https://www.academie-medecine.fr/la-medecine-face-a-la-transidentite-de-genre-chez-les-enfants-et-les-adolescents/?lang=en>.

²⁹ Contrary to the suggestion of Dr. Weiss (§ 168), that gender services for minors have been shut down in the U.K., the National Health Service replaced a centralized clinic with several regional clinics.

³⁰ The one exception is that the Swedish Agency for Health Technology Assessment and Assessment of Social Services (SBU) published its systematic review in the journal *Acta Paediatrica*, a Swedish medical journal that appears to be peer-reviewed. *See* Ludvigsson, J. F., Adolfsson, J., Höistad, M., Rydelius, P.-A., Kriström, B., & Landén, M. (2023). A systematic review of hormone treatment for children with gender dysphoria and recommendations for research. *Acta Paediatrica*. doi: 10.1111/apa.16791.

³¹ Harvard Countway Library. Systematic Reviews and Meta Analysis Q&A. Accessed: October 1, 2023, *available at* <https://guides.library.harvard.edu/meta-analysis/GettingStarted>.

the systematic review will identify the full body of relevant literature,³² nor does it tell you anything about the reliability of the review authors' description and analysis of the literature. The primary advantage to a systematic review would be its potential (though no guarantee) to identify research publications that had not previously been identified in this discussion. The reports cited by the State's experts did not identify any such new research reports that affect my conclusions about the research.

**THE STATE'S EXPERTS HAVE INAPPROPRIATELY APPLIED RESEARCH ON
PREPUBERTAL CHILDREN TO TRANSGENDER ADOLESCENTS IN CLAIMING
THAT THERE IS A HIGH LIKELIHOOD OF "DESISTANCE" AMONG
ADOLESCENTS WITH GENDER DYSPHORIA**

25. Dr. Cantor inappropriately uses studies of young prepubertal children to imply that adolescents who are candidates for gender-affirming medical care are likely to desist if not provided with gender-affirming care. (Cantor, ¶115). Though the terms "children" and "adolescents" are sometimes used synonymously in common parlance, these terms have specific and distinct meanings in the context of child and adolescent psychiatric research. In this field, "child" and "children" refer to minors who have not yet reached the earliest stages of puberty (*i.e.*, Tanner 2). The terms "adolescent" and "adolescents" refer to minors who have begun puberty. Studies of prepubertal children (who are not candidates for gender-affirming medical interventions under *any* existing clinical guidelines) cannot be conflated with studies of adolescents (who,

³² This is the case with a Cochrane review abstract from 2020 cited by Defendants' experts regarding gender-affirming hormone therapy among transgender women (Haupt, C., Henke, M., Kutschmar, A., Hauser, B., Baldinger, S., Saenz, S. R., & Schreiber, G. (2020). Antiandrogen or estradiol treatment or both during hormone therapy in transitioning transgender women. *Cochrane Database of Systematic Reviews*, 2020(11), CD013138). The Cochrane review did not identify several cohort studies examining gender-affirming medical care for adolescent gender dysphoria, likely due to its search methodology, and because it only examined studies published prior to 2019.

depending on several factors, *may* be candidates for various forms of gender-affirming medical interventions).

26. This distinction is vital in the realm of “desistence” studies (*i.e.*, studies that aim to assess how many young people who identify as transgender will later identify as cisgender). The suggestion by Dr. Cantor that a majority of transgender minors affected by the Idaho law will come to identify with their assigned sex at birth inappropriately relies on studies of gender diverse *prepubertal* children, which have, in the past, shown that many of these children will not grow up to be transgender. These studies do not apply to transgender minors who have reached puberty (*i.e.*, “adolescents”).³³ Once a transgender youth begins puberty, it is extremely rare for them to later identify as cisgender.³⁴ The notion that puberty will generally result in transgender people coming to identify as cisgender is also clearly not true given the fact that there are over 1 million transgender adults in the U.S.³⁵ and the vast majority of older cohorts were unable to access pubertal suppression.³⁶

³³ Dr. Cantor suggests that the desistance studies are not irrelevant to adolescents because they do not specify at what developmental stage the reported desistance occurred. (Cantor, ¶119). But those studies say nothing about whether desistance is common among adolescents with gender incongruence.

³⁴ See Turban, J.L., de Vries, A.L.C., & Zucker, K. (2018). Gender Incongruence & Gender Dysphoria. In Martin A., Bloch M.H., & Volkmar F.R. (Editors): *Lewis’s Child and Adolescent Psychiatry: A Comprehensive Textbook, Fifth Edition*. Philadelphia: Wolters Kluwer. This textbook chapter provides comment from the directors of two of the oldest and most established gender clinics in the world.

³⁵ Flores, A. R., Herman, J., Gates, G. J., & Brown, T. N. (2016). *How many adults identify as transgender in the United States?* (Vol. 13). Los Angeles, CA: Williams Institute.

³⁶ See, for example, Turban, J. L., King, D., Carswell, J. M., & Keuroghlian, A. S. (2020). Pubertal suppression for transgender youth and risk of suicidal ideation. *Pediatrics*, 145(2), e20191725, which found that only 2.5% of those who desired pubertal suppression for gender dysphoria were able to access it.

27. Any study regarding prepubertal children and their likelihood of ultimately identifying as transgender should not be used to assess the interventions targeted by the Idaho law, namely, pubertal suppression, gender-affirming hormones, and gender-affirming surgery, since none of these interventions are provided to prepubertal patients under current medical guidelines.³⁷

28. Further, the utility of “desistence” studies even for predicting the future gender identity of prepubertal children is not appropriate due to their reliance on an outdated diagnosis of “gender identity disorder in children,” which did not require a child to identify as a sex different than their sex assigned at birth. This diagnosis likely captured many cisgender “tomboys” or cisgender boys with feminine interests like dresses or dolls who never identified as transgender to begin with and, thus, unsurprisingly did not identify as transgender when followed up with later in life. In fact, an analysis of the so-called “desistence” studies found that, when asked their gender identity, 90% of the children with “gender identity disorder” in these studies reported an answer that aligned with their sex assigned at birth.³⁸ In contrast, the diagnosis of “gender dysphoria in children” requires one to not merely have gender atypical interests and behaviors; one must identify as a gender different than one’s sex assigned at birth. This is a vital distinction. While the diagnostic category of “gender identity disorder” would capture many cisgender children, the diagnostic category of “gender dysphoria” from the DSM-5, by definition, does not.³⁹

³⁷ Hembree, W.C., Cohen-Kettenis, P.T., Gooren, L., *et al.* (2017). Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons: An Endocrine Society Clinical Practice Guideline. *Journal of Clinical Endocrinology & Metabolism*, 102(11), 3869-3903.

³⁸ Olson, K. R. (2016). Prepubescent Transgender Children: What We Do and Do Not Know. *Journal of the American Academy of Child and Adolescent Psychiatry*, 55(3), 155-156.

³⁹ For more information on the limits of “desistence studies” see Olson, K.R. (2016). Prepubescent Transgender Children: What We Do and Do Not Know. *Journal of the American Academy of Child & Adolescent Psychiatry*, 3(55), 155-156.

THE STATE’S EXPERTS’ ASSERTION THAT GENDER AFFIRMING CARE CAUSES PERSISTENCE OF GENDER INCONGRUENCE IS NOT SUPPORTED BY EVIDENCE

29. The State’s experts suggest that gender affirming care, including social transition, causes the persistence of gender incongruence among youth. Despite Dr. Cantor spending a considerable portion of his declaration on the importance of differentiating correlation from causation, he does not apply that to the findings that social transition is correlated with “persistence.” He outlines data showing that youth who socially transition are more likely to continue to identify as transgender later in life (*i.e.*, correlation). But this correlation could be due to two possibilities: (1) social transition could influence a child’s gender identity, making them identify more strongly as transgender and thus more likely to persist, or (2) children who go on to socially transition identified more strongly as transgender than those who did not *prior* to social transition, and thus their pre-transition gender incongruence lead to the social transition in the first place.

30. Research by Rae et al. has shown that the second possibility is far more likely to be what is occurring.⁴⁰ Rae et al.’s 2019 study showed that gender identification is not significantly different before and after a social transition, but that those who ultimately underwent a social transition had a greater degree of gender incongruence *prior to social transition*.⁴¹ The study made clear that this correlation—between pre-pubertal social transition and transgender identity—is because those who undergo a pre-pubertal social transition had stronger discordance between

⁴⁰ Rae, J. R., Gülgöz, S., Durwood, L., DeMeules, M., Lowe, R., Lindquist, G., & Olson, K. R. (2019). Predicting early-childhood gender transitions. *Psychological Science*, 30(5), 669-681.

⁴¹ Note that in most studies, a lack of a statistically significant finding is not informative. This study used sophisticated Bayesian statistics to show that gender identification was not different before and after a social transition. Such a finding of something not being different is, under these methods, reliable.

their sex assigned at birth and their gender identity to begin with, and that social transition itself does not appear to increase gender discordance.

31. The State’s experts also point to studies showing that the overwhelming majority of transgender adolescents who start pubertal suppression go on to future additional gender-affirming medical interventions, suggesting that pubertal suppression causes continued gender incongruence. (*E.g.*, Weiss, ¶119, referring to a “conveyor belt of ‘gender transition’”). It is another logical fallacy to infer that a study showing that the majority of adolescents on puberty blockers proceeding on to future gender-affirming medical interventions is evidence that the treatment causes persistence; rather, it is just as possible, and in my opinion more likely, that, given the comprehensive biopsychosocial mental health assessment that is done prior to starting gender-affirming medical interventions under current guidelines, the adolescents who started pubertal suppression were those who were, through medical and mental health screening, determined, prior to starting pubertal suppression, to have a low likelihood of future desistence in their transgender identity.

THE STATE’S EXPERTS’ SUGGESTION THAT PATIENTS SEEK GENDER-AFFIRMING MEDICAL CARE BECAUSE OF SOCIAL INFLUENCE IS WITHOUT BASIS

32. The State’s experts claim that social influence is responsible for adolescents seeking gender-affirming medical care and is a cause of “rapid-onset gender dysphoria”. (Cantor ¶ 136; Weiss ¶¶ 35, 106.)

33. As an initial matter, Defendants’ experts fail to note that “rapid-onset gender dysphoria” is not a recognized mental health condition.⁴² The term “rapid-onset gender dysphoria”

⁴² Littman, L. (2019). Correction: Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria. *PLoS One*, 14(3), e0214157.

entered the literature in 2018 through a publication by Dr. Lisa Littman, discussed briefly above.⁴³ Soon after the initial publication of Dr. Littman’s article, a correction was published.⁴⁴ The correction noted, “Rapid-onset gender dysphoria (ROGD) is not a formal mental health diagnosis at this time. This report did not collect any data from the adolescents and young adults (AYAs) or clinicians and therefore does not validate the phenomenon.”⁴⁵ The correction goes on to say “the term should not be used in any way to imply that it explains the experiences of all gender dysphoric youth” The American Psychological Association has highlighted that, due to the lack of empiric basis, “rapid-onset gender dysphoria” should not be used in assessment or clinical treatment contexts.⁴⁶ Despite this, the State’s experts cite the 2018 Littman article to make unsubstantiated claims about adolescents with gender dysphoria.

34. The Littman study was an anonymous online survey of the parents of transgender youth, recruited from websites where this notion of “social contagion” leading to transgender identity is popular. The anonymous survey participants were asked what they thought was the

⁴³ Littman, L. (2018). Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria. *PLoS One*, 13(8), e0202330.

⁴⁴ Littman, L. (2019). Correction: Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria. *PLoS One*, 14(3), e0214157.

⁴⁵ A recent study by Bauer et al. in *The Journal of Pediatrics* examined some of the associations that would be consistent with the existence of “rapid-onset gender dysphoria” and concluded that their results “did not support the rapid onset gender dysphoria hypothesis.” Bauer, G. R., Lawson, M. L., Metzger, D. L., & Trans Youth CAN! Research Team. (2022). Do Clinical Data from Transgender Adolescents Support the Phenomenon of “Rapid Onset Gender Dysphoria”? *Journal of Pediatrics*, 2022(243), 224-227. Two recent publications from our group similarly did not support the notion: Turban, J. L., Dolotina, B., King, D., & Keuroghlian, A. S. (2022). Sex assigned at birth ratio among transgender and gender diverse adolescents in the United States. *Pediatrics*, 150(3), e2022056567 and Turban, J. L., Dolotina, B., Freitag, T. M., King, D., & Keuroghlian, A. S. (2023). Age of Realization and Disclosure of Gender Identity Among Transgender Adults. *Journal of Adolescent Health*, 72(6), 852-859.

⁴⁶ American Psychological Association et al. CAAPS Position Statement on Rapid Onset Gender Dysphoria (ROGD). Available at: <https://www.caaps.co/rogd-statement>. Accessed: October 1, 2023.

etiology of their children's transgender identity. Some of these parents believed that their children became transgender as a result of watching transgender-related content on websites like *YouTube* and having LGBTQ friends. The alternative interpretation, and in my opinion more likely interpretation, is that these youth sought out transgender-related media and LGBTQ friends because they wanted to find other people who understood their experiences and could offer support. The parent respondents also noted that, from their perspective, their children became transgender "all of a sudden," hence the term "rapid-onset." Once again, the problem here is that the study did not interview the adolescents themselves, nor their healthcare providers. It is common for transgender (as with gay, lesbian and bisexual) children and adolescents to conceal their identity from their parents for long periods of time. In a recent study from our research group, transgender people who first understood their gender identity in childhood waited a median 14 years before sharing this with another person.⁴⁷ In my experience working with transgender youth and adults, the reasons for this tend to be out of fear of negative repercussions (rejection, being kicked out of the house, or even physical assault) were their parents to find out that they are transgender. Children often learn to conceal their gender non-conforming behaviors and transgender identity early, particularly if their parents have strong negative reactions to them exhibiting gender non-confirming behavior.

35. The State's experts point to the increase in referrals to gender clinics, particular among birth-assigned females, over time as a point of concern. (*E.g.*, Cantor, ¶17, ¶25; Weiss ¶179). The increase in referrals has coincided with increased visibility of transgender people, including transgender men, in society and greater awareness of gender dysphoria and access to

⁴⁷ Turban, J. L., Dolotina, B., Freitag, T. M., King, D., & Keuroghlian, A. S. (2023). Age of Realization and Disclosure of Gender Identity Among Transgender Adults. *Journal of Adolescent Health*, 72(6), 852-859.

medical care to treat it. In the past, people thought of gender dysphoria as something that primarily impacted birth-assigned males. This likely led to many cases of gender dysphoria among birth-assigned females being overlooked by families or undiagnosed or “missed” by doctors. In recent years, literacy regarding gender dysphoria among birth-assigned females has increased among physicians. As fewer birth-assigned females go undiagnosed, the sex ratio in gender clinics has shifted away from predominantly birth-assigned males. This is similar to a pattern that has been seen in autism spectrum disorder. For example, a large study found that with increasing awareness that autism spectrum disorder can impact birth-assigned females as well as birth-assigned males, the sex ratio shifted more toward birth-assigned females, from 5.1:1 (birth-assigned males to females) to 3.1:1.⁴⁸ The same study saw the sex ratio for the related diagnosis of Asperger’s syndrome similarly shift from 8.4:1 to 3.0:1. Whereas parents and pediatricians in the past may have had limited literacy regarding gender diversity in adolescents, today more Americans, as well as people abroad, have greater understanding of the experiences of transgender youth. This fact has undoubtedly increased the number of parents bringing their adolescents to gender clinics for evaluation and pediatricians referring patients to gender clinics. Additionally, insurance coverage of gender-affirming medical interventions has improved drastically, meaning that more families are able to afford care, which results in an increase in referrals for evaluation.

36. Of note, not all adolescents who present at gender clinics ultimately go on to receive gender-affirming medical interventions.⁴⁹ In fact, in a large study from a Netherlands gender

⁴⁸ Jensen, C. M., Steinhausen, H. C., & Lauritsen, M. B. (2014). Time trends over 16 years in incidence-rates of autism spectrum disorders across the lifespan based on nationwide Danish register data. *Journal of Autism and Developmental Disorders*, 44(8), 1808-1818.

⁴⁹ Wiepjes, C. M., Nota, N. M., de Blok, C. J., Klaver, M., de Vries, A. L., Wensing-Kruger, S. A., de Jongh, R. T., Bouman, M. B., Steensma, T. D., Cohen-Kettenis, P., Gooren, L. J. G., Kreukels, B. P. C., & den Heijer, M. (2018). The Amsterdam cohort of gender dysphoria study

clinic, the percentage of patients who presented for evaluation who actually started any kind of gender-affirming treatment has decreased over time.⁵⁰ The authors of that study note:

“[T]his finding may be explained by the fact that in the past it was harder to find information about [gender dysphoria] and its treatment, and only people with extreme types of [gender dysphoria] managed to visit our gender identity clinic for treatment. Currently, owing to media attention and the internet, it is easier to access information about our gender identity clinic, making the threshold lower to search for help.”

This shows that while more people may be coming in for evaluation, the criteria for diagnosis and treatment remain stringent and a smaller percentage of patients are actually being diagnosed with gender dysphoria and referred on for medical treatment.

THE STATE’S EXPERTS ASSERTIONS OF HIGH RATES OF TRANSITION REGRET ARE UNSUPPORTED BY THE EVIDENCE

37. The State’s experts suggest that a large number of adolescents who undergo gender-affirming medical care go on to regret treatment; however, this is not supported by extant evidence. In 2018, Amsterdam’s VUMC Center of Expertise on Gender Dysphoria published the rates of regret among their cohort of 6,793 transgender patients who had undergone gender-affirming medical and surgical interventions.⁵¹ Among transgender women with gender dysphoria who underwent gender-affirming surgery, 0.6% experienced regret. Among transgender men with

(1972–2015): trends in prevalence, treatment, and regrets. *Journal of Sexual Medicine*, 15(4), 582-590.

⁵⁰ Wiepjes, C. M., Nota, N. M., de Blok, C. J., Klaver, M., de Vries, A. L., Wensing-Kruger, S. A., de Jongh, R. T., Bouman, M. B., Steensma, T. D., Cohen-Kettenis, P., Gooren, L. J. G., Kreukels, B. P. C., & den Heijer, M. (2018). The Amsterdam cohort of gender dysphoria study (1972–2015): trends in prevalence, treatment, and regrets. *Journal of Sexual Medicine*, 15(4), 582-590.

⁵¹ Wiepjes, C. M., Nota, N. M., de Blok, C. J., Klaver, M., de Vries, A. L., Wensing-Kruger, S. A., de Jongh, R. T., Bouman, M. B., Steensma, T. D., Cohen-Kettenis, P., Gooren, L. J. G., Kreukels, B. P. C., & den Heijer, M. (2018). The Amsterdam cohort of gender dysphoria study (1972–2015): trends in prevalence, treatment, and regrets. *Journal of Sexual Medicine*, 15(4), 582-590.

gender dysphoria who underwent gender-affirming surgery, 0.3% experienced regret. Several of those who experienced regret were classified as having “social regret” rather than “true regret,” defined in the study as still identifying as transgender but deciding to reverse their gender-affirming surgery due to factors like “the loss of relatives [being] a large sacrifice.” The study also reported that only 1.9% of adolescents who started pubertal suppression did not choose to go onto gender-affirming hormones. In a second study of 143 transgender adolescents who started pubertal suppression, 5 (3.5%) decided not to proceed with further gender-affirming medical treatments.⁵² One of these adolescents noted that pubertal suppression helped them to better understand their gender identity, and they ultimately identified with their sex assigned at birth. One birth-assigned female had ongoing chest dysphoria but chose to live with a female gender expression regardless, though was dreading further breast development and menstruation. One stopped due to unspecified “psychosocial reasons” but continued to identify as transgender. One identified as gender non-binary and felt they no longer needed treatment. One came to identify with his sex assigned at birth. There was no indication that any of these adolescents *regretted* pubertal suppression; rather, this study shows that the treatment served its goal of allowing adolescents more time to better understand their gender identity before being assessed for additional treatment.

38. The State’s experts cite some studies discussing rates of discontinuing gender-affirming medical interventions. For example, Dr. Weiss cites findings from a study by Roberts et al. published in 2022 that “[a]mong those who had started hormonal intervention before age eighteen, 26% discontinued treatment. Among all the natal females in this follow up study, 36%

⁵² Brik, T., Vrouenraets, L. J., de Vries, M. C., & Hannema, S. E. (2020). Trajectories of adolescents treated with gonadotropin-releasing hormone analogues for gender dysphoria. *Archives of Sexual Behavior*, 49(7), 2611-2618.

discontinued treatment.”⁵³ (Weiss, ¶159). It is essential to note that discontinuation of a medication does not necessarily indicate regret. This study examined only rates of discontinuation, not *reasons* for discontinuation. Reasons for discontinuing can include satisfaction with degree of physical gender congruence already attained, social stress related to transphobia, or financial reasons like loss of insurance. As the paper notes, in citing our 2021 publication in the journal *LGBT Health*, “many individuals who report [stopping] gender-affirming hormones [report] subsequently restarting treatment or the intention to restart treatment.”

39. Dr. Weiss also failed to mention that the Roberts study found that discontinuation rates were lower among those who started gender-affirming medical care as minors when compared to those who started as adults, likely due to the comprehensive psychosocial mental health evaluations conducted prior to initiating care. The publication’s discussion section notes, “Regardless of the reason for the higher hormone continuation rate among TGD youth, this finding provides support for the idea that TGD individuals below the age of legal majority, with the assistance of their parents or legal guardians and health care providers, can provide meaningful informed assent for gender-affirming hormones and do not appear to be at a higher risk of future discontinuation of gender-affirming hormones because of their young age alone.”

40. The State, on page nine of its combined memorandum of law in opposition to motion for preliminary injunction and in support of motion to dismiss, asserts that a paper by Hall et al. shows that “the medical detransition rate among youth who underwent gender transitions in recent years may be as high as 30% . . .” The cited paper shows no such thing. First, this was a study of adults, not youth. Second, the study did not find a detransition rate of 30%. The paper

⁵³ Roberts, C. M., Klein, D. A., Adirim, T. A., Schvey, N. A., Hisle-Gorman, E. (2022). Continuation of Gender-affirming Hormones among Transgender Adolescents and Adults. *Journal of Clinical Endocrinology & Metabolism*, 107(9) e3937-e3943.

notes, “twelve cases (12/175, 6.9%) were agreed by all authors to meet the case definition for detransitioning. Regret was specifically documented in two cases [1.1%]”⁵⁴ Also of note in this study is that the authors did not record reasons for detransition (defined in this study as going back to presenting as one’s sex assigned at birth). The State also cites a press release from the French Academy of Medicine, which, though it states there is an “increasing number of transgender young adults wishing to “detransition,” provides no detransition rate, nor any citation that shows this is true.⁵⁵ One of the few citations the press release does provide is to the 2018 Littman paper I discuss above.⁵⁶

41. In a peer-reviewed manuscript that was named Best Clinical Perspectives Manuscript of the year by *The Journal of The American Academy of Child & Adolescent Psychiatry*, Dr. Alex Keuroghlian and I created a framework for understanding transgender adolescent patients who discontinue gender-affirming medical interventions.⁵⁷ We explained that this may be due to external factors (*e.g.*, pressure from family, societal rejection, harassment by peers) or internal factors (*e.g.*, a change in the understanding of one’s gender identity). We highlighted that discontinuation of gender-affirming medical interventions does not always coincide with a change in understanding of one’s gender identity or with transition-related regret.

⁵⁴ Hall, R., Mitchell, L., & Sachdeva, J. (2021). Access to care and frequency of detransition among a cohort discharged by a UK national adult gender identity clinic: retrospective case-note review. *BJPsych Open*, 7(6), e184.

⁵⁵ French Academy of Medicine. (2022) Medicine and gender transidentity in children and adolescents, *available at* <https://www.academie-medecine.fr/la-medecine-face-a-la-transidentite-de-genre-chez-les-enfants-et-les-adolescents/?lang=en>.

⁵⁶ The French Academy of Medicine press release itself recommends, “in the event of a persistent desire for transition, a careful decision about medical treatment with hormone blockers or hormones of the opposite sex within the framework of multi-disciplinary consultation meetings.”

⁵⁷ Turban, J. L., & Keuroghlian, A. S. (2018). Dynamic gender presentations: understanding transition and "de-transition" among transgender youth. *Journal of the American Academy of Child and Adolescent Psychiatry*, 57(7), 451-453.

Our team later published a study highlighting that a substantial number of currently identified transgender people (13.1%) have “de-transitioned”⁵⁸ at some point in their life, with the majority (82.5%) citing external factors like family rejection, societal stigma, or harassment.⁵⁹ Given that these people *currently* identify as transgender, it highlights that many people who “de-transition” choose to transition again in the future. This harkens to the history of the “ex-gay” movement in which many gay and lesbian individuals reported that they were “cured” of their homosexuality, only to later reveal that they were still gay but felt pressured by their communities to say for many years that they were not.

42. The State’s experts cite two papers discussing the experiences of some individuals who detransitioned, one by Littman and one by Vandebussche.⁶⁰ (Weiss, ¶157). Neither of these papers provide information on the prevalence of detransition or, specifically, the rate of detransition among those who initiate gender-affirming medical care during adolescence. In fact, the introduction of the Littman article states that the paper is not “designed to assess the prevalence of detransition as an outcome of transition.” In addition, in the Littman study, 34% of the participants reported that gender-affirming care was “a necessary part of [their] journey.” And

⁵⁸ This study defined “de-transition” as an affirmative answer to the following: “Have you ever de-transitioned? In other words, have you ever gone back to living as your sex assigned at birth, at least for a while?”

⁵⁹ Turban, J. L., Loo, S. S., Almazan, A. N., & Keuroghlian, A. S. (2021). Factors Leading to “Detransition” Among Transgender and Gender Diverse People in the United States: A Mixed-Methods Analysis. *LGBT Health*, 8(4), 273-280.

⁶⁰ Littman L. (2021). Individuals treated for gender dysphoria with medical and/or surgical transition who subsequently detransitioned: A survey of 100 detransitioners. *Archives of Sexual Behavior*, 50(8), 3353–3369; Vandebussche, E. (2021). Detransition-related needs and support: A cross-sectional online survey. *Journal of Homosexuality*, 69(9), 1602-1620. Of note, of the 237 individuals in the Vandebussche study, only 25% had medically transitioned as minors and many did not medically transition at all.

among this group of people who de-transitioned, most reported that undergoing gender-affirming medical care was in some way helpful.

43. Dr. Weiss cites Reddit in his attempt to claim there is evidence that rates of detransition and regret among those initiating gender-affirming medical care are high. (Weiss, ¶156). He notes that one Reddit group called r/detrains has over 49,000 members. However, there is no indication that all or even many of the 49,000 members of that group have detransitioned, even if that term is broadly defined. In fact, in reading r/detrans, one will find posts expressing concern that the group has been dominated by members who have not actually detransitioned but rather by “people who are wanting to prey on their vulnerability and use them as political pawns.”⁶¹

44. There are undoubtedly some people who start gender-affirming medical interventions and later stop them. A small minority of these appear to regret the treatment, though differentiating regret related to transphobia from regret related to the treatment itself can be difficult to disentangle. But as I reviewed above, all existing research suggests that regret following gender-affirming medical interventions is rare. As with all medical interventions, gender-affirming medical interventions cannot claim a 100% success rate. However, for the vast majority of adolescents, these interventions improve mental health. Accordingly, it is dangerous to take this option away from families and physicians.

THERE IS NO EVIDENCE-BASED PSYCHOTHERAPY TO TREAT GENDER DYSPHORIA

45. The State’s experts suggest that psychotherapy can provide relief for gender dysphoria in lieu of gender-affirming medical care. While psychotherapy can be very helpful for

⁶¹ Post by a member of the Reddit group r/detrans, available at: https://www.reddit.com/r/honesttransgender/comments/k6fidf/rdetrans_is_just_an_antitrans_sub_now/?utm_source=share&utm_medium=web2x&context=3. Accessed: October 1, 2023.

adolescents with gender dysphoria to help explore their gender identity and address comorbid conditions like depression and anxiety, there are no evidence-based psychotherapy protocols that effectively treat gender dysphoria itself.

46. In the past, some clinicians have described psychotherapeutic strategies to attempt to lead youth with gender dysphoria to identify with their sex assigned at birth.⁶² Such practices, often referred to as “gender identity conversion efforts”, have subsequently been linked to adverse mental health outcomes, including suicide attempts, particularly when people are exposed to them as children.⁶³ In addition to being harmful, there is no peer-reviewed research to suggest that these gender identity conversion efforts are successful in changing a person from transgender to cisgender.⁶⁴

47. While the State’s experts repeatedly criticize the extensive body of research linking gender-affirming medical care to improved mental health outcomes for adolescent gender dysphoria, they do not provide evidence to support their implication that gender dysphoria can be treated with psychotherapy alone.

48. Dr. Weiss asserts that “exploratory, non-judgmental psychotherapy can alleviate suffering in patients with ‘gender dysphoria’ and may help them accept their natal sex.” (Weiss,

⁶² Meyer-Bahlburg, H.F. (2002). Gender Identity Disorder in Young Boys: A Parent-and Peer-Based Treatment Protocol. *Clinical Child Psychology and Psychiatry*, 7(3), 360-376.

⁶³ Turban, J.L., Beckwith, N., Reisner, S.L., & Keuroghlian, A.S. (2020). Association Between Recalled Exposure to Gender Identity Conversion Efforts and Psychological Distress and Suicide Attempts Among Transgender Adults. *JAMA Psychiatry*, 77(1), 68-76.

⁶⁴ Gender identity conversion efforts have therefore been labelled unethical by major medical organizations including The American Medical Association and The American Academy of Child & Adolescent Psychiatry. American Medical Association. (2017). Health Care Needs of Lesbian, Gay, Bisexual and Transgender Populations. H-160.991. Available at <https://policysearch.ama-assn.org/policyfinder/detail/gender%20identity?uri=%2FAMADoc%2FHOD.xml-0-805.xml>; The American Academy of Child & Adolescent Psychiatry. (2018). Conversion Therapy. Available at https://www.aacap.org/AACAP/Policy_Statements/2018/Conversion_Therapy.aspx.

¶40). Exploratory psychotherapy can be helpful for adolescent patients who are unsure of their gender identity to come to understand it. Dr. Weiss appears to be suggesting that such therapy can help transgender people become cisgender. The sources he cites to support this do no such thing. The first is a letter to the editor that provides no data or evidence to support the assertion.⁶⁵ The second is a description of twelve adolescent patients who underwent the psychosocial assessment that is required prior to initiating gender-affirming medical care for adolescent gender dysphoria and ultimately did not pursue gender-affirming medical care.⁶⁶ This case series is not evidence that psychotherapy is effective in promoting identification with one's sex assigned at birth, but rather, that the psychosocial evaluation is effective in identifying appropriate candidates for gender-affirming medical care.⁶⁷

CONCLUSION

49. In summary, the declarations from the State's experts do not provide justification for banning gender-affirming medical care for adolescents with gender dysphoria. The scientific evidence that I outlined above shows the benefits of the proscribed care. This research is consistent with the decades of clinical experience from around the world—including my own—of improved mental health outcomes from these interventions. None of the European countries the State's experts cite have banned care. The research the State's experts cite on “desistance” among prepubertal children has no bearing on adolescents with gender dysphoria, and there is no scientific

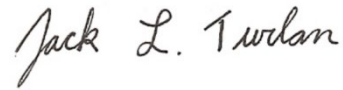
⁶⁵ D'Angelo, R., Syrulnik, E., Ayad, S., Marchiano, L., Kenny, D. T., & Clarke, P. (2021). One size does not fit all: In support of psychotherapy for gender dysphoria. *Archives of Sexual Behavior*, 50(1), 7-16.

⁶⁶ Churcher Clarke, A., & Spiliadis, A. (2019). 'Taking the lid off the box': The value of extended clinical assessment for adolescents presenting with gender identity difficulties. *Clinical Child Psychology and Psychiatry*, 24(2), 338-352.

⁶⁷ Incidentally, it is surprising to see Dr. Weiss rely on this study at all as throughout the remainder of his declaration, he dismisses research that lacks high GRADE-level data.

support for their assertions that providing gender-affirming medical care causes “persistence” of gender incongruence. Nor is there any evidence supporting the State’s experts’ claims that youth are seeking gender-affirming medical care due to peer and social media influence, or that those who receive care are likely to come to regret it. Finally, there are no evidence-based alternatives for treating gender dysphoria. While the State’s experts critique the literature regarding the benefits of gender-affirming medical care, they offer no studies supporting an alternative treatment. The Idaho ban would leave physicians, adolescents, and their parents without any evidence-based treatments for adolescent gender dysphoria, a condition that can cause immense suffering.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

A handwritten signature in black ink that reads "Jack L. Turban". The signature is written in a cursive, flowing style.

Executed on: October 13, 2023

JACK L. TURBAN, MD, MHS

Exhibit A

Jack Lewis Turban III MD MHS

401 Parnassus Ave
 San Francisco, CA 94143
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ACADEMIC APPOINTMENTS

University of California, San Francisco School of Medicine San Francisco, CA. September 2022-Present
Assistant Professor of Child & Adolescent Psychiatry and Affiliate Faculty in the Philip R. Lee Institute for Health Policy Studies. Responsibilities include serving as director of the gender psychiatry program, and as an attending psychiatrist in the adult gender and sexual minority clinic, and in the eating disorders clinic, as well as research focusing on the determinants of mental health among transgender and gender diverse youth and the teaching of medical students, residents, and fellows.

EDUCATION & TRAINING

Stanford University School of Medicine Palo Alto, CA July 2020-June 2022
Fellow in Child & Adolescent Psychiatry. Fellow in child and adolescent psychiatry. Research focused on pediatric gender identity and LGBTQ mental health. Served as administrative chief fellow 2021-2022.

Massachusetts General Hospital & McLean Hospital Boston, MA July 2017 – May 2020
Integrated Adult, Child, & Adolescent Psychiatry Resident. Resident physician in the integrated adult, child, and adolescent psychiatry program. Research focused on pediatric gender identity and LGBT mental health.

Yale School of Medicine New Haven, CT. August 2012- May 2017
Doctor of Medicine & Master of Health Science with honors. Clinical rotations included inpatient pediatrics, inpatient child psychiatry, inpatient adolescent psychiatry, residential adolescent psychiatry, psychiatric consult liaison service, clinical neuromodulation, neurology clinics, and neurosurgery. Completed award-winning masters' thesis as a Howard Hughes Medical Institute (HHMI) medical research fellow on evolving treatment paradigms for transgender youth. Clerkship Grades: All Honors
 USMLE: Step 1 (252), Step 2 (256)

Harvard University Cambridge, MA September 2007- May 2011
B.A. Neurobiology magna cum laude with a secondary in the Dramatic Arts. Coursework included clinical neuroscience, systems neurobiology, visual neuroscience, positive psychology, neurobiology of behavior, CNS regenerative techniques, neuroanatomy, vertebrate surgery, and extensive coursework in dramatic theory and practice. International study included Spanish language (Alicante, Spain), stem cell biology (Shanghai, China), and studying how visual art may be used as a window into the mechanisms of neural processing (Trento, Italy). Honors thesis completed at The Massachusetts Eye & Ear Infirmary studying inner-ear development and regeneration. GPA: 3.8/4.0

RESEARCH EXPERIENCE

The Fenway Institute Boston, MA 2017-Present
Post-doctoral Research Fellow. Currently using data from the National Transgender Discrimination Survey to determine the adult mental health correlates of recalled childhood experiences including exposure to conversion therapy and access to gender-affirming hormonal interventions. PIs: Timothy Wilens, Alex Keuroghlian, & Sari Reisner

Stanford Division of Child & Adolescent Psychiatry Palo Alto, CA 2020-2022
Post-doctoral Research Fellow. Established the Stanford Evaluation of Gender Affirmation (SEGA) study, which examines the impact of gender-affirming medical and surgical interventions on the mental health of transgender and gender diverse youth. Mentors: Dr. David Hong & Dr. Tandy Aye

McLean Institute for Technology in Psychiatry Belmont, MA. 2017-2020
Post-doctoral Research Fellow. Conducted cross-sectional studies that examine the associations between geosocial "hook-up apps," internalizing psychopathology, and compulsive sexual behavior. Utilizing the TestMyBrain platform. PI: Laura Germine

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Yale Program for Research on Impulsivity & Impulse Control Disorders New Haven, CT 2016-2019
Pre-doctoral Research Fellow. Conducted a studies of US military veterans who had recently returned from deployment, studying rates and comorbidities of those veterans who exhibit compulsive sexual behavior facilitated by social media. PI: Marc Potenza MD/PhD

Yale Child Study Center New Haven, CT 2015-2017
Pre-doctoral Research Fellow. Conducted a study to evaluate pediatric attending and medical student knowledge regarding transgender pediatric patient care. Additionally studied participants' personal ethical views regarding pubertal blockade and cross-sex hormone therapy for adolescent patients. PI: Timothy VanDeusen MD

Yale Department of Dermatology New Haven, CT 2015-2016
HHMI Medical Research Fellow. Studied the potential molecular mediators of Langerhans Cell-mediated UVB-induced epidermal carcinogenesis. Techniques included transgenic mouse models of chronic UV exposure, epidermal sheet preparations, immunohistochemistry, confocal microscopy, flow cytometry, Bioplex analysis, quantitative PCR and tissue culture. PI: Michael Girardi MD

Yale Department Laboratory Medicine New Haven, CT 2012-2014
Pre-doctoral Research Fellow. Employed mass spectrometry to compare metabolite profiles of recurrent tumor versus radiation-induced necrosis following Gamma Knife Radiosurgery for brain metastases, working to identify novel biomarkers for non-invasive imaging techniques. PI: Tore Eid MD/PhD

Yale Department of Neurosurgery New Haven, CT 2012-2012
Pre-doctoral Research Fellow. Developed a database of patients who received gamma knife radiosurgery or whole brain radiation for the treatment of brain metastases. This database is designed to evaluate the relative risks of radiation-induced necrosis following these two treatment modalities. PI: Veronica Chiang MD

Eaton-Peabody Laboratory Cambridge, MA 2009-2011
Undergraduate Research Fellow. Worked at the Massachusetts Eye and Ear Infirmary laboratory, studying stem cells of the inner ear and working toward cochlear hair cell regeneration. PI: Albert Edge PhD

Novartis Pharmaceuticals Shanghai, China 2009-2009
Intern. Worked as a biological research intern, studying the role of Math-1 in inner-ear development and regeneration.

LEADERSHIP

UCSF Child & Adolescent Psychiatry Grand Rounds Committee San Francisco, CA. 2023-Present
Member. Works with with committee to select and work with grand rounds speakers for the weekly child and adolescent psychiatry grand rounds series.

UCSF Child & Adolescent Psychaitry Fellowship Selection Committee San Francisco, CA 2022-Present
Member. Conducts interviews for applications to the UCSF child and adolescent psychiatry fellowship training program, sits on selection committee, works on recruitment efforts.

The Upswing Fund 2020-Present
Scientific Advisory Board. Member of the scientific advisory board of a \$15M charitable fund to support adolescent minority mental health during the COVID19 pandemic. Funded by Melinda Gates's Panorama Global.

Stanford Medicine Diversity Cabinet LGBTQ+ / Sexual and Gender Minority Subcommittee 2021-2022
Member. Working to improve Stanford School of Medicine in all aspects relevant to sexual and gender minorities including curriculum, clinical care, and employee support.

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Stanford Pediatric Gender Journal Club

2021-2022

Founder. Organizing a monthly journal club focusing on the latest research relevant to the care of transgender and gender diverse youth.

MGH Psychiatry Gender Lab Meetings Boston, MA

2019-2020

Founder. Established monthly lab meetings for those in the MGH psychiatry department to discuss ongoing research regarding transgender mental health.

Yale School of Medicine Cultural Competence Committee New Haven, CT

2012-2017

Chair. Worked with individual course directors to develop course material on cultural competence. Authored case studies on handling pediatric patient sexuality (Professional Responsibility Course), authored a pre-clinical lecture on LGBT healthcare (Ob/Gyn Module), and lectured on transgender pediatric patient care (Pediatrics Clinical Clerkship).

Dean's Advisory Committee on LGBTQ Affairs (Yale School of Medicine) New Haven, CT

2016-2017

Member. Served on the advisory committee to the Dean of Yale School of Medicine, advising on issues related to LGBTQ affairs.

Yale HIV Dermatology Roundtable New Haven, CT

2014-2017

Founder. Eighty percent of patients suffering from HIV face a dermatologic manifestation of their disease. Struck by these patients' experience of stigma, I organized a bi-monthly interdisciplinary roundtable to improve research, education, and clinical care in HIV dermatology. Interventions have included primary care provider training on the treatment of genital warts and improved referral systems for cutaneous malignancies.

Yale Gay & Lesbian Medical Association New Haven, CT

2013-2017

President. Led a group of medical students focused on supporting careers in medicine for LGBT individuals. Organized mixers with LGBT organizations from other graduate schools and with LGBT faculty. Coordinated trips to GLMA national conferences. Worked with the medical school administration to create an LGBT faculty advisor position.

VOLUNTEER WORK & ADVOCACY

American Academy of Child & Adolescent Psychiatry "Break the Cycle"

2017-2017

Event Coordinator. Worked with Dr. Andres Martin to coordinate a fundraising indoor cycling event for the AACAP Break The Cycle fundraising campaign to fight children's mental illness.

Yale Hunger & Homelessness Auction New Haven, CT

2012-2014

Logistics Co-Chair. Organized a group of ten students to coordinate entertainment, donations, and event logistics for the Yale annual charity auction. All proceeds for the auction go to support local charities.

Yale School of Medicine Admissions Committee New Haven, CT

2015-2017

Interviewer. Served as a full voting member of the admissions committee. Responsibilities include student interviewing, recruitment, and organizing LGBT-focused activities for admitted students.

Harvard College Admissions New Haven, CT

2012-2020

Interviewer. Interviewing students from the Boston area for admission to Harvard College.

SELECTED PEER REVIEWED PUBLICATIONS: ORIGINAL RESEARCH

Turban J.L., Dolotina B., Freitag T.M., King D., Keuroghlian A.S. Age of realization of transgender identity and mental health outcomes among transgender and gender diverse adults: examining the "rapid onset gender dysphoria" hypothesis. *Journal of Adolescent Health.* [In Press]

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Turban J.L., Dolotina B., King D., Keuroghlian A.S. (2022) Sex assigned at birth ratio among transgender and gender diverse adolescents in the United States. *Pediatrics*. [Accepted]

Turban J.L., King D., Kobe J., Reisner S.L., Keuroghlian A.S. (2022) Access to gender-affirming hormones during adolescence and mental health outcomes among transgender adults. *PLoS ONE*, 17(1): e0261039.

Passell E., Rutter L.A., **Turban J.L.**, Scheuer L., Wright N., Germine L. (2021) Generalized Anxiety Disorder Symptoms are Higher Among Same- and Both-Sex Attracted Individuals in a Large, International Sample. *Sexuality Research and Social Policy*. [ePub ahead of print]

Lewis, J. M., Monico, P. F., Mirza, F. N., Xu, S., Yumeen, S., **Turban, J. L.**, Galan A., & Girardi, M. (2021). Chronic UV radiation–induced ROR γ t+ IL-22–producing lymphoid cells are associated with mutant KC clonal expansion. *Proceedings of the National Academy of Sciences*, 118(37).

Turban J.L., King, D., Li, J.L., Keuroghlian, A.S. (2021) Timing of Social Transition for Transgender and Gender Diverse Youth, K-12 Harassment, and Adult Mental Health Outcomes. *Journal of Adolescent Health*. 69(6), 991-998.

Turban J.L., Loo, S. S., Almazan, A. N., Keuroghlian, A.S. (2021) Factors Leading to “Detransition” Among Transgender and Gender Diverse People in the United States: A Mixed-Methods Analysis. *LGBT Health*. 8(4), 273-280.

Turban, J. L., Passell E, Scheer L, Germine L. (2020) Use of Geosocial Networking Applications Is Associated With Compulsive Sexual Behavior Disorder in an Online Sample. *The Journal of Sexual Medicine*. 17(8), 1574-1578.

Turban, J. L., King, D., Carswell, J. M., & Keuroghlian, A. S. (2020). Pubertal suppression for transgender youth and risk of suicidal ideation. *Pediatrics*, 145(2), e20191725.

Turban, J. L., Shirk, S. D., Potenza, M. N., Hoff, R. A., & Kraus, S. W. (2020). Posting Sexually Explicit Images or Videos of Oneself Online Is Associated With Impulsivity and Hypersexuality but Not Measures of Psychopathology in a Sample of US Veterans. *The Journal of Sexual Medicine*, 17(1), 163-167.

Turban, J. L., Beckwith, N., Reisner, S. L., & Keuroghlian, A. S. (2020). Association between recalled exposure to gender identity conversion efforts and psychological distress and suicide attempts among transgender adults. *JAMA Psychiatry*, 77(1), 68-76.

Acosta, W., Qayyum, Z., **Turban, J. L.**, & van Schalkwyk, G. I. (2019). Identify, engage, understand: Supporting transgender youth in an inpatient psychiatric hospital. *Psychiatric Quarterly*, 90(3), 601-612.

Turban, J. L., King, D., Reisner, S. L., & Keuroghlian, A. S. (2019). Psychological Attempts to Change a Person’s Gender Identity from Transgender to Cisgender: Estimated Prevalence Across US States, 2015. *American Journal of Public Health*, 109(10), 1452-1454.

Turban, J. L., Winer, J., Boulware, S., VanDeusen, T., & Encandela, J. (2018). Knowledge and attitudes toward transgender health. *Clinical Teacher*, 15(3), 203-207.

Turban, J. L., Potenza, M. N., Hoff, R. A., Martino, S., & Kraus, S. W. (2017). Psychiatric disorders, suicidal ideation, and sexually transmitted infections among post-deployment veterans who utilize digital social media for sexual partner seeking. *Addictive Behaviors*, 66, 96-100.

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Turban J. L.*, Lu, A. Y*, Damisah, E. C., Li, J., Alomari, A. K., Eid, T., ... & Chiang, V. L. (2017). Novel biomarker identification using metabolomic profiling to differentiate radiation necrosis and recurrent tumor following Gamma Knife radiosurgery. *Journal of Neurosurgery*, 127(2), 388-396.

Kempfle, J. S., **Turban, J. L.**, & Edge, A. S. (2016). Sox2 in the differentiation of cochlear progenitor cells. *Scientific Reports*, 6, 23293.

SELECTED PEER REVIEWED PUBLICATIONS: COMMENTARY, REVIEWS, & PERSPECTIVES

Lerario, M. P., Rosendale, N., Waugh, J. L., Turban, J., & Maschi, T. (2023). Functional Neurological Disorder Among Sexual and Gender Minority People. *Neurologic Clinics*. [In Press]

Chen A, Cohen I.G., Kraschel K., **Turban J.L.** Legal & Ethical Perspectives on Criminalization of Standard of Care Medical Practices. *Cell Reports Medicine*.

Turban J.L., Brady C., & Olson-Kennedy J. Understanding & Supporting Patients with Dynamic Desires for Gender-affirming Medical Interventions. *JAMA Network Open*.

Dolotina B. & **Turban J.L.** “Phantom Networks” Prevent Children & Adolescents from Obtaining the Mental Health Care They Need. *Health Affairs*. 41(7).

Turban J.L., Kamceva M, Keuroghlian A.S. Pharmacologic Considerations for Transgender and Gender Diverse People. *JAMA Psychiatry*. 79(6): 629-630.

Dolotina B. & **Turban J.L.** (2022) A multipronged, evidence-based approach to improving mental health among transgender and gender diverse youth. *JAMA Network Open*. 5(2): e220926.

Turban J.L., Almazan A.N., Reisner S.L., Keuroghlian A.S. (2022) The importance of non-probability samples in minority health research: lessons learned from studies of transgender and gender diverse mental health. *Transgender Health*. [ePub ahead of print]

Turban J.L., Kraschel K.L., Cohen, G.C. (2021) Legislation to Criminalize Gender-affirming Medical Care for Transgender Youth. *JAMA*. 325(22), 2251-2252.

Liu M., **Turban J.L.**, Mayer K.H. (2021) The US Supreme Court and Sexual and Gender Minority Health. *American Journal of Public Health*. 111(7), 1220-1222.

Suto, D.J., Macapagal, K., **Turban, J.L.** (2021) Geosocial Networking Application Use Among Sexual Minority Adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry*. 60(4), 429-431.

Turban, J. L., Keuroghlian, A. S., & Mayer, K. H. (2020) Sexual Health in the SARS-CoV-2 Era. *Annals of Internal Medicine*. 173(5), 387-389.

Suozzi, K., **Turban, J.L.**, & Girardi, M. (2020). Focus: Skin: Cutaneous Photoprotection: A Review of the Current Status and Evolving Strategies. *The Yale Journal of Biology and Medicine*, 93(1), 55.

Malta, M., LeGrand, S., **Turban, J.L.**, Poteat, T., & Whetten, K. (2020). Gender-congruent government identification is crucial for gender affirmation. *The Lancet Public Health*. 5(4), e178-e179.

Turban J.L. (2019). Medical Training in the Closet. *The New England Journal of Medicine*, 381(14), 1305.

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Turban, J. L., & Keuroghlian, A. S. (2018). Dynamic gender presentations: understanding transition and "de-transition" among transgender youth. *Journal of the American Academy of Child and Adolescent Psychiatry*, 57(7), 451-453.

Turban, J. L., Carswell, J., & Keuroghlian, A. S. (2018). Understanding pediatric patients who discontinue gender-affirming hormonal interventions. *JAMA Pediatrics*, 172(10), 903-904.

Turban, J. L. (2018). Potentially Reversible Social Deficits Among Transgender Youth. *Journal of Autism and Developmental Disorders*, 48(12), 4007-4009.

Turban, J. L., & van Schalkwyk, G. I. (2018). "Gender dysphoria" and autism spectrum disorder: Is the link real?. *Journal of the American Academy of Child & Adolescent Psychiatry*, 57(1), 8-9.

Turban, J. L., & Ehrensaft, D. (2018). Research review: gender identity in youth: treatment paradigms and controversies. *Journal of Child Psychology and Psychiatry*, 59(12), 1228-1243.

Turban J. L., Genel, M. (2017) Evolving Treatment Paradigms for Transgender Patients. *Connecticut Medicine*, 81(8), 483-486.

Turban, J., Ferraiolo, T., Martin, A., & Olezeski, C. (2017). Ten things transgender and gender nonconforming youth want their doctors to know. *Journal of the American Academy of Child & Adolescent Psychiatry*, 56(4), 275-277.

Turban, J. L. (2017). Transgender Youth: The Building Evidence Base for Early Social Transition. *Journal of the American Academy of Child and Adolescent Psychiatry*, 56(2), 101.

Turban J. L., Martin A. (2017) Book Forum: Becoming Nicole. *Journal of the American Academy of Child & Adolescent Psychiatry*, 56(1): 91-92.

TEXTBOOKS AND TEXTBOOK CHAPTERS

Forcier, M., Van Schalkwyk, G., **Turban, J. L.** (Editors). *Pediatric Gender Identity: Gender-affirming Care for Transgender & Gender Diverse Youth*. Springer Nature, 2020.

Challa M., Scott C., **Turban J.L.** Epidemiology of Pediatric Gender Identity. In Forcier, M., Van Schalkwyk, G., **Turban, J. L.** (Editors). *Pediatric Gender Identity: Gender-affirming Care for Transgender & Gender Diverse Youth*. Springer Nature, 2020.

Turban J.L., Shadianloo S. Transgender & Gender Non-conforming Youth. In Rey, J.M. (Editor): *IACAPAP e-Textbook of Child and Adolescent Mental Health*. Geneva. International Association of Child and Adolescent Psychiatry and Allied Professionals, 2018.

Turban, J. L., DeVries, A.L.C., Zucker, K. Gender Incongruence & Gender Dysphoria. In Martin A., Bloch M.H., Volkmar F.R. (Editors): *Lewis's Child and Adolescent Psychiatry: A Comprehensive Textbook*, Fifth Edition. Philadelphia: Wolters Kluwer 2018.

INVITED GRAND ROUNDS PRESENTATIONS

Turban J.L. Transgender Youth Mental Health. Maudsley Hospital / Kings College London Grand Rounds, 2023.

Turban J.L. Research Updates: Supporting the Mental Health of Transgender and Gender Diverse Youth. Department of Behavioral Health, Wake Forest School of Medicine / Atrium Health, 2023.

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Turban JL. Supporting the Mental Health of Transgender and Gender Diverse Youth. Child & Adolescent Psychiatry Grand Rounds, Long Island Jewish Medical Center / Zucker Hillside, 2023.

Turban JL. Suicidality in Sexual and Gender Minority Youth. Psychiatry Grand Rounds, Boston Children's Hospital, 2023.

Turban JL. Opinion Writing to Promote Public Health & Evidence-Based Public Policy. Medical Education Grand Rounds, The University of Vermont Larner College of Medicine, 2022.

Turban JL. Research Updates: Supporting the Mental Health of Transgender & Gender Diverse Youth. Division of Child & Adolescent Psychiatry Grand Rounds, Stanford University School of Medicine, 2022.

Turban JL. Supporting Transgender & Gender Diverse Youth: Research Updates & Treatment Paradigms. Department of Psychiatry Grand Rounds, University of Nebraska Medical Center, 2022.

Turban JL. Supporting the Mental Health of Transgender & Gender Diverse Youth. Department of Pediatrics, Division of Behavioral Health Grand Rounds, University of Utah, 2022.

Turban JL. Gender Diverse Youth: Treatment Paradigms & Research Updates. Psychiatry Grand Rounds, Thomas Jefferson University, 2021.

Turban JL. Supporting Gender Diverse Youth Throughout Development. Child Psychiatry Grand Rounds, Georgetown, 2021.

Turban JL. Understanding Pediatric Gender Identity through Childhood and Adolescence. Grand Rounds, Institute of Living, 2021.

Turban JL. Evolving treatment paradigms for transgender youth. Pediatric Grand Rounds, Albany Medical Center, 2021.

Turban JL. Evolving Treatment Paradigms for Transgender Youth. Psychiatry Grand Rounds, McLean Hospital (Harvard Medical School), 2021.

Turban JL. Einstein Psychiatry Grand Rounds: Evolving Treatment Paradigms for Transgender Youth. Psychiatry Grand Rounds, Einstein Medical Center, 2021.

Turban JL. COVID19 and Pediatric Mental Health. Pediatrics Grand Rounds, Stanford University School of Medicine, 2021.

Turban JL. Evolving Treatment Paradigms for Transgender Youth. Psychiatry Grand Rounds, Beth Israel Deaconess Medical Center (Harvard Medical School), 2020.

ADDITIONAL INVITED PRESENTATIONS

Turban JL. Suicide Prevention for LGBTQ+ Youth. *National Institutes of Health*, Bethesda, 2023.

Turban JL. NAMI LGBTQ+ Mental Health Roundtable Discussion. *National Alliance on Mental Illness*, San Francisco, 2023.

Turban JL. Supporting the Mental Health of Transgender & Gender Diverse Youth. *United Nations NGO Committee on Mental Health*, United Nations, 2023.

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Turban JL & Spetz J. How to Give Expert Testimony. *UCSF Philip R. Lee Institute for Health Policy Studies Impacting Policy Series*, San Francisco, 2023.

Turban JL. The Research on Gender-affirming Care for Transgender Youth. *AusPATH Research Seminar*. Sydney, 2023.

Turban JL. Building a Career in Sexual & Gender Minority Health Research. *National Institutes of Health*, Bethesda, 2022.

Turban JL. Research Updates: Gender-affirming Care for Transgender Youth. MUSC LGBTQ+ Health Equity Summit, Medical University of South Carolina, 2022.

Turban JL. Keynote: Supporting The Mental Health of Transgender & Gender Diverse Youth. Edythe Kurz Educational Institute Conference, Westchester, 2022.

Turban JL, Peters B, Olson-Kennedy J. Gender-Affirming Care: Through a Medical, Surgical, and Mental Health Lens. Critical Issues in Child & Adolescent Mental Health Conference, San Diego, 2022.

Turban JL. Improving Mental Health Outcomes for Transgender and Gender Diverse (TGD) Youth Through Gender-affirming Care. National LGBTQIA+ Health Education Center, The Fenway Institute, 2022.

Turban JL. Combatting anti-trans legislation through science, data, and writing. State of Queer Mental Health Conference by The Mental Health Association of San Francisco, Online, 2021.

Turban JL. Updates on LGBTQ Mental Health. Annual Psychiatric Times World CME Conference, Online, 2021.

Turban JL. Imbasciani LGBTQ Health Equity Lecture: Evolving Treatment Paradigms for Transgender and Gender Diverse Youth. University of Vermont Larner College of Medicine, Burlington, 2021.

Turban JL. The Emergence of Gender-affirming Care for Transgender & Gender Diverse Youth, United Nations NGO Committee on Mental Health, Oral Presentation, Online, 2021.

Turban JL. Keynote – Transgender & Gender Diverse Youth: Research Updates. Stony Brook Transgender Health Conference, Online, 2021.

Turban JL. Opinion Writing on Sensitive Topics. Harvard Media & Medicine Course, Live Lecture, Online, 2021.

Turban JL. Gender affirming care for transgender and gender diverse youth: what we know and what we don't. University of Texas Pride Health Institute, Oral Presentation, Online, 2020.

Turban JL. Q&A on Transgender Youth Mental Health. PEOPLE in Healthcare at University of Toledo, Oral Presentation, Online, 2020.

Turban JL, Pagato S, Gold J, Broglie J, Naidoo U, Alvarado A. Innovation of Student Mental Health during COVID19. Panel to the People, Oral Presentation, Online, 2020.

Turban JL, Belkin B, Vito J, Campos K, Scasta D, Ahuja A, Harris S. Discussion on Abomination: Homosexuality and the Ex-Gay Movement. Panelist, The Association of LGBTQ+ Psychiatrists Virtual Session, Oral Presentation, Online, 2020.

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Turban JL. Is Grindr affecting gay men's mental health? Oral Presentation, UCLA & AETC Coping with Hope, Online, Oral Presentation, 2020.

Turban JL, Hall TM, Goldenberg D, Hellman R. Gay Sexuality and Dating. Moderator, The Association of LGBTQ+ Psychiatrists Virtual Session, Oral Presentation, Online, 2020.

CONFERENCE PRESENTATIONS & ABSTRACTS

Turban JL, Calhoun A, Gold, J. Mission-Based Media Collaborative Work Concerning "Controversial" Topics in Psychiatry. Annual Meeting of The American Psychiatric Association, Oral Presentation, San Francisco, 2023.

Turban JL, Ahuja A. Autogynephilia: Historical Context, Clarifications, and Controversy. Annual Meeting of The American Psychiatric Association, Oral Presentation, San Francisco, 2023. [Cancelled]

Turban JL. A Systematic Approach for Understanding Gender Identity Evolution. Annual Meeting of The American Academy of Child & Adolescent Psychiatry, Oral Presentation, Toronto, 2022.

Turban JL. Transgender Youth: Evolving Gender Identities and "Detransition." Annual Meeting of The American Academy of Child & Adolescent Psychiatry, Session Chair of Oral Symposium, Toronto, 2022.

Turban JL. From The New York Times to Hollywood: Communicating With the Public Through Opinion Writing, Publishing, Social Media, and Consulting for Film and TV, Annual Meeting of The American Academy of Child & Adolescent Psychiatry, Session Chair of Oral Symposium, Toronto, 2022.

Turban JL. Writing for the Lay Press to Combat Misinformation Regarding Pediatric Mental Health, Annual Meeting of The American Academy of Child & Adolescent Psychiatry, Oral Presentation, Toronto, 2022.

Turban JL. COVID-19 and Psychosexual Dynamics, Annual Meeting of the American Academy of Child & Adolescent Psychiatry, Oral Presentation, Toronto, 2022.

Dolotina B, **Turban JL,** King D, Keuroghlian AS. Age of Realization of Gender Identity and Mental Health Outcomes among Transgender Adults: Evaluating the "Rapid Onset Gender Dysphoria" Hypothesis, Annual Meeting of The American Academy of Child & Adolescent Psychiatry, Poster, Toronto, 2022.

Turban JL. Sex ratio among transgender adolescents in the United States. World Professional Association for Transgender Health Scientific Symposium, Oral Presentation, Montreal, 2022.

Turban JL. Access To Gender-Affirming Hormones During Adolescence And Mental Health Outcomes Among Transgender Adults. World Professional Association for Transgender Health Scientific Symposium, Oral Presentation, Montreal, 2022.

Turban JL, Gold J, Hartselle S, Yen J. From The New York Times to the Big Screen: Communicating With the Public Through Opinion Writing, Publishing, Social Media, and Consulting for Film and TV. Annual Meeting of The American Academy of Child & Adolescent Psychiatry, Session Chair of Oral Symposium, Online, 2021.

Turban JL. Creating Change through Opinion Writing in Child & Adolescent Psychiatry. Annual Meeting of The American Academy of Child & Adolescent Psychiatry, Oral Presentation, Online, 2021.

Turban JL, Giedinghagen A, Janssen A, Myint M, Daniolos P. Transgender Youth: Understanding "De-transition," Non-linear Gender Trajectories, and Dynamic Gender Identities. Annual Meeting of The American Academy of Child & Adolescent Psychiatry, Session Chair of Oral Symposium, Online, 2021.

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Turban JL. A framework for understanding dynamic gender identities through internal and external factors. Annual Meeting of The American Academy of Child & Adolescent Psychiatry, Oral Presentation, Online, 2021.

Turban JL. Geosocial networking application use among birth-assigned male adolescents. Annual Meeting of The American Academy of Child & Adolescent Psychiatry, Oral Presentation, Online, 2021.

Turban JL. LGBTQ Families and the US Supreme Court. Annual Meeting of The American Academy of Child & Adolescent Psychiatry, Oral Presentations, Online, 2021.

Turban JL, King D, Kobe J, Reisner SL, Keuroghlian AS. Access to Gender-affirming Hormones during Adolescence and Mental Health Outcomes among Transgender Adults. Annual Meeting of The American Academy of Child & Adolescent Psychiatry, Poster, Online, 2021.

Turban JL. Gender Identity Conversion Efforts: Quantitative Perspectives. Annual Meeting of The American Psychiatric Association, Oral Presentation, Online, 2021.

Turban JL. For Worse: Negative Aspects of Social Media for LGBT Youth. Oral Presentation, Annual Meeting of The American Academy of Child & Adolescent Psychiatry, Oral Presentation, Online, 2020.

Turban JL. Hookup App Use among Gay and Bisexual Males: Sexual Risk and Associated Psychopathology. Oral Presentation, Annual Meeting of The American Academy of Child & Adolescent Psychiatry, Online, 2020.

Turban JL. Communicating with the Public: From The New York Times to The Big Screen. Oral Presentation, Annual Meeting of The American Academy of Child & Adolescent Psychiatry, Online, 2020.

Turban JL, McFarland C, Walters O, Rosenblatt S. An Overview of Best Outpatient Practice in the Care of Transgender Individual. Oral Presentation, Annual Meeting of the American Psychiatric Association, Philadelphia, 2020. [Accepted, but cancelled due to COVID19]

Turban JL, Lakshmin P, Gold J, Khandai C. #PsychiatryMatters: Combating Mental Health Misinformation Through Social Media and Popular Press. Oral Presentation, Annual Meeting of the American Psychiatric Association, Philadelphia, 2020. [Accepted, but cancelled due to COVID19]

Turban JL. The Pen and the Psychiatrist: Outreach and Education Through the Written Word. Oral Presentation, Annual Meeting of the American Academy of Child & Adolescent Psychiatry, Chicago, 2019.

Turban JL. For Better and For Worse: Gender and Sexuality Online, Oral Presentation, Annual Meeting of the American Academy of Child & Adolescent Psychiatry, Chicago, 2019.

Turban JL. Gender Diverse Young Adults: Narratives and Clinical Considerations, Oral Presentation, Annual Meeting of the American Academy of Child & Adolescent Psychiatry, Chicago, 2019.

Turban JL. Transgender Youth: Controversies and Research Updates, Oral Presentation, Annual Meeting of the American Psychiatric Association, San Francisco, 2019.

Turban JL, Beckwith N, Reisner S, Keuroghlian A. Exposure to Conversion Therapy for Gender Identity Is Associated with Poor Adult Mental Health Outcomes among Transgender People in the U.S. Poster Presentation, Annual Meeting of the American Academy of Child & Adolescent Psychiatry, Seattle, 2018.

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Shirk SD, **Turban JL**, Potenza M, Hoff R, Kraus S. Sexting among military veterans: Prevalence and correlates with psychopathology, suicidal ideation, impulsivity, hypersexuality, and sexually transmitted infections. Oral Presentation, International Conference on Behavioral Addictions, Cologne, Germany, 2018.

Turban JL. Gender Identity and Autism Spectrum Disorder. Oral Presentation, Annual Meeting of the American Academy of Child & Adolescent Psychiatry, Washington D.C., 2017.

Turban JL. Tackling Gender Dysphoria in Youth with Autism Spectrum Disorder from the Bible Belt to New York City. Oral Presentation, Annual Meeting of the American Academy of Child & Adolescent psychiatry, Washington D.C., 2017.

Turban JL. Affirmative Protocols for Transgender Youth. Oral Presentation, Annual Meeting of the American Academy of Child & Adolescent Psychiatry, Washington D.C., 2017.

Turban, JL. Evolving Management of Transgender Youth. Oral Presentation, Klingenstein Third Generation Foundation Conference, St Louis, 2017.

Turban, JL, Potenza M, Hoff R, Martino S, Kraus S. Clinical characteristics associated with digital hookups, psychopathology, and clinical hypersexuality among US military veterans. Oral Presentation, International Conference on Behavioral Addictions, Haifa, Israel, 2017.

Lewis J, Monaco P, **Turban JL**, Girardi M. UV-induced mutant p53 keratinocyte clonal expansion dependence on IL-22 and ROR γ T. Poster, Society of Investigative Dermatology, Portland, 2017.

Turban JL, Winer J, Encandela J, Boulware S, VanDeusen T. Medical Student Knowledge of and Attitudes toward Transgender Pediatric Patient Care. Abstract, Gay & Lesbian Medical Association, St Louis, 2016.

Turban JL, Lu A, Damisah E, Eid T, Chiang V. Metabolomics to Differentiate Radiation Necrosis from Recurrent Tumor following Gamma Knife Stereotactic Radiosurgery for Brain Metastases. Oral Presentation, 14th Annual Leksell Gamma Knife Conference, New York City, 2014

Turban JL, Lewis J, Girardi M. UVB-induced HMGB1 and extracellular ATP increase Langerhans cell production of IL-23 implicated in ILC3 activation. Poster, Society of Investigative Dermatology, Scottsdale, 2016

Turban JL, Lewis J, Girardi M. Characterization of cytokine pathways associated with Langerhans cell facilitation of UVB-induced epidermal carcinogenesis. Poster, American Society of Clinical Investigation, Chicago, 2016.

Lewis J, **Turban JL**, Girardi M, Michael Girardi. Langerhans cells and UV-radiation drive local IL22+ ILC3 in association with enhanced cutaneous carcinogenesis. Poster, Society of Investigative Dermatology, Scottsdale, 2016.

Sewanan L, Zheng D, Wang P, Guo X, Di Bartolo I, Marukian N, **Turban JL**, Rojas-Velazques D, Reisman A. Reflective Writing Workshops Led By Near Peers During Third-Year Clerkships: A Safe Space for Solidarity, Conversation, and Finding Meaning in Medicine. Poster & Workshop, Society of General Internal Medicine, New Haven and Hollywood, 2016.

TEACHING PRESENTATIONS

Advanced Topics in Pediatric Gender Care. Stanford Child & Adolescent Psychiatry Fellowship Didactics, 2023.

Opinion Writing About The “Politically Sensitive” and Personal. Harvard Medical School Master of Science in Media, Medicine, and Health Degree Program, 2022.

Gender-affirming Care for Transgender & Gender Diverse Youth, Zuckerberg San Francisco General Hospital Adolescent Psychology Internship Didactics, 2022.

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Supporting Transgender & Gender Diverse Youth. UCSF Trauma Recovery Center Didactics, 2022.
Developmental Psychopathology, Psychotherapy & Psychopharmacology Course: Pediatric Gender. Stanford University School of Medicine Child & Adolescent Psychiatry Fellowship Didactics, 2021.
Supporting Gender Diverse Youth Through Various Stages of Development. University of California San Francisco Child & Adolescent Psychiatry Fellowship Didactics, 2021.
Treatment of Transgender and Gender Diverse Youth. Stanford University School of Medicine Psychiatry Residency Didactic, 2021.
Caring for Transgender and Gender Diverse Youth. University of California San Diego General Psychiatry Residency Resident Rounds, 2021.
Opinion Writing 101. Stanford Pediatrics Residency Program, 2021.
Psychotherapeutic Considerations for Transgender Youth. Stanford PsyD Child Psychotherapy Course, 2021.
Transgender Youth: Treatment Paradigms and Research Updates. Children's Health Council DBT Program Lecture Series, 2021.
Gender-affirming Care for Patients with Primary Psychotic Disorders. McLean Psychotic Disorders Division Seminar Series, 2019.
Gender-affirming Care for Transgender Elders. McLean Geriatric Psychiatry Seminar Series, 2019.
Writing about Gender & Sexuality (Guest Lecture), Course: Sexual Outcasts & Uncommon Desires, Emerson College, 2019
Gender-affirming Care for Transgender and Gender Diverse Patients on Inpatient Psychiatric Units, MGH Inpatient Psychiatry Seminar Series, 2019.
Transgender & Gender Non-conforming Youth, MGH/McLean Adult Residency program, 2018.
Writing about Gender Identity for the Lay Audience (Guest Lecture), Course: Kids These Days, Emerson Journalism Program, 2017
International Approaches to the Treatment of Gender Incongruence, VU Medical Center, Amsterdam, 2017
Time to Talk About It: Physician Depression and Suicide, Yale Clerkship Didactics, 2017
Medical Management of Adolescent Gender Dysphoria. Yale Pediatrics Clerkship, 2015-2016
Medical Management of Children and Adolescents with Gender Dysphoria, Yale Pediatrics Residency Didactics, 2016
Reflective Writing Workshop Leader. Yale Surgery Clerkship, 2015-2016
Langerhans Cell Facilitation of Photocarcinogenesis. Yale Department of Dermatology Research Forum, 2016
Panel: Treating Transgender & Gender Non-conforming Patients in the Emergency Setting. Yale Emergency Medicine Clerkship, 2016
Panel: Challenges to the Learning Climate: Difficult Patients, Harassment, and Mistreatment. Yale Pre-Clinical Orientation, 2016
Panel: Personal Behavior and Professionalism, Introduction to the Profession, 2016

RESEARCH SUPPORT

Current Funding:

Sorensen Foundation Fellowship, \$287,000 (2021-2023)

The Impact of Gender-affirming Medical and Surgical Interventions on Psychopathology and Implicit Gender Incongruence among Transgender Adolescents

Role: Principal Investigator

UCSF Population Health Equity Scholars Grant, \$20,000 (2023-2024)

Systematic content analysis of federal appellate court rulings regarding the constitutionality of bans on gender identity and sexual orientation conversion efforts

Role: Principal Investigator

Completed Funding:

Stanford Department of Psychiatry and Behavioral Sciences Trainee Innovator Grant, \$5,000 (2020-2021)

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Examining the impact of gender identity conversion therapy bans on suicidality among transgender and gender diverse people in the U.S.: a difference-in-differences analysis

Role: Principal Investigator

American Academy of Child & Adolescent Psychiatry Pilot Research Award, \$15,000 (2019-2020)

Childhood and Adolescent Experiences with Gender-related Medical Care and Adult Mental Health Outcomes: Analysis of the 2015 U.S. Transgender Survey

Role: Principal Investigator

AWARDS & HONORS

Top Peer Review Service, *Annals of Internal Medicine* (2022)

Stanford Child & Adolescent Psychiatry Chief Fellow (2021-2022)

Wasserman Award for Advocacy in Children's Mental Health (2021)

Top Manuscript of The Year - *Pediatrics* (2020)

American Psychiatric Association Child & Adolescent Psychiatry Fellowship (2019-2021)

Ted Stern Scholarship and Travel Award (2019)

Editor's Pick for Best Clinical Perspectives Manuscript – *Journal of The American Academy of Child & Adolescent Psychiatry* (2018)

SciShortform Project: Best Shortform Science Writing, Columns & Op-Eds (2018)

Ted Stern Scholarship and Travel Award (2018)

Medaris Grant (2018)

Editor's Pick for Best Clinical Perspectives Manuscript – *Journal of The American Academy of Child & Adolescent Psychiatry* (2017)

United States Preventative Health Services Award for Excellence in Public Health (2017)

NBC Pride 30 Innovator (2017)

Ferris Thesis Prize, Yale School of Medicine (2017)

Parker Prize, Yale School of Medicine (2017)

Howard Hughes Medical Institute Medical Research Fellowship (2015-2016)

American Academy of Child and Adolescent Psychiatry Life Members Mentorship Grant (2016)

Student Scholarship, Gender Conference East (2016)

Farr Award for Excellence in Research (2016)

Yale Office of International Medical Education Grant, Buenos Aires, Argentina (2016)

Yale Office of International Medical Education Grant, VU Medical Center, The Netherlands (2016)

Yale Summer Research Grant (2012)

AIG International Scholar, Harvard College (2007-2011)

Harvard International Study Grant, Alicante, Spain (2008)

David Rockefeller International Study Grant, Shanghai, China (2009)

PROFESSIONAL MEMBERSHIPS & COMMITTEES

American Psychiatric Association, Member

American Academy of Child & Adolescent Psychiatry, Member

American Psychiatry Association, Council on Communications

American Academy of Child & Adolescent Psychiatry, Media Committee

American Academy of Child & Adolescent Psychiatry, Chair of Subcommittee on Interfacing with the Media

World Professional Association for Transgender Health, Member

US Professional Association for Transgender Health, Member

US Professional Association for Transgender Health, Research Committee

Athlete Ally, Affiliate Scholar

Psychiatric Times, Editorial Board

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ACADEMIC JOURNAL SERVICE & AD HOC PEER REVIEW

PLoS One, Academic Editor
JAACAP, Contributing Editor
JAMA, Peer Reviewer
JAMA Pediatrics, Peer Reviewer
JAMA Psychiatry, Peer Reviewer
JAMA Network Open, Peer Reviewer
Annals of Internal Medicine, Peer Reviewer
Pediatrics, Peer Reviewer
Journal of the American Academy of Child & Adolescent Psychiatry, Peer Reviewer
JAACAP Open, Peer Reviewer
Journal of Child Psychology and Psychiatry, Peer Reviewer
Journal of Adolescent Health, Peer Reviewer
Academic Psychiatry, Peer Reviewer
Journal of Autism and Developmental Disorders, Peer Reviewer
American Journal of Public Health, Peer Reviewer
Perspectives on Psychological Science, Peer Reviewer
Transgender Health, Peer Reviewer
Journal of Clinical Medicine, Peer Reviewer
Brain Sciences, Peer Reviewer
Social Science & Medicine, Peer Reviewer
Sexual Health, Peer Reviewer
Women, Peer Reviewer