

IN THE UNITED STATES DISTRICT COURT  
FOR THE WESTERN DISTRICT OF NORTH CAROLINA  
CHARLOTTE DIVISION  
No. 3:22-cv-191

KANAUTICA ZAYRE-BROWN,

Plaintiff,

v.

NORTH CAROLINA DEPARTMENT OF  
ADULT CORRECTION, et al.,

Defendants.

**DEFENDANTS' RESPONSE TO  
PLAINTIFF'S MOTION TO EXCLUDE  
THE TESTIMONY OF JOSEPH PENN,  
MD**

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**INTRODUCTION**

Joseph Penn, MD, has more than 30 years of clinical and administrative experience as a psychiatrist, mostly in the correctional setting. In that time, Dr. Penn has gained specialized knowledge and experience, including both clinical and policy work, with incarcerated transgender patients seeking treatment for gender dysphoria (“GD”). Based on his professional education, knowledge, and specialized experience, Dr. Penn is qualified to offer his expert opinions in this case. Dr. Penn’s process for reaching these opinions is sound and reliable and, in fact, mirrors the approach taken by Plaintiff’s expert. In short, Dr. Penn’s opinions are admissible under Rule 702 and none of Plaintiff’s challenges to his ability to offer those opinions have merit.

**I. Factual Background Regarding Dr. Penn**

**A. Summary of Dr. Penn’s Professional Experience and Expertise**

Dr. Penn is a triple board-certified correctional and forensic psychiatrist and a Clinical Professor in the Department of Psychiatry and Behavioral Sciences at the University of Texas Medical Branch (UTMB). (DE-65-13 at 1) Dr. Penn currently serves as the Director of Mental Health Services of the UTMB Correctional Managed Care (CMC), a university-based correctional

health care system that provides direct health services to state prisoners in the Texas Department of Criminal Justice (“TDCJ”). (*Id.* at 2) In his position, Dr. Penn is responsible for overseeing the psychiatric, psychological, and mental health services at eighty state jail and state prison units. Dr. Penn has held this position since February 2008, and thus has more than fifteen years of experience in this high-level role. (*Id.*) Moreover, since 1999, Dr. Penn has focused his clinical, administrative, and forensic work primarily within correctional settings—meaning he has focused in this area for upward of twenty-five years. (*Id.*) Since 2004, Dr. Penn has maintained a specialized certification as a Certified Correctional Health Professional-Mental Health (*Id.*) Dr. Penn serves as a physician surveyor for the National Commission on Correctional Health Care (“NCCHC”) and is a member of its Board of Directors and its Accreditation and Standards Committee. (*Id.*)

### **1. Dr. Penn’s Transgender Clinical Experience**

As a practicing correctional psychiatric physician, Dr. Penn is directly involved in the evaluation, diagnosis, treatment, and oversight of the provision of mental health services for incarcerated individuals with mental disorders and behavioral issues. (DE-65-13 at 2) Similarly, Dr. Penn is directly involved in the evaluation, diagnosis, and treatment of patients with GD, and supervises other clinicians that do the same. (*Id.*) More specifically, Dr. Penn has personally evaluated patients, diagnosed them, performed chart reviews, ordered or re-ordered gender affirming hormone medications, reviewed lab studies, performed second opinions, and consulted with other health care staff, including, endocrinologists, internal medicine physicians, family physicians, psychiatrists, and others. (*Id.* at 4) Additionally, Dr. Penn directly oversees the statewide clinical evaluation and treatment program for TDCJ patients who seek treatment for GD, and directly oversees other mental health care providers in the UTMB CMC system who provide evaluation, diagnosis, and direct patient care to transgender patients. (*Id.* at 2, 4) Dr. Penn also

provides consultation for transgender patients with complex cases. (*Id.* at 2) And, Dr. Penn provides consultation and behavioral treatment recommendations regarding this patient population to other staff and to TDCJ custody and health services leadership. (*Id.* at 4)

## **2. Dr. Penn's Transgender Program and Policy Experience**

Dr. Penn also has experience developing and implementing policies concerning the care and management of the incarcerated transgender and gender diverse population. (DE-65-13 at 3) Specifically, Dr. Penn is the Chair of the Mental Health Work Group and a Co-Chair of the Gender Dysphoria Work Group, through which he oversees the review and revision of all policies, procedures, clinical practices, disease management guidelines, and medication policies. (*Id.*) Dr. Penn also oversaw the development, revision, and implementation of a disease management guideline for the evaluation and treatment of GD and provided input to a broader policy concerning the treatment of incarcerated persons with intersex conditions and GD. (*Id.*) Additionally, Dr. Penn assisted in revising and approving the NCCHC's 2020 position statement concerning this patient population. (*Id.*) Moreover, Dr. Penn oversaw the development, implementation, and expansion of a statewide specialized GD referral and clinical program, which he continues to oversee and in which he maintains direct clinical involvement. (*Id.* at 4) The program, which is a joint operation between the TDCJ, UTMB CMC, and Texas Tech University, has received numerous external requests for lectures/presentations. (*Id.*)

## **3. Dr. Penn's Other Experience and Knowledge**

To gain additional direct patient care experience with this patient population, Dr. Penn participated in a specialized clinical training program with Dr. Walter Meyer, Professor Emeritus, and now retired UTMB faculty psychiatrist and endocrinologist. (DE-65-13 at 4-5) Dr. Meyer is a respected international leader in transgender health care. (*Id.* at 5) Dr. Penn has developed and

maintained clinical knowledge regarding the mental health and health care needs of incarcerated transgender and gender diverse individuals. (*Id.* at 3) Thus, Dr. Penn is familiar with the *Standards of Care for the Health of Transgender and Gender Diverse People, WPATH 8* and the prior Version 7, published by the World Professional Association of Transgender Health (“WPATH”). (*Id.*) Dr. Penn is also generally familiar with other literature relevant to the provision of health care to this patient population both in community and in correctional settings. (*Id.*)

In addition to evaluating, diagnosing, treating, and consulting on patients in the TDCJ system, Dr. Penn has performed second opinion evaluations/consultations in other states and served as a consultant to several state prison systems, including Colorado, Kansas, New Jersey, and California, regarding GD diagnoses, evaluation and treatment programs, and policies, and practices. (DE-65-13 at 5) Dr. Penn has presented nationally and internationally on these topics. (*Id.*) For a more detailed statement of Dr. Penn’s education, training, and experience, see his affidavit (DE-18-8, ¶¶ 1-20), his CV (DE-18-9), and his Expert Report (DE-18-8 at 1-6)

### **B. Summary of Dr. Penn’s Opinions**

In reaching his conclusions, Dr. Penn reviewed and considered Plaintiff’s health and related records, Plaintiff’s video deposition, and the report and declarations of Plaintiff’s expert, Randi C. Ettner, Ph.D. (DE-65-13 at 6-7, 38-39) Dr. Penn also reviewed the North Carolina Department of Adult Correction (“the Department”), and Defendants’ individual and 30(b)(6) depositions. Additionally, Dr. Penn reviewed the expert reports of Defendants’ other experts, Fan Li, Ph.D., and Sara E. Boyd, Ph.D., including a recording of Dr. Boyd’s June 20, 2023, in-person assessment of Plaintiff. (*Id.* at 7, 39)

In his report, Dr. Penn provides three primary opinions. (DE-65-13 at 7-9, 35) First, Dr. Penn concludes that that the Department’s policy titled *Evaluation and Management of*

*Transgender Offenders* (“EMTO Policy”) comports with or exceeds what he considers to be an acceptable standard for a comprehensive set of correctional health care protocols for the evaluation and management of transgender health care. (*Id.* at 7-8, 10-18, 35) Second, Dr. Penn concludes that the framing of “medical necessity” advanced by Dr. Ettner is unworkable and not reasonable. (*Id.* at 8, 18-28, 35) Third, Dr. Penn concludes that Defendants’ decision to deny the request for gender affirming surgery (“GAS”) was appropriate and reasonable because there was no clinical indication that the surgery was necessary to protect life, to prevent clinically significant illness or significant disability, or to alleviate severe pain, and there is a lack of high-quality scientific research indicating the long-term efficacy of GAS. (*Id.* at 8-9, 28-35)

**1. In Response to Attacks by Plaintiff, Dr. Penn’s First Opinion is that the EMTO Policy is Sound and Reasonable.**

From the inception of this case, Plaintiff has attacked the EMTO Policy. For example, Plaintiff alleges that the EMTO policy “erected onerous and medically unnecessary barriers[.]” (DE-1 ¶ 71) Plaintiff also alleges that the Department’s “implementation of [the EMTO policy] has led and continues to lead to unnecessary suffering constituting cruel and unusual punishment.” (*Id.* ¶ 141) Throughout discovery and summary judgment, Plaintiff has also been critical of the EMTO policy’s multidisciplinary approach and the process for reaching a decision (*i.e.*, the inclusion of non-clinical participants on the Division Transgender Accommodation Review Committee (“TARC”), and the layers of review (Facility TARC, Division TARC, final review. (*See e.g.*, DE-63 at 8-10; DE-61-9 at 2-68; DE-61-7 at 4-7, 10-18) Plaintiff also claims that this approval process differs from (and is more difficult than) that used for other medical conditions. (DE-61-5 at 14-62) Plaintiff’s expert, Dr. Ettner, also attacks the Division TARC. (*See* DE-13-1 ¶ 91)

Dr. Penn’s first opinion responds directly to these attacks. Dr. Penn concludes that “[b]ased on [his] decades of correctional health care experience, and [his] knowledge and training

concerning the management of transgender patients[,]” the EMTO Policy “comports with or exceeds” an acceptable standard for a correctional healthcare protocol. (DE-65-13 at 10) Dr. Penn’s report highlights specific aspects of the EMTO Policy, which he concludes “contribute to its quality and effectiveness.” (*Id.* at 13)

Dr. Penn explains that the EMTO Policy’s multidisciplinary approach is similar to that used in other jurisdictions. (DE-65-13 at 10, 13-14) He opines that including members from non-clinical disciplines is valuable because a “committee of decisionmakers without any experience in non-clinical areas, such as custody, security, programming, and operations would be ill-suited to adequately consider [these requests][.]” (*Id.* at 14) As Dr. Penn puts it, “the inclusion of clinical and non-clinical personal on the Division TARC enables it to reach those decisions based on all relevant and necessary input from across the agency.” (*Id.*)

Dr. Penn further opines that another beneficial aspect of the EMTO Policy is the “layered decision-making approach (*i.e.*, the Facility and Division TARCs and the final review).” (DE-65-13 at 15) Dr. Penn concludes that “each level of the process has an important function.” (*Id.*) With respect to the Facility TARC, Dr. Penn concludes that there is value in having all requests begin there because it “permits those who interact with and are most familiar with the patient, and their needs, the ability to gather information and provide input [and it] ensures that the facility-level providers and custody personnel[,]” who would be responsible for facilitating the ultimate decision, are aware of the request. (*Id.*)

With regard to the Division TARC, Dr. Penn concludes that “the clinical personnel on the Division TARC, [*i.e.*, the Medical Director, the Chief of Psychiatry, and the Director of Behavioral Health Director] are well positioned to review a patient’s medical and mental health records and objectively assess the totality of a patient’s presentation to collectively determine [if there is a]

clinical need for” surgery. (*Id.* at 15-16) Lastly, Dr. Penn concludes that the final review process, which is only used for surgical interventions or requests for gender-identity consistent facility transfers, “acts as a quality control device [,] [that] ensure[s] consistency and completeness of the process.” (DE-65-13 at 16)

Dr. Penn further concludes that the review process contained in the EMTO Policy aligns with the Department’s policies for reviewing requests for other medical services. (DE-65-13 at 16-18) Specifically, Dr. Penn explains that the Department’s utilization management (UM) process, which is used to evaluate the appropriateness and medical necessity of services to patients, is also tiered. (*See id.* at 16) Dr. Penn concluded that “such a process is routine, necessary, and is typically utilized in correctional healthcare systems” which “effectively operate as managed care organizations.” (*Id.* at 17) Dr. Penn further explains why the multidisciplinary approach is necessary for transgender accommodations. (*Id.*) As Dr. Penn discusses, requests for interventions under the EMTO Policy “can implicate medical, behavioral health, and/or non-clinical custody issues[.]” (*Id.*)

## **2. Dr. Penn’s Second Opinion is that Dr. Ettner Advances an Unworkable Standard of Medical Necessity.**

Plaintiff alleges that the GAS is medically necessary. (DE-1 ¶ 149) Plaintiff relies on Dr. Ettner to support this allegation. (DE-63 at 22-23, 28) In response, Dr. Penn offers opinions regarding how medical necessity can reasonably be determined. In short, Dr. Penn opines that Dr. Ettner’s application of the phrase “medical necessity” is unworkable.

First, Dr. Penn explains that there “is no precise or singular definition of the phrase ‘medical necessity’ as it is interpreted in different ways in various contexts.” (DE-65-13 at 18) However, Dr. Penn opines that there are “formulations and applications of that phrase that are reasonable and some that are not.” (*Id.*) Dr. Penn further concludes that one such reasonable

formulation and application of the phrase “evaluates medical necessity by coupling a patient-specific risk-benefit analysis and an assessment of the efficacy of the proposed intervention as indicated by the scientific literature.” (*Id.*) Thus, “[w]hat a physician determines is medically necessary to adequately treat a particular condition will be guided by that clinician’s education, training, and experience, and will be informed by the patient’s presentation.” (*Id.* at 19) Moreover, Dr. Penn concludes that “[i]nherent in this determination is a patient-specific risk-benefit calculus and an assessment of whether the proposed intervention has been demonstrated, through rigorous medical research or other scientific evidence, to be an effective treatment of the target condition.” (*Id.*) Dr. Penn concludes that the Department applied this approach when determining medical necessity in Plaintiff’s case. (*Id.* at 18-20)

By contrast, Dr. Penn opines that the approach to determining medical necessity advanced by Dr. Ettner is not reasonable because it “focuses only on the capacity of the intervention to provide some possible therapeutic benefit.” (DE-65-13 at 18-19) As Dr. Penn notes, Dr. Ettner does not actually set forth a specific definition of medical necessity but instead she “makes general statements that simply assume medical necessity or reference[s] statements by organizations” that similarly offer generic statements that largely assume medical necessity. (*Id.* at 20-22) Further, Dr. Penn concludes that a “close review of the bases for Dr. Ettner’s sweeping opinion” indicates “why her formulation of ‘medical necessity’ (and by extension that of WPATH) cannot be summarily applied in the correctional context.” (*Id.* at 24)

Dr. Penn points out that, to support her conclusions, Dr. Ettner relies on research that she contends indicates the “efficacy” and “benefit” of treatments. (DE-65-13 at 24) Dr. Penn notes that these studies include a meta-analysis regarding the impact of gender transition generally (as opposed to GAS specifically) and other studies which Dr. Ettner claims indicate ““that gender-

affirming surgery improves virtually every facet of a patient's life. This includes satisfaction with interpersonal relationships and improved social functioning, improvement in self-image and satisfaction with body and physical appearance, and greater acceptance and integration into the family.” (*Id.* at 25 quoting DE-61-2 ¶ 58) Dr. Penn notes that while these are worthy goals, improving the lives of patients in this manner, “cannot set the standard for medical necessity in any system with limited resources, including the correctional setting[,] because there are undoubtedly numerous interventions, related to [GD] or other conditions, which may have the possibility of providing some benefit to the patient.” (DE-65-13 at 25) And Dr. Penn concludes that “reasonable analyses of these possible interventions” must account for “their potential benefits weighed against their potential risks, the evidentiary support underlying them, and the possibility” of “alternative treatments.” (*Id.* at 25-26) Otherwise, Dr. Penn opines “the term ‘medical necessity’ is reduced to something more akin to ‘medically beneficial’ and all types of possible treatments must always be pursued.” (*Id.* at 26)

Ultimately, Dr. Penn concludes that under Dr. Ettner and WPATH's formulation of the phrase, *any* intervention that could potentially benefit a patient's GD becomes medically necessary. (DE-65-13 at 26) And Dr. Penn further concludes that the “implication of such a formulation goes beyond interventions to treat [GD][,] because [t]he same logic would make a host of other interventions ‘medically necessary’ to treat other conditions.” (*Id.*) As an example, Dr. Penn concludes that under Dr. Ettner's formulation of medical necessity, various procedures like “a rhinoplasty, breast augmentation, botox injections, blepharoplasty (surgical rejuvenating procedure on the upper or lower eyelids)” would become medically necessary for “a patient with a perception of a large or crooked nose, small breasts, skin wrinkles, droopy eyelids” because the patient “may derive a benefit from procedures targeting that body feature[.]” (*Id.*) This is not

hyperbole—as Dr. Penn concludes, “[u]nder Dr. Ettner’s logic these procedures would be ‘medically necessary’ because they may well benefit the patient by alleviating, to some degree, their perceived distress from their physical appearance or characteristics or otherwise improving their lives.” (*Id.*) Overall, Dr. Penn’s opinion is that “the definition of medically necessary applied by the Department is far superior in that it is workable and appropriately accounts for factors that should be considered as part of these determinations – including an individualized risk/benefit/alternatives assessment and an assessment of the medical effectiveness of the requested intervention.” (*Id.* at 28)

**3. Dr. Penn’s Third Opinion is that the Department’s Denial of Plaintiff’s Requested Surgery was Appropriate and Reasonable.**

Plaintiff’s case turns on her and Dr. Ettner’s contentions that the Department wrongfully denied her medically necessary GAS, because she has GD-related “persistent distress,” faces a risk of suicidality, is suffering from “ongoing disability,” and therefore “urgently requires” GAS. (DE-61-2 at ¶¶ 76, 91-92, 105, 132-133, 136) She further claims that the denial was improper because the medical literature conclusively demonstrates that GAS is effective at treating GD symptoms. (*Id.* at ¶¶ 30-41, 50-61) Dr. Penn’s third opinion addresses both of Plaintiff’s foundational contentions.

Dr. Penn opines that the Department’s decision to deny Plaintiff’s request for surgery was reasonable and appropriate for two reasons. First, the Department appropriately evaluated “whether there were any clinical indications that the surgery was necessary to protect life, to prevent clinically significant illness or significant disability, or to alleviate severe pain[,]” which requires a patient-specific risk benefit analysis. (DE-65-13 at 28) Second, the Department appropriately evaluated whether rigorous high-quality research has shown the long-term efficacy of GAS as a treatment for GD. (*Id.*)

**a. Dr. Penn Concludes That the Department Reasonably Concluded that Surgery Was Not Needed to Avoid Risk of Severe Distress, Harm, or Disability.**

Dr. Penn concludes that, in a risk-benefit analysis, “the lack of some severe distress, harm, or disability absent the contemplated intervention indicates a lack of risks of not approving the surgery.” (DE-65-13 at 29) And based on his review of medical records, Plaintiff’s deposition, and the recorded in-person psychological evaluation conducted by Dr. Boyd. (*Id.*) Dr. Penn concluded that “there was little to no clinical indications that Plaintiff was or would be at risk of some severe distress, harm, or disability absent the requested vulvoplasty.” (*Id.*) The Division TARC reached this same conclusion after “a comprehensive review of Plaintiff’s medical and behavioral health history[.]” (*Id.*) Thus, Dr. Penn opines, Defendants’ “determination that surgery was not medically necessary was reasonable under the circumstances.” (*Id.*)

Dr. Penn specifically notes that “indicators of significant mental distress or impairment of the activities of daily living are not present[.]” in Plaintiff’s health records. (DE-65-13 at 30) Dr. Penn further concludes that “Plaintiff’s medical records do not indicate that she has or is currently experiencing significant emotional or mental distress[.]” as she has “routinely described herself as a happy person and denied experiencing depression or anxiety[,] [and] consistently denied suicidal ideation.” (*Id.* at 31) With respect to the “one instance of a reported self-harm attempt[.]” Dr. Penn concludes that the episode “appear[ed] to be isolated” and “was self-reported[.]” (*Id.*) Moreover, Dr. Penn provides additional and important context, noting that Plaintiff “contemporaneously self-described” this episode “as a protest out of frustration with a perceived delay” regarding scheduling, rather than an “actual attempt at self-harm.” (*Id.*) Dr. Penn also discusses Plaintiff’s medical records related to her transfer to an inpatient mental health unit in late 2020. (*Id.* at 31-32)

In sum, Dr. Penn concludes that “Plaintiff’s medical records demonstrate that whatever distress she may have as a result of her GD, it was and is well managed, not severe, and not causing any impairments to her daily living activities.” (DE-65-13 at 32) Dr. Penn further concludes that “the lack of such clinical indications of distress in a patient’s medical chart is an important consideration when determining whether a given intervention is medical necessary.” (*Id.*) In Plaintiff’s case, Dr. Penn opines that “there was and is no clinically significant indication that she was or is suffering from severe distress, harm, or disability as a result of her [GD].” (*Id.*) Accordingly, Dr. Penn concludes that the “Division TARC’s recommendation to not approve the surgery as not medically necessary was reasonable[.]” (*Id.*)

**b. Dr. Penn Concludes that the Division TARC Reasonably Determined that the Medical Literature is Inconclusive.**

Dr. Penn’s concludes that “there is a lack of high-quality scientific and medical literature indicating the long-term efficacy of GAS as a treatment for [GD].” (DE-65-13 at 33) As a medical practitioner, Dr. Penn notes that “the efficacy of the proposed intervention, as demonstrated through rigorous medical and scientific research, is an integral component of determining medical necessity.” (*Id.* at 34) Thus, Dr. Penn opines that an evaluation of the available literature is “an appropriate consideration when determining whether gender-affirming treatment is medically necessary.” (*Id.*) Accordingly, he concludes that this too, provided a reasonable basis for the Division TARC’s denial of Plaintiff’s request for surgery. (*Id.* at 33)

**II. Argument**

**A. Applicable Legal Standard**

Rule 702 provides that “[a] witness who is qualified as an expert by knowledge, skill, experience, training, or education” can offer expert opinions if four factors are present:

(a) that expert’s scientific, technical, or other specialized knowledge will help the trier of fact to understand the evidence or to determine a fact in issue; (b) the testimony is based on sufficient facts or data; (c) the testimony is the product of reliable principles and methods; and (d) the expert has reliably applied the principles and methods to the facts of the case.

A leading treatise on evidence condenses Rule 702 into three broad prerequisites: (1) the “testimony offered must be helpful to the trier of fact,” (2) “the witness must be qualified to offer opinions on that topic,” and (3) “the opinion testimony must be reliable from an evidentiary standpoint and must fit the facts of the case.” 4 Weinstein’s Federal Evidence § 702.syn (2023).

### **1. Rule 702 is Broadly Interpreted in Favor of Admission.**

“[T]he Federal Rules of Evidence eliminated many formalistic barriers imposed by the common law on the introduction of opinion and expert testimony.” *Kopf v. Skyrms*, 993 F.2d 374, 377 (4th Cir. 1993). “Rule 702 is broadly interpreted, and helpfulness to the trier of fact is its ‘touchstone.’” *Id.* quoting *Friendship Heights Associates v. Koubek*, 785 F.2d 1154, 1159 (4th Cir. 1986). *See also, United States v. Offill*, 666 F.3d 168, 175 (4th Cir. 2011) (noting that the “touchstone of [Rule 702] is whether the testimony will assist the jury.”)

“The presumption under the Rules is that expert testimony is admissible.” 4 Weinstein’s Federal Evidence § 702.02 (2023). The trial court has broad discretion in its “gatekeeper” function regarding these three requirements. *See GE v. Joiner*, 522 U.S. 136, 142 (1997) (admissibility of expert testimony reviewed on abuse of discretion standard). Moreover, the trial court has “broad discretion in choosing which *Daubert* factors to apply and how to consider them.” *Belville v. Ford Motor Co.*, 919 F.3d 224, 233-234 (4th Cir. 2019) (cleaned up)

Regarding the helpfulness requirement, “[t]estimony from an expert is presumed to be helpful unless it concerns matters within the everyday knowledge and experience of a lay juror.” *Kopf*, 993 F.2d. at 377. With respect to the qualification requirement, as Plaintiff acknowledges,

“a person may qualify to render expert testimony in any one of the five ways listed” by Rule 702: “knowledge, skill, experience, training, or education.” (DE 76 at 5 citing *Kopf*, 993 F.2d at 377) The expert simply must be qualified “on the issue for which the opinion is proffered.” *Kopf*, 993 F.2d at 377. And, when an expert’s qualifications are challenged, “the test for exclusion is a strict one . . .” *Id.*

Regarding the reliability requirement, the factors are flexible and will depend on the unique circumstances of the expert testimony. *Westberry v. Gislaved Gummi AB*, 178 F.3d 257, 261 (4th Cir. 1999). This flexibility is particularly applicable when expert testimony is based on experience, “as there exist meaningful differences in how reliability must be examined with respect to expert testimony that is primarily experiential in nature as opposed to scientific.” *United States v. Wilson*, 484 F.3d 267, 274 (4th Cir. 2007). While scientific expert testimony is “objectively verifiable, and subject to the expectations of falsifiability, peer review, and publication,” experiential expert testimony “does not rely on anything like a scientific method.” *Id.* (cleaned up). Even so, “this does not lead to a conclusion that experience alone—or experience in conjunction with other knowledge, skill, training or education—may not provide a sufficient foundation for expert testimony.” *Id.*

## **2. The Rules are Even More Relaxed for Rebuttal Expert Opinions.**

Furthermore, Federal Rule of Civil Procedure 26 permits parties to submit expert testimony that is “intended solely to contradict or rebut evidence on the same subject matter identified by another party.” Fed. R. Civ. P. 26(a)(2)(D)(ii). “Rebuttal evidence is properly admissible when it will explain, repel, counteract or disprove the evidence of the adverse party.” *Earthkind v. Lebermuth Co.*, No. 5:19-CV-00051, 2021 U.S. Dist. LEXIS 103080, \*10 (W.D.N.C. June 1, 2021) (cleaned up). When offering rebuttal expert testimony, the expert has “no burden to produce

models or methods of their own; they need only attack those of the opposing party's experts." *Id.* (cleaned up) Rebuttal experts still "must meet *Daubert's* threshold standards regarding" qualifications, sufficiency of the data, reliability of the methodology, and relevance of the testimony. *Id.*

### **3. Exclusion is Rare and Disfavored.**

Not surprisingly, in light of the foregoing principles, "rejection of expert testimony is the exception, rather than the rule." *Lipitor (Atorvastatin Calcium) Mktg. v. Pfizer, Inc.*, 892 F.3d 624, 631 (4th Cir. 2018); *United States v. Smith*, 919 F.3d 825, 835 (4th Cir. 2019) (same). Notably, to the extent this case proceeds with a bench trial,<sup>1</sup> exclusion is particularly inappropriate, as "[t]he main purpose of [the] *Daubert* exclusion is to protect juries from being swayed by dubious scientific testimony." *Nease v. Ford Motor Co.*, 848 F.3d 219, 231 (4th Cir. 2017). Moreover, whether the case is tried by judge or jury, many of Plaintiff's concerns about Defendants' experts "can be handled on a rigorous cross-examination." *Earthkind*, 2021 U.S. Dist. LEXIS 103080, at \*11.

#### **E. Dr. Penn's Opinions Serve as Rebuttal and are Admissible Under Rule 702.**

Dr. Penn's opinions respond directly to Plaintiff's claims and would assist the trier of fact to understand the Department's decision-making policy process, the application of the phrase medical necessity, and the Department's evaluation of Plaintiff's request for GAS. Additionally, Dr. Penn's opinions will assist the trier of fact in evaluating various aspects of Plaintiff's evidence. Moreover, Dr. Penn's knowledge, training, and his extensive experience as a psychiatrist in the carceral setting with responsibility for developing and implementing department-wide policies for

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<sup>1</sup> Although the Court has discretion to exclude expert testimony at the summary judgment stage, even if Plaintiff were to prevail on this motion, expert testimony is not necessary for Defendants to be awarded summary judgment based on the reasonable disagreement between the members of the Division TARC and Plaintiff regarding the proper course of her medical care.

evaluating and managing care for transgender patients certainly qualify him to offer these opinions. Lastly, because Dr. Penn's opinions are based on his review of records, documents, and depositions, as well as his training, knowledge, and considerable experience, they are reliable from an evidentiary standpoint and fit the facts of the case. Thus, Dr. Penn's opinions are admissible under Rule 702.

**1. Dr. Penn's Opinions Are Based on His Specialized Knowledge and Experience and Are Useful to the Trier of Fact.**

This first factor has two parts: (a) the evidence must be based on some specialized scientific, technical, or other specialized knowledge; and (b) that the evidence would be useful to the trier of fact. *Kopf*, 993 F.2d at 377. All of Dr. Penn's opinions meet these requirements. As detailed in his report and CV, Dr. Penn is a triple board-certified psychiatrist that has more than 30 years of clinical and administrative health care experience, mostly in the correctional setting. In that time, Dr. Penn has acquired considerable specialized clinical and administrative knowledge and experience, including direct clinical care, supervisory responsibilities, and involvement in process and policy, related to evaluating and treating individuals with GD.

Dr. Penn's opinion that the EMTO Policy is sound and reasonable is directly informed by his extensive experience developing and implementing policies and programs concerning the provision of care to this patient population. (*See* DE-65-13 at 3-4) Dr. Penn's second opinion that Plaintiff and Dr. Ettner's formulation of "medical necessity" is unreasonable and unworkable is rooted in his approximately 30 years of practicing medicine as a psychiatrist, primarily in the carceral setting. Lastly, Dr. Penn's opinion that the Department's denial of Plaintiff's requested surgery was appropriate and reasonable is based on his training and experience as a psychiatrist, his review of Plaintiff's medical records and other documents and materials, and his knowledge and experience developing and implementing relevant policies and programs. Accordingly, each

of his opinions are firmly rooted in his professional education, training, and specialized knowledge and experience gained as a correctional psychiatrist.

Additionally, each of Dr. Penn's opinions are useful to the trier of fact in several respects. Dr. Penn's opinion regarding the EMTO Policy is useful to the trier of fact because it assists in understanding the methods employed by the Department with respect to evaluating requests for care by transgendered patients. Moreover, Dr. Penn's opinions and conclusions regarding the EMTO policy are useful to the trier of fact by counteracting and disproving aspects of Plaintiff's attempts to malign the Department's policies and processes.

Dr. Penn's second opinion regarding the formulation of the phrase "medical necessity" is particularly useful to the trier of fact because it explains what factors are taken into account by clinicians when determining medical necessity and why and how those factors are considered. A comprehensive presentation of evidence on that point is critical to aid the fact finder in this case. Moreover, Dr. Penn's opinions directly counter Dr. Ettner's opinions on the same topic.

Lastly, Dr. Penn's opinions about the Department's decision to deny Plaintiff's requested surgery is useful to the trier of fact as those opinions provide valuable context for understanding why the Department's application of the phrase medically necessary was reasonable and appropriate. In particular, Dr. Penn's opinions on this matter assist the fact finder in understanding what clinical indications are relevant to the Department's analysis and how the state of the medical literature factors into the calculus. They also aid the fact finder in evaluating the Department's determination in this case. Ultimately, because the matters, about which Dr. Penn opines, are not "matters within the everyday knowledge and experience of a lay juror" and thus, Dr. Penn's opinions are "presumed to be helpful." *See Kopf*, 993 F.2d. at 377.

## **2. Dr. Penn is Qualified to Offer the Opinions Presented in His Report.**

When an expert's qualifications are challenged, the test for exclusion is strict. *See Kopf*, 993 F.2d at 377. Under Rule 702, one can qualify to offer an expert opinion by knowledge, skill, experience, training, or education. *See id.* Dr. Penn qualifies under all these metrics. Dr. Penn's professional education and training, as well as his extensive experience, certainly qualifies him to offer opinions about the EMTO Policy, the formulation of the phrase medical necessity, and the Department's evaluation of Plaintiff's requested surgery.

## **3. Dr. Penn's Opinions Are Reliable and Trustworthy.**

The test of reliability is flexible and will ultimately depend on the unique circumstances of the expert testimony involved. *Westberry*, 178 F.3d at 261. "Expert testimony is admissible only if: (1) it is based on sufficient facts or data; (2) it is the product of reliable principles and methods; and (3) the witness has reliably applied the principles and methods to the facts of the case[.]" 4 Weinstein's Federal Evidence § 702.05 (2023).

Dr. Penn's opinions are indeed reliable. First, Dr. Penn's opinions are based on sufficient facts and data. More specifically, Dr. Penn's opinions regarding the EMTO Policy and medical necessity are based on his decades of experience in correctional healthcare, including his clinical work with transgender patients, his administrative work on programs and policies related to that patient population, and his general knowledge, training, and experience as psychiatrist. Additionally, Dr. Penn's opinion regarding the Department's decision to deny to Plaintiff's requested surgery is based on his review of health and other records, depositions, and the recorded in-person assessment conducted by Dr. Boyd.

For the same reasons, Dr. Penn's opinions are the product of reliable principles and methods in the field of correctional healthcare. In this field, these are all reliable principles and

methods. Plaintiff cannot credibly argue otherwise since the opinions of her expert, Dr. Ettner, are based on much the same work.<sup>2</sup> (DE-61-2, ¶¶ 14-16)

#### **F. Responses to Matters Specifically Raised in Plaintiff's Challenge.**

Plaintiff makes three broad and unsupported arguments to exclude *all* of Dr. Penn's opinions. Plaintiff's first argument is that Dr. Penn is not qualified to opine on the efficacy or medical necessity of GAS because he lacks training, experience, and specialized knowledge. (DE-76 at 5) Next Plaintiff argues that Dr. Penn's methodology is unsound, and thus, his testimony as to the medical literature and Plaintiff's mental health is unreliable. (*Id.* at 12) Lastly, Plaintiff argues that Dr. Penn's opinions regarding the EMTO Policy and the formulation of medical necessity should be excluded because they are irrelevant. (*Id.* at 18) Plaintiff's arguments fail.

##### **1. Plaintiff Cannot Show that Dr. Penn is Unqualified to Offer Opinions Regarding Efficacy and Medical Necessity of GAS.**

Plaintiff contends Dr. Penn is not qualified because he lacks training, experience, and specialized knowledge. (*See* DE-76 at 5) This argument fails because it ignores Dr. Penn's considerable experience dealing with the precise matters about which he opines, as set forth above. To support this contention, Plaintiff cobbles together disconnected, incomplete, and largely irrelevant bits of Dr. Penn's report and testimony. For instance, Plaintiff states that Dr. Penn "concedes he does not have specific knowledge with regard to the exact surgical procedures[.]" (*Id.* at 8) First, this is not a concession. Defendants never positioned Dr. Penn as a surgical expert because he is a psychiatrist, and, like Dr. Ettner, is not a surgeon. Thus, none of Dr. Penn's opinions require surgical expertise.

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<sup>2</sup> Unlike Dr. Penn, Dr. Ettner did not review Plaintiff's deposition. (Ex. A at 71, 202-205) Furthermore, Dr. Penn initially sought to conduct a Rule 35 examination of Plaintiff, but Plaintiff objected. (*See* DE-37-40) Ultimately, the Court entered an order allowing Dr. Boyd to examine Plaintiff and permitting Defendants the opportunity to renew their request for Dr. Penn to conduct an examination later, if deemed necessary. (DE-47 at 7-8) Because the entirety of Dr. Boyd's assessment was video-recorded, Dr. Penn was able to review and rely upon that assessment.

Additionally, Plaintiff argues that since Dr. Penn's report notes his expertise is in the "provision of psychiatric, mental health, and certain other medical and health care services," but not in GD or GAS, he has no relevant expertise on that topic. (DE-76 at 8, quoting Dr. Penn's expert report), DE-65-13 at 1) This contention is meritless because Plaintiff completely overlooks the considerable experience, that Dr. Penn details in his report, regarding his direct and supervisory clinical and administrative work with this specific patient population. (*See* DE-65-13 at 2-5)

Moreover, where Plaintiff acknowledges Dr. Penn's experience, she does so derisively and dismissively. For example, Plaintiff unfairly characterizes Dr. Penn's factual estimate of the number of patients treated in a GD clinic as "boast[ing][.]" (*See* DE-76 at 7) Plaintiff is dismissive of Dr. Penn's "background and training . . . direct work in correctional settings and in forensic capacities" among other listed qualifications. (*See id.* at 8) And Plaintiff criticizes the nature of the tutelage that Dr. Penn received working with Dr. Meyer by contending it was "informal, lacked benchmarks, and consisted predominantly of shadowing, consultation[.]" (*Id.*) Of course Plaintiff is free to attempt to use these assertions as bases for cross-examination at trial, but they do not supply a valid basis to exclude Dr. Penn's testimony. *See Earthkind*, 2021 U.S. Dist. LEXIS 103080, at \*11 (concerns about an expert could be handled by "rigorous cross examination.").

Plaintiff also takes Dr. Penn's testimony out of context to support her argument. She claims that "when asked why the [GD] clinic has never considered a request for GAS as treatment for [GD], Dr. Penn disavowed his own qualifications to render an opinion regarding [GAS]." (DE-76 at 9) Dr. Penn does not "disavow" his own qualifications. Rather, when viewed in context, the cited deposition testimony concerns Dr. Penn's testimony about a particular clinic wherein he and his staff focus solely on diagnosis because there are no surgeons on staff. (*See* DE-75-1 at 70-80)

Plaintiff's other contentions that Dr. Penn is not qualified to render his opinions also fail. Plaintiff appears to contend that the lack of any publications on the topic and not having previously been qualified as an expert by a court on the topic counsel in favor of exclusion. (*See* DE-76 at 10) But the case law indicates otherwise. Although "publishing . . . can be a hallmark of expert witness reliability," it is "not a mandatory prerequisite to qualification" and the fact that the witness has not previously been qualified as an expert is not relevant so long as the expert's qualifications are sound. *United States v. Young*, 916 F.3d 368, 380 (4th Cir. 2019).

Lastly, Plaintiff's attempt to cast doubt on Dr. Penn's qualifications by referencing treatment of his opinions in another case, *Jensen v. Shinn*, 609 F. Supp. 3d 789 (D. Ariz. 2022), falls short. (*See* DE-76 at 11) While Plaintiff correctly points out that *Jensen* did not involve GD (*see id.*), she overlooks that the discussion of Dr. Penn's opinions in *Jensen* was not in the context of a *Daubert* motion but rather following a bench trial at which Dr. Penn was permitted to offer his opinions. *Id.* at 796. In fact, in *Jensen* the court specifically stated that "even if [the parties had not waived their *Daubert* challenges], any such challenge would have failed." *Id.* at 800. Thus, *Jensen* lends no support to Plaintiff's effort to exclude Dr. Penn's opinions.

## **2. Plaintiff Has No Basis to Exclude Dr. Penn's Opinion Regarding the Medical Literature or Plaintiff's Mental Distress.**

Plaintiff also attacks Dr. Penn's methodology regarding his opinions about the state of the medical literature and the risk-benefit analysis. (DE-76 at 11, 17) More specifically, Plaintiff asserts three attacks on Dr. Penn's methodology regarding his conclusions on the medical literature: (1) he has not published, (2) he relied on the report of another expert, Dr. Li, and (3) his own literature review was cursory. (*See* DE-76 at 12-16) None of these attacks have merit.

First, as already noted, prior publication is "not a mandatory prerequisite to qualification as an expert." *Young*, 916 F.3d at 380. Second, Plaintiff's attack on Dr. Penn's reference to Dr. Li's

work similarly fails. Dr. Penn will testify that he reached his own conclusion, independent of Dr. Li, based on his own familiarity with the literature. (DE-65-13 at 32-33) Indeed, he provided that opinion during the preliminary injunction stage long before, and independent of, Dr. Li's report. (DE-18-8 ¶¶ 53-60) Moreover, there is nothing improper about one expert relying upon the work of another. "[T]he rules [of evidence] expressly authorize that . . . expert opinions may be based, not only on data and direct observations, but also on the opinions . . . of others 'if of the type reasonably relied upon by experts in the particular field . . .'" *Westfield Ins. Co. v. Harris*, 134 F.3d 608, 612 (4th Cir. 1998) (quoting Fed. R. Evid. 703); 4 WEINSTEIN'S FEDERAL EVIDENCE § 703.04 (2023) (noting that Courts across the country have found the same).

Plaintiff's attack that Dr. Penn's methodology was not sound because, as she contends, his literature was less than robust also fails. To support this assertion, Plaintiff takes considerable liberties with Dr. Penn's testimony to suggest that he somehow conceded that he is not qualified to opine on the topic. (*See* DE-76- at 16 quoting Dr. Penn as testifying that this was not his "area of expertise") When viewed in context, it is clear that Dr. Penn was answering a question about why he did not compile a list of the studies that he reviewed in drafting his affidavit, DE-18-8. (DE-75-1 at 221-224) Dr. Penn then acknowledged that in retrospect his literature review could have been better prepared and then reiterates that because he is not a research design or methods expert, like Dr. Li, he thus would rely on her work in that regard. (*Id.*)

To be clear, Dr. Penn is not, and does not purport to be, the same type of expert as Dr. Li. Accordingly, he will not offer detailed testimony regarding the body of literature and its methodological shortcomings, study-design flaws, and inferential limitations. But none of this precludes Dr. Penn from offering his general assessment of the literature and how it informs his clinical decision-making—something he is well qualified by experience and medical training to

do. Again, to the extent Plaintiff finds this lacking, or less than robust, she can attempt to establish that on cross examination. Moreover, Plaintiff cannot credibly argue that Dr. Penn, a medical doctor, lacks the qualification to opine as to his assessment of the general state of the medical literature and how it informs clinical judgment—especially since Dr. Ettner, who is not a medical doctor, nor an expert in study design or research methodology (Ex. A at 62-63), provides the same kind of opinions about the state of the literature. (DE-61-2 at ¶¶ 50-61)

Next, Plaintiff attempts to exclude Dr. Penn’s opinions regarding Plaintiff’s mental health and his risk-benefit discussion by making a similar argument—that his methodology is unsound. (See DE-76 at 17) This contention lacks merit because Dr. Penn’s methodology is both sound and equivalent to (if not more robust than) Dr. Ettner’s. Plaintiff’s only contention here is that Dr. Penn does not meaningfully engage with Plaintiff’s medical records in setting out his opinions. (See DE-76 at 17-18) But Dr. Penn’s report articulates how Plaintiff’s health records inform his opinion.

As noted in section (I)(B)(3)(a) above, Dr. Penn discusses his review of Plaintiff’s records and the clinical indications of severe distress, harm, or disability, and their manifestations that he was looking for. (See also, DE 65-13 at 28-30) Dr. Penn’s report also notes his conclusion about Plaintiff’s adjustment, and her ability to participant in current activities of daily living without impairment. (*Id.* at 30-31) Thereafter, Dr. Penn notes three specific episodes indicated in Plaintiff’s health records and describes the import of those events. (*Id.* at 31-32) Thus, Plaintiff’s contention that Dr. Penn’s conclusions regarding her mental health and the risk-benefit analysis not having a foundation in his records review is inaccurate. Simply put, Dr. Penn’s analysis of Plaintiff’s records is *more* robust than Dr. Ettner’s.

Plaintiff’s attacks on Dr. Penn’s opinions not being methodologically sound are really attacks on the basis for his opinions. And that sort of attack is not sufficient to warrant exclusion.

Rather, those attacks are better saved for cross-examination. Ultimately, “questions regarding the factual underpinnings of the expert witness’ opinion affect the weight and credibility of the witness’ assessment, not its admissibility. *Bresler v. Wilmington Tr. Co.*, 855 F.3d 178, 195 (4th Cir. 2017) (cleaned up) Moreover, any suggestion or implication that Dr. Penn’s conclusions were predetermined baselessly assumes bad faith that lacks any record support. (*See* DE-39 at 13) Dr. Penn opines that GAS could be considered medically necessary for some patients in some circumstances. (DE-65-13 at 32; DE-75-1 at 162)

### **3. Plaintiff Cannot Show that Dr. Penn’s Opinions Regarding the EMTO Policy and Medical Necessity Are Irrelevant.**

Plaintiff contends that expert opinion evidence regarding the Department’s EMTO Policy and criticisms of how Dr. Ettner applies the phrase “medical necessity” are “wholly irrelevant from the inquires at issue.” (DE-76 at 18)<sup>3</sup> This argument is specious as these opinions are provided in direct response to Plaintiff’s focus and assertions.

As noted above, throughout this litigation, while Plaintiff has not sought to enjoin the EMTO Policy, she has targeted it and used its purported deficiencies as a basis for her claim that the Division TARC’s decision was unreasonable. (*See* DE3-1 ¶¶ 71, 141; DE-13-1 ¶ 91; DE-61-2, ¶¶ 95-121; DE-63 at 9-11, 17-20) Thus, Dr. Penn’s opinions with respect to the EMTO Policy and how it operates including in this case, are indeed relevant rebuttal testimony. Unless Plaintiff is abandoning her own arguments (which would not be clear until trial) or conceding their irrelevance, Dr. Penn’s rebuttal testimony on this topic is relevant.

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<sup>3</sup> Plaintiff also incorrectly asserts that Dr. Penn’s opinions on medical necessity are limited to the notion that there is a different standard in the correctional setting. (*See* DE-76 at 19) Rather, as explained in Section I(B)(2) above, Dr. Penn opinions regarding the formulation of medical necessity are not rooted in the idea of two different standards. (*See also* DE-65-13 at 18-20) Dr. Penn is prepared to further explain this at trial.

Likewise, Plaintiff's contention that Dr. Penn's opinions regarding medical necessity are irrelevant is demonstrably false. His opinions on this topic relate to a core issue in this case and serve as a direct rebuttal of Dr. Ettner's opinion of medical necessity. (DE-1 ¶ 149; DE-63 at 22-23, 28) Thus, it is hard to see how these opinions can be considered irrelevant. Ultimately, the fact that Plaintiff does not like Dr. Penn's opinions and that they do not support her case does not render them irrelevant—especially where she seeks to introduce contrary testimony from her own expert.

### CONCLUSION

For the reasons stated herein, Defendants respectfully request that this Court deny Plaintiff's motion to exclude the testimony of Dr. Penn, DE-75.

This the 11th day of December 2023.

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**Attorney General**

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*Attorneys for Defendants*

IN THE UNITED STATES DISTRICT COURT  
FOR THE WESTERN DISTRICT OF NORTH CAROLINA  
CHARLOTTE DIVISION  
No. 3:22-cv-191

KANAUTICA ZAYRE-BROWN,  
  
Plaintiff,  
  
v.  
  
NORTH CAROLINA DEPARTMENT OF  
ADULT CORRECTION, et al.,  
  
Defendants.

**APPENDIX TO DEFENDANTS'  
RESPONSE TO PLAINTIFF'S MOTION  
TO EXCLUDE THE TESTIMONY OF  
JOSEPH PENN, MD**

<b>Exhibit A</b>	Excerpts of the deposition of Randi Ettner Ph.D., taken on August 21, 2023.
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This the 11th day of December 2023.

**JOSHUA H. STEIN**  
**Attorney General**

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IN THE UNITED STATES DISTRICT COURT  
FOR THE WESTERN DISTRICT OF NORTH CAROLINA  
CHARLOTTE DIVISION

KANAUTICA ZAYRE-BROWN, )  
Plaintiff, )  
vs. ) No. 3:22:cv-191  
NORTH CAROLINA DEPARTMENT )  
OF PUBLIC SAFETY, et al., )  
Defendant. )

The videotaped deposition of RANDI C. ETTNER, Ph.D., called for examination, pursuant to the Federal Rules of Civil Procedure of the United States District Courts pertaining to the taking of depositions, taken before YVETTE BIJARRO-RODRIGUEZ, CSR No. 084-003734, a Certified Shorthand Reporter within and for the County of Cook and State of Illinois, at 1 North Franklin Street, Suite 3000, Chicago, Illinois, on the 21st day of August, 2023, at 9 o'clock a.m.

REPORTED BY: YVETTE BIJARRO-RODRIGUEZ, CSR  
LICENSE NO.: 084-003734

1 five-minute, ten-minute break. Let's do a  
2 ten-minute break.

3 THE VIDEOGRAPHER: This marks the end of  
4 media unit one. The time is 11:31.

5 (Whereupon, a break was taken,  
6 after which the following  
7 proceedings were had:)

8 THE VIDEOGRAPHER: This marks the  
9 beginning of media number two. The time is  
10 11:46 a.m. We are on the record.

11 BY MR. RODRIGUEZ:

12 Q. Dr. Ettner, do you consider yourself to  
13 be an expert in corrections?

14 A. No.

15 Q. How about correctional administration?

16 A. No.

17 Q. What about managed care organizations?

18 A. No.

19 Q. What about psychiatry?

20 A. No.

21 Q. Medicine?

22 A. No.

23 Q. Comparative defectiveness research?

24 A. No.

1 Q. Statistics?

2 A. No.

3 Q. Research design?

4 A. No.

5 Q. Have you ever spoken with anybody from  
6 the UNC Trans Health Program with respect to the  
7 Plaintiff in this case, Kanautica Zayre-Brown?

8 A. Spoken with whom? I'm sorry.

9 Q. Anyone from the UNC Trans Program?

10 A. No.

11 Q. Have you spoken with any of the  
12 providers for Mrs. Brown in this case?

13 A. No.

14 Q. So you've never spoken with Dr. Hahn?

15 A. I have not.

16 Q. Jennifer Dula?

17 A. No.

18 Q. Donald Caraccio?

19 A. No.

20 Q. Carla Pugh?

21 A. No.

22 Q. Have you spoken with the Plaintiff's  
23 husband, Mr. Deon Brown?

24 A. No.

1 have in front of you but it's a filing in  
2 opposition to something that Defendants had filed.  
3 In that document it was represented that the  
4 interview, the in-person interview, was five hours  
5 long.

6 So do you think it may have been  
7 four or five?

8 A. I'm not certain.

9 Q. And then have you reviewed the  
10 Plaintiff's deposition in this case?

11 A. No.

12 Q. So if she testified that it was three  
13 hours long, could it be three hours?

14 A. At a minimum it would have been three  
15 hours.

16 Q. In the same page here you've got at the  
17 bottom of the end of this fourth line, "5-26-22:  
18 score and interpret psychometric tests .75 hours;  
19 begin report draft 1.0 hour."

20 Was that your first declaration  
21 that you were referring to drafting there?

22 A. I believe so.

23 Q. Let's turn to PLAINTIFF0254 which is the  
24 second -- third to last page in the stack. The

1 Q. So why did you review them?

2 A. They were sent to me and so I review  
3 whatever documents I receive.

4 Q. You didn't review the Plaintiff's  
5 deposition?

6 A. No.

7 Q. Did you review Dr. Bowman's deposition?

8 A. No.

9 Q. If you flip to Page 14 of your rebuttal  
10 report, Paragraph 23.

11 MR. DAVIDSON: It's Exhibit 12.

12 THE WITNESS: Pardon me?

13 MR. DAVIDSON: Exhibit 12.

14 THE WITNESS: Thank you.

15 BY THE WITNESS:

16 A. And what page was that?

17 BY MR. RODRIGUEZ:

18 Q. Actually, hold on one second. I meant  
19 to do this. So just for closing the universe on  
20 this, did you review any other depositions like of  
21 Dr. Campbell, Dr. Piper, Dr. Junker, Dr. Hahn?

22 A. No.

23 Q. Did you review any other depositions  
24 beyond the Defendants' experts' depositions?

1 A. I did not.

2 Q. And you are aware that they were -- or  
3 are you aware that there were close to ten  
4 depositions taken in this case aside from the  
5 experts?

6 A. I'm not aware of that.

7 Q. Is that something that you sometimes  
8 would be made apprised of?

9 A. Sometimes? You mean in other --

10 Q. In other cases.

11 A. Sometimes, yes. Sometimes, no.

12 Q. Does the testimony of the parties in the  
13 litigation impact your conclusions or opinions  
14 ever?

15 A. I can't answer that as a general  
16 question.

17 Q. Could it?

18 A. It depends I think on the case and the  
19 situation.

20 Q. But you wouldn't know unless you  
21 reviewed them, right?

22 A. I wouldn't know unless you were more  
23 specific about what was at issue and what my  
24 opinions were.

1 Q. Right. So theoretically would it be  
2 possible that a fact witness' deposition could have  
3 information in it that would affect your opinions  
4 and conclusions?

5 MR. DAVIDSON: Object, speculation.

6 THE WITNESS: I'm sorry.

7 BY THE WITNESS:

8 A. Perhaps in a personal injury case.

9 BY MR. RODRIGUEZ:

10 Q. But in a case like this that's not a  
11 theoretical possibility?

12 A. If I'm asked to opine on a particular  
13 intervention, I'm not going to be influenced by  
14 someone else's deposition. I might -- if it were  
15 someone who was also an expert in gender dysphoria  
16 and disagreed with me, I would be interested in  
17 hearing their reason. If it was a WPATH member who  
18 perhaps had a different view, I would be interested  
19 in reading that deposition or that might influence  
20 my thoughts about it. I don't know that it would  
21 change my opinion.

22 Q. Would reviewing the deposition  
23 transcripts of the plaintiffs -- a plaintiff's  
24 mental health care provider be something that you

1 think might be fruitful?

2 A. It might be, but I've reviewed the  
3 medical notes.

4 Q. So you don't need to review the  
5 depositions?

6 A. It would depend on who the provider was,  
7 I think.

8 Q. What about the deposition of the  
9 Plaintiff?

10 A. I read the plaintiff's declaration.

11 Q. The one submitted in support of her  
12 motion for a preliminary injunction?

13 A. I think -- I believe that's what it was.  
14 I'm not certain. I just know it was her  
15 declaration.

16 Q. Are you aware of whether any of the  
17 Defendants in this case are WPATH members?

18 A. I don't know if Dr. Figler is a member  
19 of WPATH or not.

20 Q. Is Dr. Figler a defendant in this case?

21 A. No.

22 Q. Are you aware of whether any Defendants  
23 in this case are WPATH members?

24 A. I'm not aware of that.