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

REV. PAUL A. EKNES-TUCKER, *
et al., *
Plaintiffs, * 2:22-cv-00184-LCB
vs. * May 6, 2022
* Montgomery, Alabama
* 9:00 a.m.
KAY IVEY, in her official *
capacity as Governor of the *
State of Alabama, et al., *
Defendant. *

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

Proceedings recorded by OFFICIAL COURT REPORTER, Qualified
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P R O C E E D I N G S

(In open court.)

THE COURT: Good morning. Please be seated.

All right. I am going to aim my question at you,

09:08:27 5 Mr. LaCour.

6 You heard the testimony of Pastor Eknes-Tucker. What, if
7 anything, in his testimony would trip the Alabama statute?

8 MR. LACOUR: Your Honor, we don't think anything in
9 his testimony would trip the statute, as you said. The key
09:08:45 10 language is does he engage in or causing the prescription or
11 administration of puberty blockers? Is he engaging or causing
12 the prescription or administration of the cross-sex hormones?

13 Clearly, he is not under the plain text of the statute, so
14 we don't think he has standing, which I think is probably good
09:09:06 15 news and bad news for him. But the good news is he is not
16 going to be prosecuted. The bad news is he doesn't get to --
17 in his words -- make a difference by continuing in this case.

18 But that's the State's answer.

19 THE COURT: All right. Since he has addressed
09:09:23 20 standing, anybody want to touch on that from the plaintiffs'
21 side?

22 MR. DOSS: Yes, Your Honor.

23 Our concern remains that under this Act's language, it
24 does capture speech for referrals, for actions by people who
09:09:42 25 are counseling patients, or people who are counseling anyone to

1 put them in touch with medical providers knowing full well what
2 those medical provisions may or may not be.

3 I think this does also feed into the void for vagueness
4 argument, Your Honor, because the State is making these
09:10:01 5 post-hoc decisions about when the statute does apply, despite
6 its plain language and when it does not apply.

7 So we still think that the statute on its face is
8 triggered. We appreciate the State's statement on the record
9 that it doesn't think that the statute is triggered.

09:10:19 10 On the other hand, it shows just how vague the statute is,
11 that we can't know just by reading it, which violates the Fifth
12 Amendment rights' notice.

13 THE COURT: All right. One other thing that I will
14 put the parties on notice about when we get to closings.

09:10:32 15 So I assume everybody has read the Arkansas order and
16 transcript. Would that be a correct statement?

17 All right. So I would like everybody to be able to
18 address at the conclusion of these proceedings what parts of
19 that order, if any, that they disagree with, why, and to what
09:10:58 20 degree those -- that legal reasoning is applicable here. And I
21 know that we do have some differences in that statute.

22 So just put that in your back pocket, and let's be
23 prepared to talk about that.

24 Okay. So I understand the United States has a witness
09:11:20 25 this morning; is that correct?

1 MR. POWERS: Yes, Your Honor.

2 Before we get started, I have a quick bit of housekeeping.
3 The United States moves to admit United States Exhibit Numbers
4 1 through 12.

09:11:36 5 MR. BOWDRE: No objection, Your Honor.

6 THE COURT: Be admitted.

7 MR. POWERS: Thank you. Now, the United States would
8 like to call Dr. Armand Antommara to the stand.

9 THE COURT: All right.

09:11:47 10 ARMAND AN TOMMARA,

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

13 DIRECT EXAMINATION

14 BY MR. POWERS:

09:12:15 15 Q Good morning.

16 A Good morning.

17 Q Doctor, could you please introduce yourself for the Court?

18 A My name is Armand Herbert Matheny Antommara. I am a
19 pediatrician and bioethicist. I am employed by Cincinnati

09:12:32 20 Children's Hospital Medical Center where I direct its ethics
21 center. I'm the Lee Ault Carter chair of pediatric ethics and
22 an attending physician in the division of hospital medicine.

23 THE COURT: Mr. Powers, I neglected to ask you how
24 long you think this witness will be.

09:12:51 25 MR. POWERS: Well under half an hour.

1 THE COURT: Okay. All right.

2 BY MR. POWERS:

3 Q Doctor, do you hold an MD from the Washington University
4 School of Medicine?

09:13:01 5 A I do.

6 Q Do you hold a Ph.D. from the University of Chicago
7 Divinity School?

8 A Yes.

9 Q Doctor, what are your areas of specialty?

09:13:09 10 A As a physician, my area of specialty is pediatric hospital
11 medicine. So I take care of general pediatric patients,
12 patients with asthma or pneumonia, who are admitted to the
13 hospital. And I'm also a bioethicist and specialize in
14 pediatric clinical ethics.

09:13:31 15 Q Thank you.

16 Can you please explain what a bioethicist is?

17 A Bioethics is a multidisciplinary field that addresses the
18 ethical issues that arise in medicine and the life sciences.

19 Q Doctor, are you board certified?

09:13:48 20 A I am. I am board certified in pediatrics and in pediatric
21 hospital medicine. And I'm also certified as a health-care
22 ethics consultant.

23 Q Are you part of a multidisciplinary team that provides
24 treatment to adolescent patients with gender dysphoria?

09:14:07 25 A Yes. Cincinnati Children's has a clinic that provides

1 care for children and adolescents with gender dysphoria, and I
2 participate in their monthly multidisciplinary team meetings,
3 as well as consult on an as-needed basis when special ethical
4 issues arise in the care of the patients that they treat.

09:14:34 5 Q And are the sorts of ethical issues that do arise when
6 you're consulted regarding the care of transgender patients?

7 A At times, there are issues regarding who is able to
8 provide informed consent, whether adult patients have medical
9 decision-making capacity or ethical issues when there are
09:14:55 10 unusual risks or benefits involved in the care of a particular
11 patient.

12 Q Are you involved in the development of treatment protocols
13 related to treating adolescent patients with gender dysphoria?

14 A Yes, to the extent that they have ethical issues in
09:15:10 15 particular. I participated in the development and the periodic
16 review of the clinic's informed consent documents.

17 Q Thank you, Doctor.

18 As part of your duties, do you consult with medical
19 providers on the treatment of infants and children with
09:15:28 20 differences in sex development?

21 A Yes. Cincinnati Children's also has a clinic that
22 provides care to individuals with differences of sex
23 development. And I participate in similar ways in that
24 multidisciplinary's team meetings both in terms of patient care
09:15:50 25 and in terms of gender policies.

1 Q Thank you.

2 MR. POWERS: Your Honor, the United States moves to
3 have Dr. Antommaria qualified as an expert in bioethics and
4 treatment protocols for adolescents with gender dysphoria.

09:16:05 5 MR. BOWDRE: No objection, Your Honor.

6 THE COURT: All right. He will be accepted for that
7 purpose.

8 MR. POWERS: Thank you.

9 BY MR. POWERS:

09:16:11 10 Q Dr. Antommaria, is a diagnosis of gender dysphoria made by
11 physicians and other medical professionals, or is it made by
12 the patient or the parents?

13 A A diagnosis of gender dysphoria is made by clinicians.

14 Q And are there external indicators that can be evaluated as
09:16:29 15 part of that process?

16 A Yes. There are patient behaviors that can be observed
17 that support the diagnosis such as, you know, missing school or
18 other behaviors which can be observed that support that
19 diagnosis.

09:16:48 20 Q Doctor, as part of your work, are you familiar with
21 research studies, systematic reviews, and clinical practice
22 guidelines in a variety of areas related to pediatric care?

23 A Yes, I am.

24 Q And are you familiar with studies, reviews, and guidelines
09:17:06 25 regarding treatment specifically for adolescents experiencing

1 gender dysphoria?

2 A Yes.

3 Q And what is the difference between research and clinical
4 care?

09:17:17 5 A Research and clinical care are differentiated both in
6 terms of their goals and their methods. So the goal of
7 research is to generate generalizable knowledge. And the
8 methods are the use of a protocol that defines the steps in a
9 study.

09:17:36 10 Clinical care's goal is to provide benefit to individual
11 patients, and its procedures are individualized decision
12 making.

13 Q And what is the difference between observational studies
14 and randomly controlled trials?

09:17:51 15 A So the two big categories of studies are observational and
16 experimental.

17 In observational studies, the investigators don't control
18 who's exposed to the intervention. The most -- one of the
19 common forms of an observational study would be a prospective
09:18:15 20 observational study in which individuals who receive a
21 treatment are followed over time to see the effects of that
22 treatment.

23 In experimental studies, the investigators control who
24 receives the intervention. Commonly in a randomized controlled
09:18:31 25 trial, neither the participant nor the investigator controls

1 who receives the treatment or the intervention or the control.
2 People analogize randomization to a coin flip in terms of
3 determining who receives which.

09:18:53 4 Q And, Doctor, do you have an opinion about the viability of
5 conducting randomly controlled trials testing the use of
6 treatment, like puberty blockers and hormone therapy, for
7 adolescents with gender dysphoria?

8 A Yes, I do. I would have concerns that randomized
9 controlled trials of these interventions would be unethical,
09:19:11 10 and even if they could be ethically performed, they would have
11 substantial methodological limitations.

12 Q And what are the ethical concerns first?

13 A In order for a research study to be ethical, particularly
14 a randomized controlled trial, there must exist something
09:19:29 15 called equipoise. The investigator must believe that the
16 intervention and the control are each likely to be equally
17 efficacious. And many investigators in this field would
18 believe that there is sufficient evidence of the benefit of the
19 use of puberty blockers or gender-affirming hormone therapy
09:19:51 20 that a randomized controlled trial would not be ethical.

21 In addition, you would need to be sure that the study
22 could be completed. For example, that you would have enough
23 participants sign up to be in the study to make exposing them
24 to the risks of the study to be beneficial. And there would be
09:20:12 25 concerns that not enough participants could be recruited to

1 such a trial to be ethical.

2 Q And do you have any additional methodological concerns
3 regarding randomly controlled trials?

4 A Yes. One of the key factors in a randomized controlled
09:20:29 5 trial is they're what's called blinded, but neither the
6 participants nor the investigators know whether the
7 participants is receiving the intervention or the control.

8 And in a randomized control trial of this nature, it would
9 be -- not be possible to blind investigators that are
09:20:50 10 participants because they would know which -- what's called an
11 arm, which arm the participant is in by the development or lack
12 of development of secondary sexual characteristics. So such a
13 randomized controlled trial would be of substantially less
14 value.

09:21:10 15 Q Thank you.

16 Now, what's the difference between a systematic review of
17 the literature and a clinical practice guideline?

18 A So in a systematic review of the literature, the
19 individual will collect all of the evidence and -- relevant to
09:21:27 20 a particular outcome and grade the quality of that evidence.

21 Systematic reviews of the literature, however, do not make
22 treatment recommendations. Just because the level of evidence
23 for intervention might be low doesn't mean that that
24 intervention should not be used.

09:21:50 25 A clinical practice guideline both evaluates the quality

1 of the evidence, makes treatment recommendations, and grades
2 the quality of those recommendations, because there are many
3 other factors rather than in addition to the quality of the
4 evidence that need to be considered in making treatment
09:22:09 5 recommendations.

6 Q Doctor, can a clinical practice guideline be based on the
7 results of observational studies?

8 A Yes, they can. And frequently in pediatrics, clinical
9 practice guidelines are based on observational studies, because
09:22:27 10 unfortunately there are fewer randomized controlled trials
11 available in pediatrics than in adult medicine.

12 So other Endocrine Society guidelines for other pediatric
13 conditions like congenital adrenal hyperplasia or obesity are
14 largely based on observational studies. And even treatment
09:22:50 15 guidelines for important crucial things, such as the American
16 Heart Association's guidelines for performing CPR in children,
17 are largely based on observational studies.

18 Q I think you might have mentioned one of them already, but
19 what guidelines help establish the standard of care when
09:23:08 20 treating adolescents with gender dysphoria?

21 A The two predominant clinical practice guidelines for
22 treating adolescents with gender dysphoria would be the
23 Endocrine Society's and WPATH's.

24 Q Thank you.

09:23:23 25 Is the level of evidence supporting these puberty blockers

1 and hormone therapy in these guidelines comparable to the level
2 of evidence for other treatments in pediatrics?

3 A Yes.

4 Q Doctor, are you familiar with the European policies, with
09:23:41 5 respect to treating adolescents diagnosed with gender
6 dysphoria?

7 A I am.

8 Q And could you please summarize your understanding of that?

9 A So in part, particularly reference has been made to the
09:23:56 10 Swedish policy. That policy is only available in an official
11 English translation of a three-page summary.

12 So it's difficult to fully evaluate these policies, given
13 the limited amount of material that's available in official
14 English translation.

09:24:17 15 But my understanding of the policies are that they have
16 reviewed the literature, but they use less robust methods than
17 the Endocrine Society, because they neither grade the evidence
18 nor the strength of their recommendations, and that none of the
19 policies instantiate a ban on gender-affirming health care, the
09:24:40 20 use of puberty blockers or gender-affirming hormone treatment.

21 Q Thank you.

22 Doctor, are you familiar with the provisions of Senate
23 Bill 184?

24 A I am.

09:24:49 25 Q Are the provisions of Senate Bill 184 consistent with the

1 guidelines issued by any country in Europe?

2 A No.

3 Q Doctor, once a diagnosis of gender dysphoria has been
4 made, how does the informed content process work in the
09:25:09 5 pediatric context?

6 A In the pediatric context, parental consent is required --
7 in general, parental consent is required for treatment.

8 Adolescents should participate in medical decision making
9 to the extent that it is appropriate, and for adolescents,
09:25:27 10 their assent should also be sought.

11 And the informed consent process requires a discussion of
12 the potential benefits, risks, and alternatives of the
13 treatment.

14 Q Doctor, do you have an opinion as to whether puberty
09:25:41 15 blockers and hormone therapy treatments have benefits to some
16 adolescents diagnosed with gender dysphoria that outweigh the
17 potential risks?

18 A Yes. That for some individuals with gender dysphoria the
19 benefits of treatment outweigh the risks.

09:25:56 20 Q And what role does desistance play, or what our friends
21 have referred to as desistance play in your analysis?

22 A So in evaluation of the risk, if treatments are
23 discontinued, there may be effects of those treatments, which
24 are only partially reversible. But that is only one of the
09:26:24 25 factors that needs to be weighed in the risks and benefit

1 analysis. And that the evidence about the current rates of
2 desistance are that it is sufficiently low, that that would not
3 be in general a reason not to proceed with treatment.

4 Q Thank you.

09:26:43 5 Is there high quality evidence supporting the alternative
6 of psychotherapy alone, so without the assistance of puberty
7 blockers and hormone therapy? Is there high quality evidence
8 supporting that as a treatment for gender dysphoria in
9 adolescents?

09:27:03 10 A I am not aware of any randomized controlled trials of
11 psychotherapy alone for the treatment of adolescents with
12 gender dysphoria.

13 Q As an ethicist, do you have an opinion regarding parents
14 and adolescents' ability to adequately understand the potential
09:27:23 15 cause and benefits in giving informed consent to the provision
16 of puberty blockers and hormone therapy?

17 A Although this decision involves a complex set of risks,
18 benefits, and alternatives, it is comparable to other decisions
19 that parents and their children make in pediatric health care
09:27:42 20 on a frequent basis.

21 Q And in the instance that there was a medical provider who
22 violated their ethical obligations to their patients with
23 respect to obtaining informed content, are there forms of
24 oversight in place?

09:27:57 25 A There would be multiple mechanisms to address those

1 potential shortcomings. If that provider worked for a
2 health-care institution, they would be credentialed by that
3 institution. The institution would have a responsibility for
4 oversight of their practice.

09:28:14 5 The state medical board could review their practice and
6 potentially discipline them or withdraw their license.

7 And although I am not a lawyer, it's my understanding that
8 there would be the potential for malpractice claims for
9 inadequate informed consent.

09:28:32 10 So there are multiple mechanisms that exist to address the
11 case in which somebody obtained inadequate informed consent.

12 Q So there are other mechanisms in place other than a direct
13 ban on the treatment itself?

14 A Yes. I'm sorry. You're correct.

09:28:48 15 Q Doctor, I would like you to consider a circumstance where
16 adolescents no longer have access to puberty blockers or
17 hormone treatments. Are there any equally effective
18 alternative medical treatments for adolescents with gender
19 dysphoria?

09:29:03 20 A There are not.

21 Q Is there an ethical basis for distinguishing the provision
22 of treatment to minors experiencing precocious puberty, from
23 transgender minors experiencing gender dysphoria?

24 A There is not.

09:29:19 25 So in particular, the type of evidence for both treatments

1 are the same. The evidence supporting the use of puberty
2 blockers for the treatment of central precocious puberty are
3 also prospective observational trials with relatively small
4 numbers of participants.

09:29:42 5 There are no randomized controlled trials to support the
6 use of puberty blockers for central precocious puberty.

7 Q Compared to treatments in other contexts, is there
8 anything about treatments for adolescents with gender dysphoria
9 that would require prohibition by the State from an ethical
09:29:58 10 perspective?

11 A No.

12 Q And last question, Doctor. What are the ethical
13 implications for medical providers treating minors diagnosed
14 with gender dysphoria if Senate Bill 184 is implemented?

09:30:11 15 A They would be unfortunately placed in the untenable
16 position of either violating their ethical obligations to their
17 patients to conform with the law, or fulfilling their
18 professional duties to their patients and being criminally
19 charged.

09:30:28 20 MR. POWERS: Thank you. No further questions.

21 THE COURT: Cross?

22 CROSS-EXAMINATION

23 BY MR. BOWDRE:

24 Q Good morning, Dr. Antommaria. My name is Barrett Bowdre.
09:30:53 25 I represent the State defendants.

1 A Good morning.

2 Q You agree, don't you, that most individuals who experience
3 gender dysphoria in childhood desist?

4 A The evidence would support that individuals who experience
09:31:18 5 gender dysphoria at young ages such as three or four, that the
6 majority of them do desist.

7 Q You noted that the goal of clinical practice is the
8 individualized assessment in providing care for the individual
9 patient that you're treating. But no clinician can accurately
09:31:45 10 predict whether the patient sitting in front of him will
11 persist in their gender dysphoria or will, as the majority do,
12 desist; isn't that correct?

13 A So at the point of evaluating an adolescent, the
14 desistance rate is substantially smaller than it is for the
09:32:11 15 desistance rate of young children, and that there would be the
16 ability to be fairly certain that they are unlikely to desist.
17 But expecting perfection in the practice of medicine and being
18 able to predict with 100 percent certainty is unrealistic
19 because there's nothing in health care that can occur with 100
09:32:36 20 percent certainty.

21 Q Can you predict with 80 percent certainty whether the
22 individual patient sitting in front of you will persist or
23 desist in his or her gender dysphoria?

24 A The evidence of which I am aware would suggest that the
09:32:53 25 desistance rate is -- for adolescents is substantially less

1 than 80 percent. If the desistance rate for adolescents -- I
2 apologize -- is substantially less than 20 percent.

3 Q Is that for adolescents who are treated with puberty
4 blockers, or adolescents who are not treated with medical
09:33:11 5 interventions?

6 A The most robust data that is available are adolescents who
7 are treated with gender-affirming health care.

8 Q So can you tell with 80 percent certainty whether an
9 individual patient, an adolescent who is not treated with
09:33:30 10 puberty blockers, would desist or persist in the gender
11 dysphoria?

12 A So the evidence base in that area is less robust, but the
13 evidence of which I'm aware would still suggest that the
14 desistance rate for individuals who are adolescents is less
09:33:52 15 than 20 percent.

16 Q And what studies do you rely on to say that it's -- I
17 mean, for adolescents -- we're talking about a 12 or 13 year
18 old who has entered what, Tanner Stage 2 of puberty; is that
19 correct?

09:34:04 20 A Correct.

21 Q Okay. So what evidence do you rely on to say that without
22 treating with puberty blockers the group who are not treated
23 there's a more than 80 percent likelihood that the individual
24 patient is going to desist to that point?

09:34:19 25 A So I would say that that is based on -- so I am not aware

1 of a specific prospective observational trial that answers your
2 question, but that experience in the field would suggest that
3 that -- the desistance rate is low.

4 Q And what is that experience?

09:34:47 5 A Of the clinicians who provide care to this patient
6 population.

7 Q I guess my question is -- I'm trying to figure out -- I
8 understand that the majority of children who are started on
9 puberty blockers go on to cross-sex hormones. Is that true?

09:35:02 10 A Can you restate your question?

11 Q The majority of children who are -- who start on puberty
12 blockers will then go on to take cross-sex hormones; isn't that
13 right?

14 A Correct.

09:35:16 15 Q Okay. And so my question is: If a child does not start
16 on puberty blockers, what degree of certainty can we say that
17 the gender dysphoria would go away? And we are talking about a
18 Tanner Stage 2 adolescent.

19 A So I would differentiate the likelihood of them desisting
09:35:42 20 from the quality of evidence that supports that claim. The
21 likelihood of them desisting based on the available evidence
22 would be that it would still be infrequent, the evidence is --
23 would currently be based on expert opinion of individuals who
24 provide that care.

09:36:01 25 Q Okay. So there are no studies to support that claim; is

1 that right?

2 A I'm not aware of a study on that specific question.

3 Q Okay. Would you agree that the combination of puberty
4 blockers and cross-sex hormones -- let me start over.

09:36:24 5 Because you testified that most children who begin on
6 puberty blockers go on to cross-sex hormones, wouldn't it be
7 reasonable when we're talking about the risks to view those
8 together?

9 A No.

09:36:42 10 Q Why is that?

11 A Because they occur at separate periods of time. So that
12 informed consent is obtained for the use of puberty blockers,
13 there are ongoing conversations about the efficacy of that
14 treatment and the individual symptomology, and a separate
09:37:01 15 detailed informed consent process is obtained prior to the
16 start of gender-affirming health care.

17 Q But wouldn't it be relevant to a parent or a child
18 determining whether to start puberty blockers to know that
19 almost everyone who starts on this treatment goes on to
09:37:18 20 cross-sex hormones?

21 A It would be relevant for parents to know that the clinical
22 practice guidelines for the treatment of gender dysphoria
23 generally recommend treatment with puberty blockers followed by
24 treatment with gender-affirming hormone therapy.

09:37:42 25 Q Okay. My question was: Wouldn't it be relevant for them

1 to know that almost everyone who starts on puberty blockers
2 then goes on to cross-sex hormones?

3 A I don't believe that that would -- that category of
4 information would be relevant. I don't know that that specific
09:38:08 5 framing would be useful and informative to patients.

6 Q Okay. So you do not think that the --

7 THE COURT: Hold on a minute, Mr. Bowdre.

8 Ladies and gentlemen, let me say this: If you are sitting
9 in the audience and you're head nodding or you're mouthing
09:38:23 10 words and looking at the witness, please stop that, because
11 that could give the appearance that you are trying to influence
12 the witness.

13 So let me just put that out there. Please follow my
14 guidelines on that.

09:38:38 15 I am not suggesting that you are being influenced by
16 anyone out here, but it's possible that someone might want to
17 influence you.

18 So go ahead, Mr. Bowdre.

19 MR. BOWDRE: Thank you, Your Honor.

09:38:47 20 Could you read the last question? I'm sorry.

21 (Whereupon, the Court Reporter read back the pending
22 question.)

23 BY MR. BOWDRE:

24 Q Would you agree that there are substantial risks involved
09:39:26 25 in someone starting puberty blockers and going on to cross-sex

1 hormones?

2 A There are risks involved in the treatment course for the
3 treatment of gender dysphoria.

4 Q What are some of those risks?

09:39:39 5 A Can you be more specific? Of the entire course of
6 treatment, or particular parts of the treatment?

7 Q The entire course of treatment.

8 A So I would disaggregate the risks of puberty blockers from
9 the risks of gender-affirming hormone therapy and the risks of
09:40:06 10 testosterone therapy are different from the -- or are somewhat
11 different than the risks of estrogen therapy.

12 Would you like me to review all of that.

13 Q Let me just ask you a couple of those.

14 Would you agree that some of the risks of puberty blockers
09:40:18 15 and cross-sex hormones would be loss of fertility?

16 A There is a risk of impaired fertility.

17 Q Okay. Would you agree that a risk would be loss of sexual
18 function?

19 A Particularly the use of testosterone therapy has a risk of
09:40:42 20 changes in sexual function. I apologize. The use of estrogen
21 therapy in -- has a risk of alterations in sexual function.

22 Q So if someone cannot predict with very much accuracy
23 whether gender dysphoria will desist, then you cannot predict
24 whether the interventions will help or harm that person; is
09:41:20 25 that true?

1 A No, that is not true.

2 Q Why is that not true?

3 A Because there is sufficient certainty that gender
4 dysphoria will persist to have a discussion about the potential
09:41:37 5 benefits and risks of treatment.

6 Q Okay. So if it were the case that one could not tell with
7 much accuracy whether the, you know, 11 or 12 year old at
8 Tanner Stage 2 sitting in front of you, whether that person's
9 gender dysphoria would desist, assuming that, then is it true
09:41:56 10 that you would not be able to know whether the intervention
11 treatments of puberty blockers and the cross-sex hormones would
12 be helpful or harmful to that person?

13 A So it would depend on how much uncertainty there was, and
14 that would likely be information that was relevant to the
09:42:24 15 informed assent discussion and the parents' decision about
16 whether to proceed with treatment.

17 Q What if you were 40 percent sure that the -- that the
18 child would persist, then could you tell whether the
19 interventions would be helpful or harmful?

09:42:52 20 A It -- so part of -- so do you mean 40 percent sure that
21 your prediction of their likelihood of persisting was accurate,
22 or do you mean that their likelihood of persisting was
23 40 percent?

24 Q I'm sorry. Let's assume that you are -- that you -- that
09:43:18 25 it is 40 percent accurate that the person sitting in front of

1 you is going to persist. The person has a 40 percent chance of
2 persisting.

3 A Then in that hypothetical case, there would be less
4 justification for proceeding with that course of treatment.

09:43:40 5 But that is a hypothetical case and not the decision that
6 patients and their families are currently facing.

7 Q Okay. Dr. Antommara, what is a detransitioner?

8 A So I don't know that there's a technical -- currently a
9 widely accepted technical definition of that term, because
09:44:05 10 people -- individuals use that term in a variety of different
11 ways to mean different things.

12 Q Okay. Would one definition, sort of a common definition
13 be someone who identifies or has been diagnosed with gender
14 dysphoria, has begun puberty blockers, cross-sex hormones, and
09:44:27 15 then the dysphoria desists, or for whatever other reason they
16 realign with their biological sex and they stop the medical
17 interventions; is that a fair overall description?

18 A So that is a potential definition. The one qualification
19 I would make is if it's defined in terms of an individual who
09:44:53 20 discontinues medical therapy, there may be a wide variety of
21 reasons for individuals to discontinue their medical therapy
22 beyond change in their gender identity.

23 Q And have you reviewed the literature -- let me be more
24 specific.

09:45:14 25 Have you reviewed recent surveys of people who identify as

1 detransitioners, specifically Lisa Littman's and Elie
2 Vandebussche's? Have you reviewed those two?

3 A No, I have not reviewed those two.

4 Q Are you -- do -- let me -- I will strike that.

09:45:34 5 Are you aware that at least, according to one of those
6 studies, only 25 percent of people who detransition ever tell
7 their gender-affirming care doctors that they have
8 detransitioned?

9 A I heard you state that yesterday in court. But, no, as I
09:45:54 10 said, I'm not aware of those particular studies.

11 I would say that, for example, our clinic's informed
12 consent documents emphasize if individuals discontinue their
13 treatment, it's very important for them to provide that
14 information to their health-care providers.

09:46:11 15 Q Okay. Does the fact that some people who are diagnosed
16 with gender dysphoria, given puberty blockers and cross-sex
17 hormones, dramatically change their bodies, sometimes
18 permanently, and then divert to identifying with their
19 biological sex give you any pause that we might not be so good
09:46:32 20 at identifying who are good candidates for these medical
21 interventions and who might not be good candidates?

22 A Can I ask what you mean by give me pause?

23 Q Does it give you concern?

24 A So I think that in this field, all the available data and
09:46:46 25 information should be considered in making treatment decisions.

1 That would be potentially relevant information that should be
2 incorporated in an ongoing basis in treatment decisions and
3 revisions of clinical guidelines when they're revised.

09:47:09 4 Q But you have not reviewed at least these studies on
5 detransitioners to consider whether those would impact your
6 clinical standards; is that true?

7 A So those -- so I am aware of the discussion about
8 detransition, including the stories of individual patients who
9 have detransitioned. The body of literature is large.

09:47:38 10 And at this point in time, no, I have not reviewed those
11 two specific studies. If it became relevant, I would make
12 effort to review those studies.

13 Q Thank you.

14 You do not touch on this in your testimony, but in your
09:47:56 15 declaration, you spent a couple of pages talking about access
16 to top surgery for gender dysphoric minors; is that right?

17 A Yes. There's reference to top surgery in my declaration.

18 Q Okay. In such surgeries -- we're talking about
19 mastectomies usually; is that right?

09:48:14 20 A That's one way to characterize the procedure.

21 Q Okay. And they are performed on minors in at least some
22 states in the United States; isn't that true?

23 A That is true.

24 Q Okay. At what age do you think that a -- someone can
09:48:36 25 consent to a double mastectomy as part of the gender-affirming

1 care?

2 A So I would be unable to answer that in terms of an age.
3 The relevant factor is their decision-making capacity, which
4 only has a correlation with age, but is not specific to age.

09:48:56 5 Q Okay. You said in your declaration that adolescents
6 generally possess comparable medical decision-making capacity
7 to adults; is that right?

8 A So part of the question is how you define adolescents.
9 But, yes, older adolescents generally have comparable medical
09:49:22 10 decision-making capacity to adults.

11 Q So what age are we talking about?

12 A So the specific study that I cited in my declaration
13 compared 14 year olds to older adults.

14 Q Okay.

09:49:35 15 A Or to adults.

16 Q And you would agree that Tanner Stage 2 puberty normally
17 occurs before age 14?

18 A Correct.

19 Q Okay. So given that adults can consent to both top and
09:49:51 20 bottom sex-change surgeries, why can't a 14 year old not?

21 A Can you restate the question?

22 Q Yeah. Given that adults can consent to both top and
23 bottom sex-change surgeries, why should a 14 year old not be
24 able to consent to those procedures?

09:50:15 25 A Because in general, adolescents are not permitted to

1 consent to medical treatment, and we rely on their parents or
2 legal guardians to consent.

3 Q But why is that? If they -- you just testified that 14
4 year olds have comparable medical decision-making abilities to
09:50:31 5 adults, is it simply a matter of law that they cannot consent,
6 or is there some basis in the literature that would require the
7 parental consent for 14 year olds?

8 A So at a minimum, the legal requirement -- so informed
9 consent is in part a legal requirement. And although there are
09:50:53 10 exceptions to permit minor -- some minors to provide consent
11 for certain forms of medical treatment, parental consent is
12 required for a variety of different reasons, not a single
13 reason.

14 Q I want to read to you a paragraph -- I will go -- I want
09:51:30 15 to read to you a paragraph on an amicus brief to the American
16 Psychological Association, the American Psychiatric
17 Association, and the National Association of Social Workers did
18 in a case called Miller vs. Alabama.

19 All right. And so this is the amicus brief. And I am
09:51:50 20 going to flip to page 12.

21 In highlighted portion, paragraph 3, it says, Finally,
22 juveniles differ from adults in their ability to foresee and
23 take into account the consequences of their behavior. By
24 definition, adolescents have less life experience on which to
09:52:15 25 draw, making it less likely that they will fully apprehend the

1 potential negative consequences of their actions. Moreover,
2 adolescents are less able than adults to envision and plan for
3 the future, a capacity still developing during adolescence.
4 The study of maturity of judgment discussed above found that
09:52:39 5 adolescents' future orientation is weaker than adults'.

6 I will skip the sentence about the specific subjects.

7 Then it says, Similarly, studies have shown that among 15
8 to 17 year olds, realism in thinking about the future increases
9 with age, and that the skills required for future planning
09:53:03 10 continue to develop until the early 20s. The ability to resist
11 and control emotional impulses, to gauge risks and benefits in
12 an adult manner, and to envision the future consequences of
13 one's actions -- even in the case of environmental or peer
14 pressures are critical components of social and emotional
09:53:21 15 maturity necessary in order to make mature, fully considered
16 decisions. Empirical research confirms that even older
17 adolescents have not fully developed these abilities and hence
18 lack an adult's capacity for mature judgment.

19 Do you disagree with that?

09:53:40 20 A So you would appreciate having seen this for the first
21 time and not being able to review the evidence on which it's
22 based, it's difficult for me to form a full opinion, but I am
23 happy to provide my initial reaction.

24 And that would be that informed consent is generally
09:54:04 25 considered to be a threshold at which people need to meet. The

1 language that I see here refers to optimal capacities which
2 might far exceed that threshold. If you read the language that
3 it continues to mature into the 20s, I don't take it that
4 that's justifying that the age of consent should be moved to 20
09:54:30 5 or 22 instead of 18.

6 So I think it's consistent to say that individuals'
7 medical decision-making capacity may continue to mature over
8 time without saying that adolescents lack the sufficient
9 capacity to assent to treatment.

09:54:49 10 Q Thank you.

11 THE COURT: How much longer do we have with our cross?

12 MR. BOWDRE: 20 minutes, maybe 30.

13 BY MR. BOWDRE:

14 Q Do you agree that more research is needed to study the
09:55:23 15 efficacy and the cost and benefits of providing
16 gender-affirming care to minors?

17 A I would say that more research is needed in all areas of
18 health care, and that the State's legislation would prohibit
19 such research.

09:55:44 20 Q And what are the questions that would need to be answered
21 that the research needs to answer in this area that are left
22 open?

23 A There are a range of questions that might benefit from
24 further refinement, including issues about the timing of the
09:56:10 25 initiation of therapy, dosing. There are a variety of

1 considerations that could be further refined and developed.
2 But further refining those treatment protocols would be a
3 refinement.

4 Q In your declaration, you noted that once the FDA has
09:56:41 5 approved a medication for one indication, thereby agreeing that
6 it is safe and effective for this intended use, prescribers are
7 generally free to prescribe that for other indications; is that
8 correct?

9 A That is correct.

09:56:54 10 Q Okay. But that does not mean that an off-label use would
11 always be safe to prescribe to an individual simply because it
12 is an FDA-approved medication for some purpose?

13 A Correct.

14 Q So, for instance, a nine-year-old boy with diabetes, the
09:57:14 15 FDA has approved the use of insulin for that purpose, but
16 providing insulin to a nine-year-old boy without diabetes would
17 be very dangerous, wouldn't it?

18 A Yes.

19 Q So whether an off-label use is appropriate depends on the
09:57:33 20 proven risks and benefits of that particular use that we're
21 looking at?

22 A Yes. But the fact that a medication is used off label
23 does not intrinsically mean that that evidence does not exist.

24 Q Okay. In your direct testimony, you said -- I think you
09:58:02 25 said -- correct me if I'm wrong -- that randomized controlled

1 trials in this area would be unethical because no equipoise
2 exists between treating someone simply with psychotherapy
3 versus treating someone with psychotherapy and puberty blockers
4 and cross-sex hormones; is that fair?

09:58:21 5 A Correct.

6 Q When did that equipoise come into existence?

7 A I don't know that I can provide you a particular date as
8 to when that lack of equipoise came into existence.

9 Q For that equipoise or lack of equipoise to come into
09:58:48 10 existence, wouldn't we need studies that, you know -- doesn't
11 there need to be at least one study that shows -- that looks at
12 a group treated only with psychotherapy and one group treated
13 with the medical interventions?

14 A Can you restate your question?

09:59:09 15 Q For the lack of equipoise to come into existence, for us
16 to know that, you know, psychotherapy plus puberty blockers and
17 cross-sex hormones are the way to go and that any other
18 treatment would be unethical, don't we first need to have a
19 study that treats someone with psychotherapy and has a
09:59:30 20 controlled group that way versus someone who is treated with
21 all of those interventions?

22 A No. There are prospective observational trials that
23 demonstrate the efficacy of puberty blockers and
24 gender-affirming hormone therapy, and withhold those treatments
09:59:48 25 from an individual may be considered unethical.

1 Q Okay. So you were asked whether there were any high
2 quality randomized controlled studies looking only at
3 psychotherapy, which I will note is not the level of evidence
4 that you are relying on.

10:00:29 5 But doesn't that concern you that we have no idea whether
6 psychotherapy alone versus psychotherapy plus puberty blockers
7 plus cross-sex hormones is doing the work in creating any
8 benefits that we see?

9 A So there is substantial clinical experience that -- so I
10:00:53 10 will differentiate psychotherapy from psychological and
11 psychiatric treatment given that psychotherapy is a distinct
12 entity. But that there is substantial experience that
13 providing mental health care to adolescents with gender
14 dysphoria in and of itself is not sufficient to resolve
10:01:21 15 individuals' dysphoria and hence the reason for proceeding with
16 medical interventions.

17 If a patient had gender dysphoria and was -- their gender
18 dysphoria was adequately treated with mental health care, they
19 would not proceed to medical therapy.

10:01:40 20 Q Do you contend that the Endocrine Society's practice
21 guidelines that were released in 2017 provides a more robust
22 overview of the literature than the UK's recent literature
23 review of looking at puberty blockers and cross-sex hormones?

24 A Can you be specific as to which British report you're
10:02:16 25 referring to?

1 Q Yes. And if you want to look at them, they are
2 Defendants' Exhibits 9 and 10. I think you do have the right
3 binder.

4 A So I can't answer your question because it's asking me
10:02:49 5 what in effect are apples and oranges. One is a systematic
6 review of the literature, and one is a clinical practice
7 guideline, which are different types of material.

8 Q Okay. I believe you testified that the -- I mean, the
9 clinical practice guidelines you said does a comprehensive
10:03:11 10 review of the literature and then suggests -- suggests, you
11 know, practices. Is that fair?

12 A So a clinical practice guideline will be based on a
13 systematic review of the literature and grades the quality of
14 the evidence and the strengths and recommendations.

10:03:29 15 Q Okay. So for that part of the practice guideline
16 analysis, the literature review part, would you say that the
17 Endocrine Society's review was more extensive and is more
18 accurate than the UK's more recent literature reviews that
19 you're looking at in Defendants' Exhibits 9 and 10?

10:03:53 20 A So I can't answer your question in detail without more
21 thoroughly reviewing the documents.

22 Based on my understanding of the Endocrine Society's
23 methodology, I would expect them to be comparable, but I can't
24 form a formed opinion based on the information that I currently
10:04:19 25 have.

1 Q Okay. You have not reviewed closely the UK's recent
2 literature reviews?

3 A So I've reviewed their conclusions. I haven't reviewed
4 them in the degree of methodological detail that your question
10:04:33 5 would require.

6 There are a large number of systematic reviews available
7 in the literature. Some of which I know in detail, and others
8 of which I know at less -- a lesser level of detail.

9 Q What are the prospective observational studies that you
10:05:02 10 claim demonstrate the efficacy of puberty blockers and
11 gender-affirming care?

12 A So the specific references are included in my report. But
13 in general, they're the studies that are conducted by the Dutch
14 group.

10:05:19 15 Q And in that study, both the 2011 study that looks only at
16 puberty blockers and then the 2014 report that reported on
17 people who then went on to cross-sex hormones and total
18 surgical interventions, those studies -- so everyone in those
19 studies got psychotherapy and psychiatric help the entire time;
10:05:47 20 is that true?

21 A Correct.

22 Q Is it also true that people who had psychological
23 comorbidities, depression, things like that, were excluded from
24 the treatments from the medical interventions?

10:05:59 25 A So I would have to review their specific inclusion and

1 exclusion criteria to be able to answer your question.

2 Q Okay. Do you know if everyone in that study, whether
3 their psychological functioning and improvements went to a new
4 clinical range or not?

10:06:29 5 A So there were a variety of different outcome variables
6 that were examined in the study, some of which were unchanged,
7 but some -- but others of which showed statistically
8 significant improvement. And so can you clarify what you mean
9 by a new range?

10:06:52 10 Q I think I will move on, given our time.

11 If parents of a 14 year old can consent to cross-sex
12 hormones, why cannot parents of -- and the 14 year old consent
13 to a double mastectomy?

14 A As a legal matter -- can you clarify your question?

10:07:28 15 Q As a medical ethical matter.

16 A So I don't believe that there would be an indication to
17 perform a mastectomy on a 14 year old.

18 Q Why not? Isn't mastectomy a gender-affirming care for a
19 transgender man?

10:07:52 20 A So in general, the purpose of utilizing puberty blockers
21 would be to prevent the development of those secondary sexual
22 characteristics, and the use of cross-sex hormones would be to
23 promote the development of secondary sexual characteristics
24 that are consistent with an individual's gender identity. And
10:08:19 25 there would be a period of time in which it would be required

1 for the gender-affirming hormone therapy to take an effect.

2 The effects develop over a period of years. So it's hard
3 for me to understand the clinical scenario that you're
4 presenting.

10:08:37 5 Q Well, what if someone did not start on puberty blockers
6 and comes to the clinic as a 14 year old already having
7 developed?

8 A So in -- so it would be my general understanding that that
9 individual -- would they be -- presumably may be pursuing
10:08:59 10 gender-affirming hormone therapy and would not -- so I'm having
11 trouble understanding.

12 Are you suggesting that they're not starting
13 gender-affirming hormone therapy and are simply moving to top
14 surgery?

10:09:12 15 Q Either that, or -- I mean, my understanding is that if,
16 you know, if a biological woman has already developed breasts,
17 then providing testosterone, you know, doesn't make the breasts
18 go away, right? You still need the double mastectomy. So why
19 could not that person, a 14 year old, not -- her and her
10:09:31 20 parents not consent to that?

21 A So I'm having trouble with your construction, particularly
22 related to the age.

23 But I would say that I think that parents and their
24 adolescent children who are less than 18 potentially are
10:09:54 25 capable of consenting to top surgery. And it would depend,

1 then, on the specific clinical circumstance.

2 It's hard for me to answer your abstract formulation.

3 Q You provided an example in your declaration on -- I guess
4 as an example of how the medical community often relies on
10:10:22 5 low-quality evidence. And your example was that a doctor might
6 prescribe, you know, 20 minutes of exercise and a low-calorie
7 diet as a way to treat obesity. And I guess your point was
8 there were no randomized controlled studies showing that
9 20 minutes of exercise and a good diet, you know, is always
10:10:47 10 going to treat obesity.

11 But in that example, the risks of following that protocol
12 are pretty low, aren't they?

13 A Yes.

14 Q Yeah. And would you agree that it might make sense to
10:11:04 15 follow minimal low-quality evidence for low risks for high
16 reward endeavors, such as exercising for 20 minutes, but that
17 we might want higher quality of evidence or more robust mound
18 of it before relying on it for something where the risks were
19 quite high?

10:11:24 20 A That assumes that we cannot make decisions until some
21 speculative future in which that evidence is available.
22 Unfortunately, clinicians have to make decisions based on the
23 evidence that is currently available to them.

24 Q Okay.

10:11:48 25 MR. BOWDRE: May have just a moment to confer with

1 counsel?

2 THE COURT: Yes.

3 MR. BOWDRE: Thank you, Dr. Antommaria.

4 THE WITNESS: Thank you.

10:12:02 5 MR. POWERS: No further questions.

6 THE COURT: All right. May the witness be excused?

7 Sir, you can step down. Thank you.

8 THE WITNESS: Thank you, sir.

9 THE COURT: All right. In the interim -- do you have
10:12:15 10 something you want to say?

11 MR. DAVIS: No, Judge. I wanted to see how you wanted
12 to proceed.

13 THE COURT: All right. Well, I thought -- I know we
14 have several parties seeking leave to file briefs, including
10:12:27 15 several states and several professional organizations. I just
16 wanted to see if the parties wanted to address that very
17 quickly, whether there are any objections or not.

18 MR. LACOUR: I will go first, if that's all right,
19 Your Honor.

10:12:41 20 THE COURT: That's fine.

21 MR. LACOUR: Would you like me to approach the podium?

22 THE COURT: Yes, please.

23 MR. LACOUR: Your Honor, we think that the brief from
24 states should come in. It was filed in a timely manner, indeed
10:12:57 25 before Alabama's brief was even on file, which gave plaintiffs

1 time to assess those arguments before their brief was filed.

2 We do not -- for similar reasons, we do not think that the
3 brief from the AAP should come in. They did not file it until
4 we were actually here about the beginning of opening
10:13:20 5 statements. So there was not time to look it over.

6 I will be candid. I have not even had time to read it
7 myself. I think some people on the team have, but there has
8 been a lot to do in a very short amount of time.

9 And so I think for that reason the Court would -- we would
10:13:38 10 oppose that brief coming in at this moment.

11 THE COURT: All right. What about original
12 plaintiffs?

13 MR. DOSS: Your Honor, we think both sets of amicus
14 briefs are another data point that Your Honor could consider in
10:13:55 15 looking at all of the evidence and thinking through all the
16 arguments.

17 We have no opposition to the several states, their amicus
18 brief, provided that the amicus brief of the professional
19 organizations is also allowed to be filed in.

10:14:10 20 This has been a long week. I think, if I remember
21 correctly, the states' brief was filed on Tuesday, the
22 professional organizations' brief was filed on Wednesday. I
23 don't think the timing makes any difference one way or the
24 other.

10:14:25 25 But to the extent Your Honor is wishing to consider any

1 amicus brief, I would submit that both should be considered,
2 Your Honor.

3 THE COURT: Well, I certainly will consider them all,
4 you know, on final merits. The issue is whether we consider
10:14:41 5 them now. Obviously, if I do consider them now, we are looking
6 at this deadline.

7 Does anyone have any thoughts on that, just the
8 practicality of me trying to take that in and consider it with
9 all this evidence under a time crunch? I think that's worth
10:14:56 10 addressing by both sides.

11 MR. DOSS: As I read the states' brief, Your Honor, it
12 expresses general criticism as to what it -- what they refer to
13 as consensus-based medicine. I don't really see the states'
14 amicus brief is presenting really any legal argument, as best I
10:15:18 15 could tell. The only legal citations were two citations to
16 dissenting opinions from the U.S. Supreme Court. It seemed to
17 me more of a policy statement rather than really much of
18 evidence or legal argument.

19 As to the professional organizations, their amicus brief,
10:15:37 20 I think we have gotten a sense of what those positions are over
21 the past day and a half from Dr. Ladinsky and Dr. Hawkins. If
22 consideration of any brief is going to delay consideration of
23 the merits for present purposes, I would say -- I would submit
24 defer consideration of those amicus briefs until later. We're
10:16:03 25 just trying to get the preliminary relief at this point.

1 THE COURT: A very practical position.

2 How about the United States?

3 MR. CHEEK: We would concur with the plaintiffs on
4 that.

10:16:16 5 THE COURT: Do you want another bite at the apple,
6 Mr. LaCour?

7 MR. LACOUR: Your Honor, I would just note -- sorry --
8 point out the ECF notice. The Arkansas brief was on file by
9 5:23 p.m. or 5:30 p.m. on Monday. So just for the record, that
10:16:43 10 is when it came in.

11 And, of course, the brief from the medical organizations
12 did not come in until the hearings were essentially already
13 begun, so...

14 THE COURT: All right. All right. Last question that
10:17:00 15 I have, and it won't offend me if nobody wants to address this,
16 but it's possible I have missed this in the briefing or the
17 filings, but I certainly know who sponsored this bill. Where
18 did this bill come from? Who wrote this bill? Is that
19 something any party wants to address?

10:17:27 20 MR. LACOUR: Your Honor, it was a bill introduced into
21 the Legislature, considered by the Legislature, enacted, so
22 this is the work product of the Legislature.

23 If there are more detailed questions, we can certainly try
24 to answer them.

10:17:58 25 THE COURT: I'm just throwing the door open for any

1 party to say what they want to.

2 MR. LACOUR: That's what we have to say, Your Honor.

3 THE COURT: All right.

4 MR. CHEEK: Your Honor, the United States does not
10:18:13 5 know, but we are happy to get some people to work on it. And
6 if we can find it out during the course of, you know, the next
7 couple of hours, would it be permissible for us to revisit that
8 question or submit a one-page notice to the Court if we can pin
9 that down?

10:18:31 10 THE COURT: We have got more time. We can take it up
11 again if somebody wants to.

12 Mr. Doss, is this something that you want to address?
13 Again, nobody has to. I am just asking the question.

14 MR. DOSS: I don't know, Your Honor.

10:18:45 15 THE COURT: All right. Who is our next witness?

16 MR. DAVIS: Your Honor, we are going to call Dr. James
17 Cantor. I don't know if you want us to begin now. We're
18 prepared.

19 THE COURT: I think this is a great time to have a
10:18:58 20 short break.

21 So why don't we come back in 12 minutes?

22 (Recess.)

23 THE COURT: Thank you. Please be seated.

24 All right. Any further witnesses from either of the
10:39:14 25 plaintiffs?

1 MS. EAGAN: No, Your Honor.

2 THE COURT: All right. State's case.

3 MR. DAVIS: Your Honor, the State calls Dr. James
4 Cantor when you are ready.

10:39:28 5 THE COURT: I'm ready.

6 JAMES CANTOR, MD,

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

9 DIRECT EXAMINATION

10:39:46 10 BY MR. DAVIS:

11 Q Good morning, Dr. Cantor.

12 A Good morning.

13 Q Would you state your full name?

14 A James Michael Cantor.

10:40:02 15 Q What is your profession, Dr. Cantor?

16 A I am a clinical psychologist and neuroscientist.

17 Q What degrees do you have? Academic degrees.

18 A Bachelor's degree in computer science and mathematics, a
19 master's degree in applied psychology, and a Ph.D in clinical
10:40:17 20 psychology.

21 Q Where do you work?

22 A I am currently in private practice in Toronto, Canada.

23 Q And what is the nature -- are there any particular focuses
24 of the counseling you provide or the research that you have
10:40:32 25 performed?

1 A Human sexuality and atypical sexualities.

2 Q Would that include studies of gender identity?

3 A Yes, it is. Yes, it does.

4 Q Are you knowledgeable about the research surrounding
10:40:47 5 gender dysphoria?

6 A Yes, I am.

7 Q Have you analyzed research concerning the benefits and
8 harms of different ways of treating gender dysphoria?

9 A Yes, I have.

10:40:54 10 Q Do you have skills and expertise assessing the strengths
11 and weaknesses of scientific studies?

12 A Yes, I do.

13 Q And do these skills and expertise include judging what
14 those studies do and do not prove as a matter of science?

10:41:13 15 A Yes.

16 Q Have you treated people who presented with gender
17 dysphoria?

18 A Yes.

19 MR. DAVIS: Your Honor, we proffer Dr. Cantor as an
10:41:25 20 expert on psychology, human sexuality, research methodology,
21 and the state of the research literature on gender dysphoria
22 and its treatment.

23 THE COURT: Any objection?

24 MS. EAGAN: No, Your Honor.

10:41:37 25 THE COURT: All right. He will be accepted for that

1 purpose.

2 BY MR. DAVIS:

3 Q Dr. Cantor, there is a notebook in front of you with a
4 blue cover. Would you please turn to the second tab?

10:41:51 5 A I'm sorry. It just occurs to me I didn't bring my reading
6 glasses. They're in my brief case.

7 MR. DAVIS: Your Honor, can the witness get his
8 glasses?

9 THE COURT: Absolutely.

10:42:43 10 THE WITNESS: Part 2, you said?

11 BY MR. DAVIS:

12 Q Yes. Tab 2, which is Defendants' Exhibit 2.

13 Can you identify that document, Dr. Cantor?

14 A Yes. That is my report, which I submitted for these
10:42:54 15 proceedings.

16 Q Thank you.

17 I think actually, since we just heard Dr. Antommara, I
18 would like to begin with addressing some things that we heard
19 this morning.

10:43:02 20 Did you have the opportunity hear this morning's testimony
21 by Dr. Antommara?

22 A Yes, I did.

23 Q Did you understand Dr. Antommara to testify that randomly
24 controlled studies are not available in this area of medicine?

10:43:16 25 A Yes.

1 Q Did he then say, if you understand -- as you understand,
2 that because the randomly controlled trials are not available,
3 we can rely on observational trials?

4 A That is roughly what I understood him to say, yes.

10:43:33 5 Q Do you have any response to that?

6 A Yes. That's not -- it is true that none of the existing
7 studies are randomized, but it is entirely untrue that we
8 therefore can rely -- can make decisions based on the least
9 reliable kinds of studies.

10:43:48 10 There is a wide, wide range of studies in between, and
11 there's a wide, wide, range of different scientific
12 methodologies that we can employ in order to minimize the laws
13 that we get from completely randomized studies.

14 It's also actually possible if we wanted to conduct such
10:44:09 15 studies such as by allowing people to undergo different parts
16 of a treatment at different times, so we can compare the
17 differences between them when one group has started on that
18 type of treatment and the other hadn't yet.

19 Q Okay. So the randomized trials would be considered like
10:44:29 20 the gold standard, the top-tier level of scientific research?

21 A Randomization is one factor in determining how high
22 quality a study is. It is not a -- it's neither an all or
23 nothing.

24 Q I understand. But did I understand you to say that if you
10:44:47 25 assume that's not available, that's no reason to drop down to

1 the lowest quality of evidence?

2 A That is correct.

3 Q I understood Dr. Antommaria to testify that the level of
4 evidence supporting the WPATH and Endocrine Society guidelines
10:45:05 5 is comparable to the level of evidence supporting other
6 treatments in pediatrics. Can you respond to that?

7 A I am not aware, of course, of all the other treatments in
8 pediatrics. However, there are no studies yielding positive
9 effects of either the Endocrine Society standards or the WPATH
10:45:24 10 standards.

11 The studies which have shown effects have used the Dutch
12 model, which uses a higher set of standards than either the
13 Endocrine Society or the WPATH group.

14 Q Speaking of the Dutch study, I also understood
10:45:42 15 Dr. Antommaria to say there is no high quality evidence
16 supporting the use of psychotherapy alone for gender dysphoria.
17 Do you agree with that?

18 A No, I do not.

19 Q What would you say in response? What's the countervailing
10:45:56 20 evidence?

21 A There exists roughly 15-ish studies following up these
22 kids at all. All of the studies, which without exception that
23 used medical interventions also used psychological --
24 psychotherapy at the same time. So all of the studies which
10:46:17 25 could seem to show a benefit for medical interventions are

1 unable to distinguish that it was the medical intervention
2 causing the benefit, versus the psychotherapy causing the
3 benefit.

4 Of those studies, two were designed in a way that it was
10:46:33 5 possible to peel apart the effects of psychotherapy versus
6 medicine -- the Costa study and the Achille study. The full
7 references are in my report.

8 In the Costa study, there was a -- there were two phases.
9 There was a phase that people went through when they received
10:46:52 10 psychotherapy alone. And then in the subsequent phase, they
11 received both psychotherapy and medical interventions.

12 There were no significant differences between the group.
13 Both groups improved, and there were no significant differences
14 between the group that received psychotherapy alone and the
10:47:08 15 group that received psychotherapy plus medical interventions.

16 The other study, the Achille study, used a statistical
17 method to control for the effects of psychotherapy. That group
18 also improved after medical intervention, but when the effects
19 of psychotherapy were statistically controlled, there was no
10:47:28 20 additional benefit of the medical interventions after that.

21 Q I want to break some of that down. You mentioned studies
22 where all the participants were receiving both psychotherapy
23 and medical-affirming care at the same time, right?

24 A Correct.

10:47:48 25 Q Is that the Dutch -- oh, is the Dutch protocol, the Dutch

1 study an example of such a study?

2 A Both Dutch studies, the 2011 and the 2014, yes.

3 Q If, at the end of that trial, you look and see the people
4 that were receiving both psychotherapy and medical-affirming
10:48:06 5 care at the same time, improved in mental health at the end of
6 the trial, can you as a scientist tell whether the improvement
7 is the result of the pharmaceuticals or the psychotherapy?

8 A Not in the design of those studies, no. That's what in
9 science is called a confound.

10:48:27 10 Q Confound?

11 A Correct.

12 Q What does that mean, confound?

13 A It describes exactly that situation. When two things are
14 done at once, when you see the result, you can't peel apart
10:48:37 15 which -- which of those two interventions was responsible or
16 the interaction between those two interventions was
17 responsible.

18 Q Okay. But the Costa and Achille study, on the other hand,
19 they do provide scientific evidence that psychotherapy alone is
10:48:53 20 helpful, did --

21 A That's correct.

22 Q Okay.

23 A That psychotherapy is helpful and not the medical
24 interventions.

10:49:01 25 Q I also understood Dr. Antommaria to say that he had not

1 read studies about detransitioning. But if it ever became
2 relevant, he would make an effort to review such studies.

3 You are familiar with the body of the literature
4 concerning gender dysphoria, correct?

10:49:21 5 A Yes.

6 Q In your opinion, are the studies of detransitioning
7 relevant to someone trying to assess the benefits and harms of
8 these treatments?

9 A Yes, of course. It's very difficult -- detransition would
10:49:35 10 be the situation that one is trying to avoid. The best way to
11 avoid a situation is to understand that situation.

12 Q Dr. Antommaria said that there are prospective
13 observational trials that demonstrate the efficacy of puberty
14 blockers in gender-affirming care, and then later said the
10:49:59 15 trials he is referring to were primarily the Dutch group
16 studies.

17 Are those the studies you just mentioned, the 2011, 2014
18 studies?

19 A Those are the Dutch studies that usually we use. I can't
10:50:12 20 know if he is referring to some other study that I didn't make
21 a specific reference to.

22 Q That's fair.

23 In this area of medicine, when someone's talking about the
24 Dutch studies, the Dutch group studies, is it your
10:50:25 25 understanding they're generally referring to these 2011 and

1 2014 studies from the Dutch project?

2 A Almost always, yes.

3 Q Okay. And those are the studies you just mentioned that
4 have the confound problem, right?

10:50:36 5 A Correct.

6 Q You can't unpack whether it's the psychotherapy or -- not
7 from that study, you can't unpack whether it is the
8 psychotherapy or the pharmaceuticals that are making the
9 difference?

10:50:47 10 A That's correct.

11 Q Okay. More generally, I'd like to read for you a
12 statement from the plaintiffs' brief in support of their
13 preliminary injunction motion.

14 For the record, it's Doc 8 at page 18.

10:51:07 15 Dr. Cantor, the plaintiffs wrote in that brief, For more
16 than four decades, medical organizations have studied and
17 created an evidence-based standard for the medical treatment of
18 transgender patients. This standard confirms that transition,
19 including puberty blockers and hormone therapy where
10:51:26 20 appropriate, is the only safe and effective treatment for
21 gender dysphoria?

22 Dr. Cantor, does the research literature support that
23 statement?

24 A No, it does not.

10:51:37 25 Q Do you understand the plaintiffs primarily to be pointing

1 to the guidelines of medical organizations such at WPATH and
2 the Endocrine Society and the American Academy of Pediatrics to
3 support their positions that wish to continue giving these
4 treatments to children?

10:51:52 5 A Yes. They cited those repeatedly.

6 Q Okay. What observations have you had about the WPATH
7 guidelines and whether they have support in evidence?

8 A The WPATH guidelines and the Endocrine Society guidelines
9 have been tested among the set of -- as I say, roughly 15
10 outcome studies, some of them have used the WPATH guidelines or
11 Endocrine Society guidelines instead of the Dutch protocol.
12 And those studies demonstrated that there was no improvement at
13 all.

14 I shouldn't say none at all. One of them used several
10:52:36 15 kinds of measures of improvement, and I think it was all but
16 one demonstrated no differences at all. And one small one gave
17 an indication that suggested the possibility.

18 Q Have these organizations acknowledged anything about
19 desistance rates -- these organizations, I'm referring
10:52:57 20 specifically to WPATH and the Endocrine Society?

21 A I can't say that they've never addressed it, but to the
22 extent if it was ever addressed, they are grossly, grossly
23 minimized.

24 Q Can I refer you to paragraph 12 of your report on page 4?

10:53:33 25 A I got it.

1 Q You say in that paragraph that the plaintiffs'
2 documentation -- and I assume by documentation, you mean
3 their -- the pleadings in this case and the briefs that you had
4 seen?

10:53:50 5 A That's correct.

6 Q You said the plaintiffs' documentation misrepresents the
7 contents of the associations' policies themselves.

8 Which associations were you speaking of there?

9 A They mentioned several other societies which made short
10:54:04 10 statements in general support of sexual diversity, but without
11 actually issuing specific standards about how to treat people
12 in that community with what or at what ages.

13 Q And what inconsistencies did you see between what those
14 organizations have said and the arguments you saw in
10:54:23 15 plaintiffs' briefing?

16 A The plaintiffs referred to the societies as if they were
17 providing very specific support for very specific policies
18 rather than general recommendations to provide, for example,
19 respect and values for diversity, but no specific guidelines.

10:54:48 20 Q Okay. Well, looking at paragraph 12, is one of your
21 points here looking at the bullet points that even WPATH and
22 Endocrine Society acknowledge as you write, that desistance of
23 gender dysphoria occurs in the majority of prepubescent
24 children?

10:55:04 25 A That is correct.

1 Q And then turning the page, were there other issues you saw
2 that the statements -- that these organizations believed and
3 plaintiffs' briefing was inconsistent with what the
4 organizations had stated?

10:55:16 5 A That the issue of mental health and that mental illnesses
6 and similar concerns need to be resolved before considering
7 transition rather than depending on transition to be the
8 resolution of, for example, depression and anxiety.

9 Q And have any of these organizations acknowledged that
10:55:42 10 puberty-blocking medication is an experimental not a routine
11 treatment?

12 A Yes, they have used that phrase.

13 Q Which organization?

14 A Again, I would have to look up to see exactly who used
10:55:52 15 which word. I believe it was WPATH, but I again have to go
16 back and check to make sure that it was they.

17 Q And let's turn to the American Academy of Pediatrics. And
18 I will refer you to your appendix.

19 And, Dr. Cantor, if you look at the top of the page, you
10:56:12 20 will see a line of blue figures. And it's page X out of 106.
21 The appendix I am referring to is page 100 out of 106.

22 A Got it.

23 Q What does the American Academy of Pediatrics or AAP, what
24 do they recommend in this area of care?

10:56:42 25 A They recommend what I can best describe as affirmation on

1 demand.

2 Q Okay. Did you review their recommendation when it came
3 out?

4 A Specifically I reviewed the sources on which they based
10:56:58 5 their recommendations.

6 Q Okay. Did you write about that?

7 A Yes, I did.

8 Q And does that appear as an appendix to your report
9 beginning at page 100 of that pdf?

10:57:09 10 A That is correct. I summarized all of my comments. I
11 submitted them to a journal where they underwent peer review.
12 And it's an official published peer-reviewed paper.

13 Q This is not a letter to the editor?

14 A That is correct. This is part of a scientific -- now part
10:57:22 15 of the scientific literature.

16 Q What did you comment upon?

17 A I really just checked what the authors of the AAP policy,
18 Dr. Rafferty, what their claims were, what they said was in
19 their references versus what was actually in their references.

10:57:43 20 And not only did their sources not contain what they were
21 alleged to have obtained, they often contained the very
22 opposite of what the AAP policy said they contained.

23 Q Did you have an agenda to disprove -- to prove or disprove
24 anybody when you undertook that review of the evidence?

10:58:01 25 A I wouldn't say an agenda other than to set the record --

1 pardon the pun -- straight.

2 This was a situation where these sources I had known for
3 many years. I had read them when they had first come out.

4 And when AAP came out with its policy, I was stunned by
10:58:21 5 its content. And as I read what they were basing it on, my
6 recollection was immediately this is not what those sources
7 said.

8 So immediately I just started double checking myself. Did
9 I misread something? Am I misremembering something?

10:58:36 10 And as I just checked in my own files with copies of these
11 papers -- most of these papers already in it, my memory was
12 correct. They said as -- the kinds of things I recalled them
13 to be saying.

14 Because we were now talking a major medical association
10:58:51 15 rather than an individual other scientist. This was different
16 from just one scientist like me disagreeing with another
17 scientist. This was now -- now had the potential to cause a
18 great deal of damage to a great number of people.

19 So because I had the ability to do it, I simply summarized
10:59:11 20 the contents of the original paper and contrasted point by
21 point the claims being made by AAP and simply quoting verbatim
22 what was in the original studies.

23 That entire thing was published, and the AAP has never
24 responded. They were approached by the media, and they just
10:59:33 25 would refuse to talk even to the media. They have yet to have

1 any response.

2 Q So to date, the AAP has not responded to the criticisms
3 that you raised?

4 A That is correct.

10:59:42 5 Q I will refer you now to page 6 of your report. Going by
6 the numbers at the bottom of the pages.

7 A Yep.

8 Q As you noted in your review of the plaintiffs' expert
9 report -- well, first off, did you review the expert reports
11:00:08 10 submitted by the plaintiffs by Dr. Hawkins and Dr. Ladinsky?

11 A Yes, I did.

12 Q And did you note that they studied a 2016 Olsen study
13 claiming that it proves that transition reduces the risk of
14 mental illness? That that was their claim?

11:00:23 15 A Correct.

16 Q Does the Olsen study show that?

17 A Just referring to my own report. Ultimately, no, it did
18 not. There was several statistical errors in the Olsen study.
19 The data were obtained then by the -- they -- upon request, and
11:00:45 20 Olsen provided their data to another author who reanalyzed -- I
21 should say, correctly analyzed the Olsen data, who demonstrated
22 that Olsen's data did not contain evidence of improvement. In
23 fact, it contained evidence of deterioration.

24 Q So in your opinion, does the 2016 Olsen study support
11:01:04 25 plaintiffs' position that children need these affirming --

1 these medicalized affirming treatments in order to improve
2 their mental health?

3 A No, it does not. Making such a claim is a half truth. It
4 would ignore the subsequent entries in the scientific
11:01:20 5 literature.

6 Q And what about the de Vries study that plaintiffs cited in
7 which you address on page 9 of your report? And does it show
8 that medical transition of minors improves mental health?

9 A No. It contains part of the confound. The de Vries study
11:01:43 10 as part of a Dutch group also included psychotherapy during
11 transition. So it is not possible to differentiate which type
12 of therapy, medical or psychotherapy, is responsible for the
13 benefits reported in that study.

14 Q I see. So participants in that study did have improved
11:02:00 15 mental health, correct?

16 A Yes.

17 Q But it's just not possible scientifically to tell what
18 caused the improvement?

19 A Correct.

11:02:06 20 Q And what about the Greene and Turbin studies plaintiffs'
21 experts cited which you discuss in paragraph 24 of your report?

22 A Yep.

23 Q Do those studies show that medical transition improves
24 mental health?

11:02:25 25 A No, they do not. These are retrospective correlational

1 studies. They are not able of describing any causal effect
2 coming to any causal conclusion.

3 Q Okay. Now, you mentioned there that -- you say this very
4 pattern is what one would predict from clinical gatekeeping.

11:02:43 5 What do you mean by clinical gatekeeping?

6 A One of -- across the various clinical standards are to
7 prevent somebody with mental illness from undergoing
8 transition. So such people are being held back. They're being
9 filtered out of groups who do undergo transition.

11:03:03 10 So when a clinic then compares the people who underwent
11 transition to the people in their files who did not undergo
12 transition, they are necessarily comparing a group of people
13 from whom the mental illness was removed and comparing them to
14 a group of people from whom the mental illnesses were not
11:03:22 15 removed.

16 So when you see better mental health amongst the people
17 who had transitioned, the improvement is not because of the
18 transition, the improvement is because you have removed the
19 people with the worst mental health from the group in the first
11:03:40 20 place.

21 Q Okay. So is it correct, then, that one thing you might
22 see in these studies is by picking out the people with the best
23 mental health, and giving them the treatment, then comparing
24 them to the people with lower mental health, then, of course,
11:03:57 25 the people who went through the study would do better?

1 A That is correct.

2 Q Did you review any of the other studies that plaintiffs
3 have submitted into evidence such as the Allen study, the
4 Turban articles, the Biggs (phonetic) study, the Lopez de Lara
11:04:24 5 study, Tordoff?

6 A Yes, I have.

7 Q Do you have any comments on those studies and whether they
8 support plaintiffs' position?

9 A They suffered from the same methodological problems as the
11:04:35 10 other studies.

11 Q Did any of those studies support the position that medical
12 transition improves mental health?

13 A No, they did not.

14 Q In minors with gender dysphoria?

11:04:47 15 A Correct. No, they do not.

16 Q Oh. What has been called the Yale study by Brouware,
17 B-R-O-U-W-A-R-E, was the first named author. Did you review
18 that one?

19 A Yes, I did, but it wasn't a study.

11:05:07 20 Q What was --

21 A Apparently, that was a report submitted by those authors
22 for another -- or for a combined set of court cases.

23 Q Okay. But you would not refer to that document as a
24 scientific study?

11:05:21 25 A From the Yale group with -- again, the name I don't -- I

1 hesitate to try to pronounce, but, no, it was not a study at
2 all. It was those authors' report reviewing the literature and
3 providing their opinions.

4 Q Okay. As a matter of fact, Dr. Ladinsky was asked about
11:05:39 5 that study yesterday. And for the record, that testimony
6 appears on page 116 of the rough transcript.

7 The question was: In this document, do the authors also
8 cite a number of peer-reviewed studies that contradict some of
9 the supports or the principles that the State articulated as
11:06:00 10 the reasons for SB 184? And Dr. Ladinsky responded, They do, a
11 considerable compendium of them.

12 Is she right? Did those authors show that there are
13 studies that contradict the State's position in this case?

14 A There was such a statement. There was no meaningful way
11:06:21 15 to try to put together what claim went together with what
16 source. Rather than -- what's done more typically either in
17 science or in pause, best as I understand, is here the claim
18 and here is the source justifying it. Here is next claim, here
19 the source justifying it.

11:06:38 20 Instead, that document made a long series of unsourced
21 claims and then provided a long series -- a series of very
22 large footnotes with 20 and 30 references. And there was just
23 no way to see what fact was alleged to have come from what
24 source.

11:06:56 25 Q So we've talked about whether the literature the

1 plaintiffs' -- the studies that plaintiffs cite to support
2 their position. Let's talk about whether the literature
3 supports the State's position. But a little background first.

4 Could you describe from your review of the literature just
11:07:17 5 what's the difference between adult onset gender dysphoria,
6 child onset, and adolescent onset? And I know this is a broad
7 question, but I just mean like age groups.

8 A Usually we would be referring to these as a prepubescent
9 onset. Then the literature is very, very long, but reported on
11:07:37 10 adult onset. And by adult, on average, these were people in
11 their 20s and in their 30s and 40s. It was very, very
12 distinct. It was not, you know, a bell-shaped curve with some
13 midpoint around 18 or 19 years old.

14 It's only within the past --

11:08:02 15 THE COURT: Hold on one second.

16 Go ahead. Sorry.

17 THE WITNESS: It's only within the past ten years or
18 so that a different profile has begun to emerge and was noticed
19 by clinicians. And that now is being called either adolescent
11:08:20 20 onset or rapid onset.

21 Now, all three of these groups have in common that they're
22 complaining about the same thing. Doc, I feel like I am in the
23 wrong body. Doc, I am the brain of one, but in the body of the
24 other.

11:08:34 25 So the way that they describe it is similar. But every

1 objective way we have of measuring these people shows that
2 these are independent phenomena. They are not related except
3 in the way that people describe the situation, describe what
4 they're experiencing.

11:08:50 5 The best analogy I have would be if somebody came to a
6 doctor saying I have a headache. Okay. I got it. Got that's
7 a symptom. I have some more questions. But we cannot from
8 that say that a migraine headache is the same thing as a
9 tension headache is the same thing as having just suffered a
11:09:08 10 head injury.

11 The causes are different. How we respond to them is
12 different. And the other characteristics about each of these
13 are different. They only resemble each other in the most
14 superficial ways.

11:09:19 15 Childhood onset or prepubescent onset gender dysphoria
16 appears to be entirely unrelated to adult onset gender
17 dysphoria. And the two of those appear to be entirely
18 unrelated to the rapid onset or adolescent onset gender
19 dysphoria.

11:09:40 20 BY MR. DAVIS:

21 Q Well, let's break that down. Adult onset, typically
22 people who present with what you're referring to adult onset
23 gender dysphoria, what age are they when they come into the
24 doctors' office and say, something's wrong?

11:09:50 25 A On average, in their 30s and 40s.

1 Q Okay. Has there been research considering whether
2 those -- that universe, the adult onset universe does well
3 after transitioning?

4 A Those who are mentally healthy by and large do, do well
11:10:08 5 after transition.

6 Q Can you apply those studies to consider whether someone
7 with child onset gender dysphoria is going to do well after
8 transitioning?

9 A No. Because these are independent phenomena. The
11:10:23 10 information from one does not -- from one group does not
11 generalize to the other.

12 Q Comparing the adult and the child onset, what is the
13 difference that makes the studies of one, you know, it's not
14 apples to apples?

11:10:35 15 A Correct.

16 Q Okay. What is the difference between those patients?

17 A The -- they -- as I say, differed in just about every
18 objective measure we've been able to apply to them.

19 There are, of course, the ages themselves. Something --
11:10:53 20 the sex ratios in them are different. The adults are almost
21 100 percent biological male. There's more of a mix amongst the
22 childhood onset.

23 The adults are almost always attracted to females. That
24 is to say, relative to being biological male, they are almost
11:11:13 25 always heterosexual.

1 The childhood onset almost always are attracted to the
2 same biological sex. They are almost always homosexual.

3 Q Talking about the child onset, is that a new phenomenon,
4 child onset gender dysphoria?

11:11:31 5 A I wouldn't say new. It's been systematically studied for
6 20 to 30 years'ish.

7 Q From the literature that you reviewed, do most of these
8 kids, if not socially transitioned and given hormones, will
9 they want to transition after reaching puberty?

11:11:52 10 A Generally not.

11 Q And page 36 -- excuse me -- paragraph 36 of your report,
12 Dr. Cantor, what statistics do you provide about the rates of
13 desistance among those presenting with childhood onset gender
14 dysphoria?

11:12:15 15 A The exact numbers are between 61 to 88 percent of them
16 desist. In the appendix in my report, I list all of the
17 studies that have ever been conducted with that group, all the
18 outcome studies that have been conducted with that group.

19 Q We probably both need to slow down just a little bit
11:12:37 20 for...

21 A I'm from New York. It just happens.

22 Q We'll do our best.

23 Dr. Hawkins was asked about your paragraph 36 yesterday.

24 And I will represent that on page 30 of the rough transcript,
11:12:54 25 she said that when the study such as the ones you're citing

1 offers this elevated rate of desisters, quote, what we tend to
2 find is that the initial cohort that was given the diagnosis of
3 gender dysphoria is actually false.

4 My question, Dr. Cantor, is: Does the research literature
11:13:15 5 support Dr. Hawkins's statement?

6 A No. As I say, I listed every single such study.

7 Q Do we have any tools today that reliably tell us which
8 kids will desist and which kids will persist?

9 A No, we do not. There have been some attempts to develop
11:13:34 10 such a test, but they have never been able to find a good
11 characteristic, a feature, a pattern, a test result in which
12 the majority continued to want to persist.

13 The best that they have ever been able to do was find a
14 tool which distinguished unlikely to want to persist versus
11:13:54 15 even less likely to want to persist.

16 Q There's been testimony about something called the DSM-5.
17 Do you know what that is?

18 A Yes, I do.

19 Q What is it?

11:14:04 20 A The full name is the Diagnostic and Statistical Manual of
21 Mental Illnesses, published by the American Psychiatric
22 Association.

23 Q If someone were to claim that now that we have the DSM-5
24 we may be able to do a lot better with identifying who's the
11:14:24 25 desister and who is the persister, is there any research on

1 that?

2 A No. Nobody's ever tried to differentiating any of the
3 DSMs from DSM-I through its various versions to the current
4 one.

11:14:38 5 Q So there have been at least five?

6 A There was a I, a II, a III, III-R, IV, IV then had a text
7 revision. They switched some of the commentary around the
8 diagnoses, but they didn't change any of the diagnostic
9 criteria themselves. There was then the 5. And there is as of
11:15:01 10 last month a 5 again with a text revision, but no changes to
11 any of the actual diagnostic criteria.

12 THE COURT: Mr. Davis, how much longer do you think we
13 will be?

14 MR. DAVIS: Your Honor, direct will take us up to
11:15:14 15 about noon, I would predict. There's just a lot to cover with
16 Dr. Cantor.

17 THE COURT: I am not rushing you. I am just trying to
18 get a road map of that.

19 So how long do we think cross might be?

11:15:25 20 MS. EAGAN: It's difficult to predict because I am not
21 sure what else he may say, but maybe an hour, hour or less, I
22 would think.

23 THE COURT: All right. I am leaning toward an earlier
24 lunch than we did yesterday. So maybe -- if it's okay with
11:15:45 25 you, let's just go ahead and find a stopping point at your

1 leisure, and we will just pick back up after lunch.

2 MR. DAVIS: Thank you, Your Honor. This is as good as
3 any.

4 THE COURT: Is it?

11:16:00 5 MR. DAVIS: Yes. We have just talked about DSM-5.
6 Going to watchful waiting next. This is as good a place as
7 any.

8 THE COURT: Okay. Good. Good. With that said, then
9 are we still on target with your last witness?

11:16:17 10 MR. DAVIS: Yes, Your Honor. Ms. Wright is here. I
11 don't know if she is in the courtroom yet or not, but she is in
12 Montgomery, and she will be ready to go when we finish with
13 Dr. Cantor.

14 THE COURT: We think the length of that witness would
11:16:30 15 be what?

16 MR. DAVIS: Oh, I would say direct would be well under
17 30 minutes, but I don't know about cross.

18 THE COURT: Okay. All right. Okay. Well, I think
19 we're on target.

11:16:38 20 Let's take a good long lunch today. Let's see here.
21 Let's come back at 12:45.

22 MR. DAVIS: Thank you, Judge.

23 THE COURT: Thank you.

24 MR. DOSS: Judge?

11:16:54 25 THE COURT: Yes?

1 MR. DOSS: Closing, how long would you like?

2 THE COURT: You know, I mean, this is important. I'm
3 not going to, you know, jack everybody up on this, but to the
4 extent you can hold it to around 25, I think would probably be
11:17:07 5 a good thing.

6 And in your openings, I think you really road mapped it
7 very well, both sides did.

8 So, you know, again, I know the arguments. I'm really
9 interested in, you know, some analysis with case law. And I am
11:17:22 10 going to be directly asking about a few cases. I'm very
11 interested to know parallels between the Arkansas decision and
12 that law. And then I may give you some hypotheticals that you
13 won't like.

14 See you after lunch.

11:17:40 15 (Recess.)

16 THE COURT: All yours, Mr. Davis.

17 MR. DAVIS: Thank you, Judge.

18 BY MR. DAVIS:

19 Q Welcome back, Dr. Cantor.

12:51:00 20 We spoke earlier about the Dutch protocol. Did the
21 participants in those Dutch studies have psychotherapy before
22 beginning treatment? Before that study?

23 A They were receiving treatment as part of their
24 participation in the study. I don't think they reported
12:51:21 25 whether anybody happened to have attempted psychotherapy before

1 approaching the clinic at all.

2 Q Okay. Forgive me if I'm mistaking which study is which.

3 I was reading about a study that described the psychotherapy

4 that was available to the participants as extensive. And that

12:51:40 5 that extensive psychotherapy was at least two years. Which

6 study am I thinking of?

7 A That wouldn't have been a particular study so much as what

8 they use in their process in general.

9 And then the Dutch group was reporting the results, you

12:51:56 10 know, of -- periodically over the course of the study.

11 Q I see.

12 A But by the time the first set of results, their earlier

13 study, the 2011 study, the participants in it will have already

14 been through a substantial amount of therapy.

12:52:13 15 Q Okay.

16 A They also emphasize that in assessing the children that

17 it's a very extensive assessment, and the assessment itself was

18 also ongoing over the course of the study.

19 So even before deciding who might be eligible for

12:52:30 20 hormones, they have now many, many months to years' experience

21 with the particular case even with a particular child even

22 before making a decision. That's very, very different from

23 just having an appointment, taking a test, and then having a

24 diagnostic decision an hour later.

12:52:46 25 Q That is exactly what I was meaning to ask you about. I

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1 was using sloppy language.

2 So this extensive assessment that happened before some of
3 these children began treatments, they were assessed, you said,
4 over a course of a couple of years?

12:52:59 5 A Correct.

6 Q Okay. So does literature support having such an extensive
7 assessment period before subjecting someone to these
8 treatments?

9 A I don't know if I would say support it, but all of the
12:53:16 10 conclusions that come from the literature depend on it.

11 Q Thank you.

12 Is there a way of treating gender dysphoria that some
13 practitioners refer to as a watchful waiting approach?

14 A Yes. Watchful waiting usually refers specifically to
12:53:40 15 withholding any decision about medical interventions until they
16 have a better idea or feel more confident for a particular case
17 about whether that kid is going to be a persister or desister.
18 It is given the knowledge that that's available that the
19 majority of these kids do desist. Nobody wants to make a
12:54:00 20 decision upon first appointment.

21 And so -- so they tend to provide psychotherapy, whatever
22 kind of care, whatever is appropriate to the individual kid
23 until enough time has gone by to give -- to suggest is this a
24 kid whose feelings like they're feelings are slowing down and
12:54:19 25 they just need more time, are they building up, or are they

1 staying steady?

2 So the watchful waiting period would be postponing any
3 decision about medical interventions until the clinicians had
4 some confidence.

12:54:31 5 Q While you are watching and while you are waiting, are you
6 just leaving him alone, or her?

7 A No. That would be the time during which one would be
8 supplying a therapy for whatever else is going on in the kid's
9 life.

12:54:42 10 Q Okay.

11 A Usually they're associated with -- there's a great deal of
12 what we call comorbidity. They're also suffering from other
13 problems at the same time, either depressions, anxieties, early
14 evidence of personality disorders, for example. And it's never
12:55:00 15 clear whether their gender dysphoria is a result of those other
16 psychological problems.

17 So by helping them develop the tools to deal with those
18 other problems, if they remain dysphoric afterwards, we know
19 that the dysphoria wasn't the result of those other problems.
12:55:17 20 So rather than just leaving them alone, they're still receiving
21 support, and the family is still receiving support over that
22 period.

23 Q So I believe you pointed out in your report that clinical
24 guidelines suggest that mental health issues such as the
12:55:33 25 comorbidities you mentioned should be resolved before

1 transition; is that correct?

2 A Yes.

3 Q Okay. Why?

4 A Because it's never clear what's causing what. We cannot
12:55:44 5 from a correlation conclude anything about a causation. It's
6 very possible, and it's been frequently observed that a lot of
7 these kids are using gender issues as an explanation for the
8 unhappiness that they're experiencing elsewhere in their life.

9 So rather than developing the skills to -- for example --
12:56:04 10 better social skills. If a person feels awkward and they're
11 withdrawing from kids their own age, we are not sure if they
12 want to transition because they're blaming gender dysphoria for
13 why they feel unpopular or uncomfortable, and we're not --
14 versus we can't tell if anxiety or depression is a result of
12:56:27 15 how they're being treated by the rest of society.

16 So it's only by helping them deal with and by giving them
17 the skills to overcome those other disorders that we can see if
18 the gender dysphoria itself resolves just as a result of that.

19 Q So if a person is suffering from depression, or is
12:56:48 20 struggling with their own sexual identity, or some type of
21 abuse, or any of these other comorbidities, explain how this
22 psychotherapy process would work, how a psychotherapist such as
23 yourself would try to dig down into the issue and see if that
24 is something that's generating these feelings that are being
12:57:08 25 mistaken as gender dysphoria, or whether the gender dysphoria

1 is its own thing.

2 A Just to be specific, I'm specifically an adult clinical
3 psychologist. I see clients ages 16 and up. So it wouldn't be
4 me personally.

12:57:23 5 What the literature shows about these kids is that they
6 can be very, very diverse. It certainly is feasible that they
7 are experiencing, for example, depression or anxiety as a
8 result of social transphobia, but that doesn't explain the
9 other things that we're observing.

12:57:41 10 For example, a transphobia doesn't cause autism, which is
11 another very, very common disorder in that group. Transphobia
12 wouldn't cause the development of borderline personality
13 disorder, which we're seeing in very, very, large proportions
14 among the teenagers.

12:57:58 15 So although certain symptoms like anxiety and depression
16 can feasibly be the result of social reactions to being trans,
17 but that does not explain the overall phenomenon. What does
18 better explain the overall phenomenon is that there is some
19 thing troubling this kid, and it is resulting in both the
12:58:20 20 psychological symptoms, depression, anxiety in someone, and
21 also producing the gender dysphoria, that discomfort with being
22 their natural sex.

23 Q I would expect this could vary wildly from patient to
24 patient, but if you -- and I recognize and thank you for
12:58:37 25 clarifying that you deal with a more adult-age group.

1 But if you're helping someone, an adolescent, work through
2 some of these issues, how often do you think a psychotherapist
3 would want to see the patient and over what period of time?

4 A It does vary widely. And the kind of disorders that
12:58:57 5 they're reporting do tend to be the kinds that require very
6 long-term interventions.

7 As I say, autism, and related Asperger's syndrome, and
8 also very, very high rates of borderline personality disorders,
9 which, again, is a very, very long-term disorder to help
12:59:14 10 somebody deal with.

11 Q Fair to say this would not be two or three sessions?

12 A Correct. This would be over the course of months or
13 years.

14 Q Does the research literature show that there are risks
12:59:30 15 associated with medical transitioning?

16 A Yes, quite substantial, including both loss of --
17 primarily loss of function, and depending on the person's point
18 of view, whatever the cosmetic effects are.

19 Q What are the risks of the watchful waiting approach in
12:59:48 20 providing psychotherapy in helping the child deal with any
21 underlying emotional issues?

22 A There don't appear to be any, at least any concrete.

23 Q I will refer you to paragraph 68 of your report,
24 Dr. Cantor.

13:00:06 25 Tell me what the advantages there are to a patient, what

1 opportunities it opens up to him or her if any emotional issues
2 are dealt with before the decision to transition.

3 A If a person fails to deal with whatever emotional issues
4 before it transition, and then transitions and discovers that
13:00:30 5 they continue with whatever psychological issues are pervading
6 them, they have gone through the entire transition process
7 entirely unnecessarily. They haven't been helped. They have
8 now lost whatever -- they have now been sterilized, lost
9 whatever sexual -- or other functions, but it hasn't actually
13:00:49 10 resulted in any improvement in their psychological function.

11 If you go the other way around and you help the person
12 deal with psychologically whatever it is that's going on, they
13 still retain the option for transition after that. And it's
14 that situation that the professional societies have
13:01:05 15 repeatedly -- that the standards of care have repeatedly
16 pointed out.

17 Q So watchful waiting approach does not eliminate a person's
18 ability to transition to the opposite sex later in life if they
19 so choose?

13:01:19 20 A Correct.

21 Q Does the research literature show there's any relationship
22 between children who present with gender dysphoria and those
23 who later in life turn out to identify as gay?

24 A Yes. The large majority of the ones who believe that they
13:01:42 25 were born the wrong sex turn out to be gay or lesbian.

1 To a prepubescent child who doesn't yet have a sex drive,
2 they have no way to interpret why they feel different from
3 other boys or other girls their age. It's only with the onset
4 of sex drive that they start -- and start developing crushes
13:01:58 5 and physical attractions that they now have the information
6 they need to realize why they're different. But to an eight
7 year old or to prepubescent children, the only explanation they
8 have for why they're not like other boys or not like other
9 girls is they must be the wrong sex. They're misinterpreting
13:02:18 10 their feelings.

11 THE COURT: Let's take a quick time out.

12 So, you know, I guess I'm wondering how both sides are
13 wanting me to use all this expert testimony. I mean, the
14 Eleventh Circuit has said more than one time that, you know,
13:02:31 15 medical psychiatric professionals are in a far better position
16 to make decisions about medical and psychiatric issues than
17 judges are.

18 So I guess I want to know from each side real quickly, how
19 do y'all envision that I use these experts? I mean, are you
13:02:48 20 asking me to say, well, this guy's science is junk and this
21 guy's science is perfect; or something in between? What am
22 I -- tell me how you envision me using this.

23 MR. LACOUR: May I?

24 THE COURT: Perfect. Absolutely.

13:03:05 25 MR. LACOUR: Your Honor, as we began the opening

1 statements, when there's an area of medical uncertainty, the
2 State has wide discretion to regulate. So if it's not so clear
3 to you as to which side's experts have it right, if you see
4 that uncertainty, then under Supreme Court precedent, the State
13:03:29 5 is allowed to regulate.

6 The State has to think about all 5 million Alabamians. We
7 have to take all that into account when regulating in these
8 areas where it is not certain.

9 The judge has an important but a limited role in our
13:03:45 10 federal system to see whether those judgments the State has
11 reached in those areas of uncertainty somehow conflict with the
12 Constitution.

13 And we submit we have come forward with evidence to at
14 least put into question whether there is this consensus that
13:04:03 15 has been proclaimed by the plaintiffs here.

16 Again, I think the bar on the plaintiffs is quite high, to
17 show an absence of uncertainty, or to show some great
18 certainty.

19 And when you look at the international studies and the
13:04:19 20 literature reviews, when you hear from very qualified experts
21 like Dr. Cantor, who have applied great rigor to these studies
22 that are being relied upon by the plaintiffs, by their experts,
23 by the AAP, for example, then I think that is enough to create
24 that doubt to create that space for uncertainty. And when that
13:04:45 25 is there, the State can step in.

1 So that's how we see it. We don't think that you sit here
2 as an independent medical board to assess whether a particular
3 treatment is going to be the best for any particular
4 individual. The role of the federal courts in our federal
13:05:01 5 system, the laboratories of democracy is to see if we have done
6 something that is somewhat inexplicable.

7 I think there is ample evidence to explain why the State
8 has done what it's done in addition to the lengthy legislative
9 findings in SB 184.

13:05:22 10 We have come forward with multiple experts from fields of
11 endocrinology, psychology, and pediatrics, and have brought
12 forward substantial amount of other peer-reviewed research and
13 literature reviews to show that this very novel area of the
14 law -- keep in mind the UAB clinic didn't open until
13:05:44 15 seven years ago. This is a novel area of medicine, rather --
16 is just, in the State's judgment, too risky. And if that's a
17 reasonable judgment for the State to make, then that's the end
18 of the case.

19 THE COURT: All right. Mr. Doss.

13:06:03 20 MR. DOSS: Your Honor, I'm unaware of a case that
21 establishes that principle that's so long as there's
22 uncertainty and a reasonable judgment, then that alone is
23 sufficient for the State to violate constitutional protections.

24 The standard of review is what I think helps frame some of
13:06:23 25 this testimony. So, for example, if strict scrutiny applies,

1 it is the State's burden to establish a compelling state
2 interest. And that its infringement on the constitutional
3 protection has been narrowly tailored.

4 And I guess to preview Your Honor for closing, that is a
13:06:40 5 key focus that I plan to spend some time with in closing on why
6 this testimony we've heard yesterday and today, number one,
7 does not establish a compelling State interest. But number
8 two, even if you assume that it does establish some interest by
9 the State, the interest that the State has identified and the
13:06:58 10 regulation that it has imposed are mismatched. It's not
11 narrowly tailored for the very reasons offered by the State
12 through its witnesses.

13 And based on the standard of review, it is not a reasoned
14 judgment. That's not the test for when a constitutional
13:07:13 15 violation has occurred. The test is whether there is
16 satisfaction of this demanding standard for the law's
17 viability.

18 And so as I mentioned in opening, I don't think that Your
19 Honor's job for the purpose of this hearing is deciding
13:07:31 20 ultimately maybe even who is right. It's to show that there is
21 scientific -- there are standards of care that exist, there are
22 approved approaches to dealing with these issues. These are
23 real medical diagnoses. These are real medical treatments.

24 And though the State may disagree them, that's not enough
13:07:50 25 to establish the violation of the constitutional rights, Your

1 Honor.

2 THE COURT: And on that note, at least from what I can
3 tell from both sides, State and government, and original
4 plaintiffs, am I correct to say that everybody agrees that
13:08:07 5 these are real diagnoses? Or no?

6 MR. LACOUR: Your Honor, could you --

7 THE COURT: And I am going to say this one more time.
8 I don't need head nods. It is out of hand. This is not
9 entertainment. This is the real world and the law. So we're
13:08:25 10 not in a movie theater. I don't need head nods. I don't need
11 approval or disapproval. If you want to do that, take it
12 outside.

13 Go ahead.

14 MR. LACOUR: Your Honor, I think -- Your Honor, we
13:08:46 15 agree that gender dysphoria is a psychological diagnosis, but
16 as we have shown in both our written evidence and through
17 witness testimony from both defense witnesses and plaintiffs'
18 witnesses, we don't know whose gender dysphoria is likely to
19 persist. And that's very important.

13:09:07 20 Even Dr. Antommara this morning said that if you -- the
21 level of certainty you have --

22 THE COURT: You are giving me more detail than I want.
23 I just need you to answer my question.

24 MR. LACOUR: Okay. Can I respond to something
13:09:21 25 Mr. Doss said before?

1 THE COURT: Very quickly.

2 MR. LACOUR: He is unaware of the standard. We cited
3 it multiple times in our P.I. response. It's Gonzales vs.
4 Carhart, a 2007 decision from the Supreme Court where the
13:09:32 5 federal government had regulated partial birth abortion. That
6 was an area of medical uncertainty.

7 There were -- I will go back and I will look at the
8 filings in that case, but I would be shocked if the AMA did not
9 chime in, in favor of the plaintiffs who were challenging the
13:09:46 10 ban on partial birth abortion there saying that it was a safe
11 or necessary -- medically necessary treatment for some people.

12 It was enough that Congress found medical uncertainty
13 there. And there were values, as well, in unborn life that
14 Congress was able to promote even though there were medical
13:10:04 15 organizations.

16 I will confirm this before closing, but I am fairly
17 certain there were medical organizations who were not fans of
18 Congress's action there.

19 Even so, and even in an area like abortion where there is
13:10:16 20 more law at least for the last 49 years in that space,
21 addressing some right to abortion, even then, that ban was
22 upheld by the Supreme Court.

23 THE COURT: And I'm sure you can get into that on
24 closing.

13:10:31 25 Let's go back to my original question. Just answer it

1 succinctly for me.

2 MR. LACOUR: And that would be are these real
3 diagnoses?

4 THE COURT: Yes. Just answer my question in two
13:10:41 5 sentences.

6 MR. LACOUR: Gender dysphoria is a diagnosis. I think
7 the debate is how should it be treated. And SB 184 is
8 expressed in Section 6.

9 There's no ban on psychotherapy whatsoever. The ban only
13:10:58 10 applies to these novel risky potentially long-term
11 harm-inducing or causing medications.

12 THE COURT: So no argument from the State on status,
13 diagnosis, any of that? You are only -- your only issue is
14 treatment; is that correct?

13:11:17 15 MR. LACOUR: Correct, Your Honor.

16 THE COURT: Got it. Thank you.

17 Anything else, Mr. Doss? And I will give the government a
18 shot --

19 MR. DOSS: No, Your Honor.

13:11:25 20 THE COURT: -- if they want to be heard.

21 MR. CHEEK: Nothing else to add that hasn't already
22 been said, Your Honor. Thank you.

23 THE COURT: Okay. All right.

24 Mr. Davis, I have gotten right in the middle of your
13:11:34 25 witness again. Sorry. Pick it back up.

1 MR. DAVIS: I certainly understand, Judge.

2 BY MR. DAVIS:

3 Q Okay. Dr. Cantor, we to try to pick up where we were.

4 Let's take two young boys, eight years old, say. So
13:11:52 5 puberty hasn't started yet. They both have gender dysphoria,
6 even though they may not really understand it yet.

7 And I know I'm asking you to assume some things that an
8 outside observer may not be able to confirm just by looking at
9 that child.

13:12:06 10 And let's assume that both those young boys would, if not
11 intervened with transitioning care, would both grow up to
12 identify as gay.

13 So the boy who is left alone to go through natural
14 puberty, what does he come to understand once puberty kicks in?

13:12:24 15 A Once he -- as puberty kicks in, of course, sex drive comes
16 in as a part of that, and he starts experiencing sexual
17 attractions and sexual arousal.

18 That, then, because he is experiencing it towards other
19 men, teachers, peers, whoever it is, he can now -- he now has
13:12:41 20 the opportunity to understand the nature of his experiences and
21 why he doesn't feel quite like other boys, why he doesn't feel
22 as masculine, and why he doesn't feel as masculine.

23 Now, in otherwise healthy circumstances, he will grow up
24 to be a healthy gay man.

13:12:57 25 Q Now, the other boy is given puberty blockers. What

1 happens in his case?

2 A Such a person who does not develop sexual -- the capacity
3 for sexual arousal and sexual attractions because the very
4 biological features which produce that have been held from him,
13:13:14 5 he never experiences an orgasm. He never experiences sexual
6 arousal, and doesn't have the opportunity to understand the
7 other potential explanations for why he feels the way he does,
8 and go from a child's understanding of why he doesn't feel like
9 other boys, to an adult's understanding of why he doesn't feel
13:13:36 10 like other boys.

11 By blocking puberty, you are blocking the very information
12 that he needs to understand his own situation.

13 Q And you are not claiming to describe every person who is
14 experiencing gender dysphoria, I take it?

13:13:49 15 A Correct.

16 Q Does the evidence show that sexual orientation changes
17 after a person identifies as gay or lesbian?

18 A No. There is no evidence to suggest that sexual
19 orientation is unstable or changes.

13:14:05 20 Q What does the evidence show about whether a person's
21 gender identity can change?

22 A That shows the very opposite. Among the children, it
23 changes in the majority of them.

24 They're even people who identify and describe themselves,
13:14:19 25 for example, as being fluid, the very definition of which is

1 that their gender identity changes on a constant basis.

2 Q Are you familiar with the argument that if we do not allow
3 minors to transition medically, the result will be increased
4 suicides within these group of young people?

13:14:38 5 A I've heard that said, yes.

6 Q Does the research literature support the argument that
7 denying these treatments will lead to an increase in
8 suicidality?

9 A No, it does not.

13:14:50 10 Q Are you familiar with what other countries are doing, with
11 respect to treatment of gender dysphoria?

12 A Yes, I am.

13 Q Are there any changes going on in recent years?

14 A Very much. In fact, things -- it's almost as if the
13:15:10 15 pendulum has reached its far point, and it's now coming back to
16 a much more moderate evidence-based tone.

17 There was really -- sparking off of the social media age
18 more than anything else, we're able to identify a greatly,
19 greatly accelerated, great and greatly expanded number and type
13:15:31 20 of person who was potentially going to go through transition
21 entirely, unlike the groups which we had previously studied.

22 Several countries, especially in Europe, permitted them
23 with lower and lower standards. And then once the reports
24 started coming out that that was failing greatly, they're now
13:15:53 25 restricting very, very quickly and very, very greatly.

1 The two most substantial bans have been in Sweden and in
2 Finland. And there are also now very, very strong statements
3 urging the medical field to pull things back in the UK and in
4 France.

13:16:08 5 Q Dr. Ladinsky testified yesterday that -- I don't have her
6 exact words in front of me -- but she said that what's going on
7 in the UK and Sweden and Finland isn't as relevant here because
8 those countries have a centralized health-care system, whereas
9 we have a less centralized health-care system, and all these
13:16:35 10 experts unrelated can see the same child.

11 That's a poor paraphrase. The record will speak for
12 itself. But assume she made that type of testimony. Would you
13 agree with her?

14 A No. I can't see the logic of it. It's certainly
13:16:53 15 feasible, in fact, more than likely that decisions are made
16 differently when there are centralized boards and a centralized
17 authority charged specifically with reviewing the evidence that
18 will be the basis of the medical procedures of that country,
19 and the U.S. lacks that.

13:17:11 20 But there's no reason to think that that situation would
21 change the actual outcomes of the actual children getting the
22 actual interventions.

23 Q So is it possible, then, that a more centralized
24 health-care system may provide the ability -- an even greater
13:17:24 25 ability to study and evaluate the risks and benefits of

1 gender-affirming care?

2 A That's demonstrably true. That is exactly the process
3 they have gone through. They have published the results of
4 exactly their reviews, and that is how their health-care
13:17:40 5 systems -- that is what their health-care systems are
6 responding to.

7 The American professional associations have not gone
8 through such a comprehensive process. They're merely coming up
9 with policies and citing only individual pieces of studies that
13:17:54 10 appear to support it, rather than a comprehensive review.

11 Q I want to close a loop on adolescent onset gender
12 dysphoria. We talked about ways different groups are
13 different.

14 What's unique about this group of adolescent onset, or you
13:18:11 15 referred to it also as rapid onset gender dysphoria?

16 A Yeah. It's been called both.

17 Where both the childhood onset and the adult onset are
18 primarily male, the adolescent -- the adult onset and childhood
19 onset are primarily male. The adolescent onset is primarily is
13:18:28 20 female. They present with a different set -- it's a different
21 epidemiological set of characteristics, and the evidence that
22 we have about both adults and children don't seem to apply to
23 that middle group.

24 Q Does this group of people presenting with gender dysphoria
13:18:45 25 in their adolescence -- you said primarily female?

1 A Yes.

2 Q Do they tend to have any issues or comorbidities in common
3 with each other?

4 A The most common one of those would be borderline
13:18:57 5 personality disorders and other difficulties with integrating
6 socially into their environments. As I say, such as autism and
7 Asperger's syndrome.

8 Q You are not saying that's true for everyone presenting
9 with gender dysphoria for the first time in their adolescence?

13:19:13 10 A Correct.

11 Q But many?

12 A Correct.

13 Q What does the research literature show about the
14 desistance or detransition rates of people who transition after
13:19:25 15 first presenting with gender dysphoria in their adolescence?

16 A There has never been any such study.

17 Q Did you review the plaintiffs' reply brief, Dr. Cantor?

18 A Yes, I did.

19 Q Did you see any response to your report in plaintiffs'
13:19:41 20 reply?

21 A Not a single comment. My name was never mentioned. None
22 of the studies that I cited were referred to. None of the
23 arguments were addressed. I don't believe I was quoted
24 anywhere in it, unlike the other experts.

13:19:56 25 Q I did note a line that the plaintiffs criticized the

1 defendants' experts in general for relying on older studies.

2 A Yes. I saw that claim. I was a bit confused by it.

3 In my report, I provided a comprehensive list of every
4 single study. There were 11 in total. So the old studies were
13:20:18 5 listed, the new studies were listed. It was comprehensive.

6 It was also a tangential argument. As I said, the 11
7 studies which have been conducted were unanimous in their
8 findings. They all found the same thing. The majority
9 desists.

13:20:33 10 So it doesn't matter even if one did rely only on the
11 older studies, the newer studies showed exactly the same thing
12 as the older studies.

13 Q We spoke a little bit about some of the things we heard
14 from Dr. Antommara this morning. I want to turn to some of
13:20:55 15 the things in his report.

16 You reviewed his written expert report, did you not?

17 A Yes, I did.

18 Q He -- Dr. Antommara wrote on -- in paragraph 17 of his
19 report -- and I will find a copy if you need it, but this is
13:21:07 20 one sentence.

21 Quote, gender-affirming medical care is supported by
22 clinical studies. Is he right?

23 A That's true for adults, but that's not true for the other
24 groups.

13:21:21 25 Q And Dr. Antommara spoke about how if a drug is FDA

1 approved in one area, it's okay to use it off label in another
2 area?

3 A That's what he said, yes.

4 Q What does the research literature say, or what opinion do
13:21:44 5 you have about using the same drug, a puberty-blocker in the
6 case of a person who's six, seven, eight, the purpose is to --
7 precocious puberty, what about the cases of precocious puberty
8 and using puberty-blockers to help someone medically transition
9 at the beginning of normal puberty?

13:22:03 10 A Well, the ability to use a medication off label is not a
11 blanket permission to give any drug you want for any reasons
12 you want or for any conditions you want.

13 Ultimately, it's going to depend on what the scientific
14 literature itself says, which in turn is what the various
13:22:22 15 regulatory bodies use to make their decisions to decide what's
16 off label or on label to begin with.

17 So because a medication would be useful for some people in
18 some situations and some circumstances, does not mean it's
19 automatically going to be useful for other people in other
13:22:37 20 circumstances. Indeed it could be deleterious.

21 If you use a puberty-blocker in somebody with precocious
22 puberty, you are pushing somebody who is far below the average
23 age of puberty, and you are bringing them closer to the
24 species-typical range of puberty.

13:22:55 25 If you give that same drug to somebody who is already

1 having a typical age of puberty, you are now pushing them
2 outside of the species-typical age.

3 Q Thank you, Dr. Cantor.

4 I am going to sum up. Does the research literature
13:23:21 5 support plaintiffs' claims that we need to treat children and
6 adolescents with gender dysphoria with social transition
7 puberty-blockers and cross-sex hormones?

8 A I'm sorry. Could you say that -- I missed the first half
9 of that sentence.

13:23:33 10 Q My apologies.

11 Does the research literature support plaintiffs' claims
12 that we need to treat children and adolescents with gender
13 dysphoria with social transition, puberty-blockers, and
14 cross-sex hormones?

13:23:46 15 A No. That's terrible overstatement.

16 Q Does the research literature support Alabama's description
17 of these treatments as experimental?

18 A Yes. They're fairly called experimental.

19 Q When does a drug or a course of treatment stop being
13:24:02 20 experimental?

21 A That's an excellent question. There is no real test for
22 it. There is no objective way to decide something is one
23 versus the other.

24 Science is never finished. It's always possible for there
13:24:14 25 always to be some future piece of information that changes what

1 we know.

2 There are, of course, you know, different situations --
3 drugs, issues under active investigation, where it's very clear
4 that it's still experimental, and others where, you know, there
13:24:32 5 is only very little question left.

6 For this particular situation, we have a very small number
7 of studies that in certain situations might look like they
8 might be helping, but a much larger body of better performed
9 studies showing that the improvement is not actually coming
13:24:47 10 from the transition itself.

11 Indeed, there were other areas of the report that were
12 referred to already ongoing studies testing exactly these
13 interventions. Well, that there exists ongoing tests of these
14 interventions is pretty much the definition of calling
13:25:05 15 something experimental.

16 Q If scientists are eventually able to replicate the same
17 results under the same conditions over and over again, can you
18 then pretty much say something is established?

19 A Yes.

13:25:17 20 Q Has anybody been able to replicate the results of, say,
21 the Dutch study that showed at least some positive results with
22 a combination of treatments?

23 A No. Most of the studies have demonstrated no improvement
24 in these children from medical transition.

13:25:32 25 Q Do you understand plaintiffs to argue that Alabama is out

1 of step with groups like the American Academy of Pediatrics?

2 A Yes, I've heard them say that.

3 Q What's your response?

4 A Well, it's actually the American Academy of Pediatrics
13:25:54 5 which is out of step with the international standards.

6 Q Is there a consensus, a medical consensus internationally
7 in support of these treatments?

8 A There is now a very quickly developing one. It is still
9 ongoing debate, so I would hesitate to describe it -- describe
13:26:12 10 that there is a solid consensus.

11 As I say, really what we have seen is a pendulum swing
12 which is overswung and now is substantially and very quickly
13 correcting itself.

14 Q Is the pendulum swinging in favor of medical transition
13:26:27 15 use of puberty-blockers and cross-sex hormones for children and
16 adolescents?

17 A No. It's swinging now against that.

18 Q Is there a medical consensus in the United States for the
19 best way to treat gender dysphoria?

13:26:39 20 A No, there is not.

21 MR. DAVIS: Thank you, Dr. Cantor.

22 THE COURT: So I do have a question myself.

23 Dr. Cantor, you said that an adult should be affirmed in
24 their transgender status.

13:26:58 25 THE WITNESS: An otherwise mentally healthy adult,

1 yes.

2 THE COURT: All right. So make it clear to me, then,
3 when should an adolescent or a child be affirmed in that
4 status?

13:27:10 5 THE WITNESS: That, to me, is an empirical question.

6 We are not sure actually when the best time do that is.
7 Every time we check, we keep finding that, no, that's not
8 exactly the right way. No, that's not exactly quite working.

9 And when we do think we have run into a clue that gives us
13:27:26 10 an idea of when, we are not able to recreate that situation.

11 THE COURT: Is that case by case, then?

12 THE WITNESS: I would hesitate to say case by case
13 exactly because --

14 THE COURT: Let me rephrase it. Under what
13:27:44 15 circumstances would you affirm a child or an adolescent?

16 THE WITNESS: I can't say that there's a situation --
17 all of the situations will be gray. I can't think of any
18 evidence that would give us the kind of certainty in any case
19 that would outweigh the potential risks.

13:28:19 20 THE COURT: So you would never affirm a child or an
21 adolescent?

22 THE WITNESS: Not with the current evidence available,
23 no.

24 THE COURT: Okay. All right. Cross?

13:28:28 25 CROSS-EXAMINATION

1 BY MS. EAGAN:

2 Q Good afternoon, Dr. Cantor.

3 A Good afternoon.

4 Q Dr. Cantor, you are an adult clinical psychologist,
13:29:15 5 correct?

6 A Yes.

7 Q You are not a medical doctor?

8 A Correct.

9 Q Your private practice -- in your private practice in

13:29:22 10 Toronto, the average age of your patients is 30 to 35 years
11 old?

12 A Average, that would be about right, yes.

13 Q You've not ever provided clinical care to transgender
14 prepubertal children?

13:29:39 15 A Correct.

16 Q You have not provided care to a transgender adolescent
17 under the age of 16?

18 A Correct.

19 Q The extent of your experience, Dr. Cantor, working with

13:29:52 20 transgender adolescents consists of counseling six to eight
21 transgender patients between the ages of 16 and 18; isn't that
22 correct?

23 A Yes.

24 Q So your clinical experience with gender dysphoria really
13:30:09 25 lies in the counseling of adult patients?

1 A Correct.

2 Q And you acknowledge that gender dysphoria in children does
3 not represent the same phenomenon as adult gender dysphoria,
4 correct?

13:30:24 5 A Correct.

6 Q And, in fact, to use your words, they differ in every
7 known regard, from sexual interest patterns to responses to
8 treatments?

9 A Correct.

13:30:36 10 Q Dr. Cantor, you have never diagnosed a child or an
11 adolescent with gender dysphoria?

12 A Correct.

13 Q Never treated a child or an adolescent for gender
14 dysphoria?

13:30:48 15 A Correct.

16 Q You have no experience personally with monitoring patients
17 who are undergoing puberty-blocking treatment?

18 A Correct.

19 Q You don't know what type of monitoring is typically done
13:31:04 20 or not done on those types of patients; isn't that fair?

21 A No.

22 Q No, that's not fair?

23 A Well, you -- I personally didn't do it, but I am aware of
24 the procedures that are done.

13:31:15 25 Q Okay. But you have no experience with that?

1 A That's correct.

2 Q Similarly, you have never monitored -- or you have not
3 monitored an adolescent or teenage patient on hormone therapy?

4 A Correct. Until -- well, I wouldn't be monitoring the
13:31:34 5 status in any case, so, yes, that's correct.

6 Q I am going to switch to UAB Children's, the gender clinic
7 here in Alabama.

8 Have you ever spoken to a child or adolescent who was
9 treated at the gender clinic here in Alabama?

13:32:00 10 A No.

11 Q Have you ever spoken to any former patients of the clinic?

12 A No.

13 Q You weren't here yesterday to hear Dr. Ladinsky talk about
14 the treatment protocols they have at children's UAB, were you?

13:32:12 15 A Correct.

16 Q You weren't here to listen to the results of treatments
17 provided to adolescent patients at UAB's Children's in the
18 gender clinic; fair?

19 A Yes. They have never published them.

13:32:27 20 Q And you weren't here to hear them?

21 A Correct.

22 Q Dr. Cantor, you have no personal knowledge of the
23 assessment or the treatment methodologies that are used here in
24 Alabama at UAB Children's Hospital, correct?

13:32:42 25 A Correct. Correct.

1 Q You do not know the disciplines of the medical providers
2 who are part of the treatment team involved in that assessment
3 at UAB Hospital?

4 A Correct.

13:32:56 5 Q Now, I heard your opinion that it's important to assess
6 the mental health issues of an adolescent patient to see
7 whether that is a potentially contributing factor to gender
8 dysphoria and whether there's a need to address. That's a fair
9 statement of your opinion?

13:33:17 10 A I'm sorry. Would you repeat that, please?

11 Q Sure. It's your belief that mental health issues need to
12 be assessed and addressed before a transition occurs?

13 A Correct.

14 Q Do you know what assessment protocols at UAB Children's
13:33:31 15 are to address mental health issues before a child is put on
16 any transitioning medication?

17 A No, I do not.

18 Q Do you have any idea or do you know what the doctors at
19 UAB Children's discuss with their adolescent patients about the
13:33:48 20 risks and the benefits of medical treatments at UAB?

21 A No.

22 Q Wouldn't you agree -- well, never mind. I am going to
23 move on.

24 Dr. Cantor, I want to talk with you a minute about -- or a
13:34:18 25 little bit about your criticisms of the various studies

1 regarding the efficacy of puberty blockers and hormone
2 treatments, okay?

3 A Yep.

4 Q As I understand your report and your testimony today, one
13:34:36 5 of the criticisms you have of some of those studies is that it
6 relies on participant's self-assessment I believe is the
7 language that you used.

8 Essentially, it is based upon what socially transitioned
9 youth and their family is reporting about their mental health
13:34:53 10 in these studies?

11 A I would say that's incomplete. My criticisms would be
12 relying on such subjective accounts entirely for all the
13 decision making rather than using it as one part of the
14 decision making.

13:35:08 15 Q In other words, basing your study based upon what the
16 participants in the study tell you how they're feeling at
17 different points in the study?

18 A Being limited to that is a problem, yes.

19 Q And I believe the way that you phrased it, you said,
13:35:22 20 subjective self-reports about how one is doing may not be
21 reflecting reality objectively.

22 A Correct.

23 Q But, Dr. Cantor, self-reports about how one is doing may
24 reflect reality, fair?

13:35:38 25 A That's correct.

1 Q So when somebody says, I am doing well, my mental state is
2 better, that very well may be the case?

3 A May be the case, yes.

4 Q Another complaint that you have, I believe, is what you
13:35:58 5 call confounded data. And I believe you referred to the de
6 Vries study for that?

7 A The two de Vries's studies, yes. As a matter of fact,
8 it's all but two of all papers in that set of literature.

9 Q And by confounded data, the way that I am understanding
13:36:13 10 it, what you're saying is that you are not able to tell because
11 the data is, quote, confounded, whether one's improved mental
12 health for a minor who has socially transitioned, whether that
13 came from the actual medical services, whether it came from the
14 psychotherapy, or whether it came from the combination of both?

13:36:34 15 A Correct.

16 Q But one thing, Doctor, that you do have to admit is when
17 adolescents with gender dysphoria have transitioned through a
18 combination of medical services and psychotherapy, you have to
19 admit that based upon the studies, their mental health
13:36:55 20 improved, correct?

21 A No. There were several studies that showed no improvement
22 even though -- even though they were receiving both. I've
23 listed them in my report.

24 Q Can you direct me to where in your report those are,
13:37:11 25 please, sir?

1 A Sure.

2 THE COURT: While he is looking, did you say your
3 target is an hour; is that right?

4 MS. EAGAN: Yes, sir. I believe I should be able to
13:37:33 5 be done in an hour.

6 THE WITNESS: Page 20, footnote 40.

7 BY MS. EAGAN:

8 Q I'm sorry, sir?

9 A Page 20, footnote 40. The Carmichael study, the
13:37:48 10 Hisle-Gorman, et al, study, and Kaltiala.

11 My full sentence was, New studies continue to appear at an
12 accelerating rate, repeatedly reporting deteriorations or lacks
13 of improvement in mental health, footnote 40 -- or again, those
14 were the specific studies -- and then or lack of improvement
13:38:23 15 beyond psychotherapy alone, footnote 41.

16 Q Certainly, Dr. Cantor, though, there are many study -- or
17 there are studies that indicate when adolescents with the
18 combination of medical service and psychotherapy transition,
19 their mental health has improved. You agree with that
13:38:40 20 statement?

21 A I would have to check to see if the number is zero or a
22 handful. There have been reports of there having been such
23 improvement, such as the Branstom study, which once it was
24 reanalyzed, discovered to have problems, and the finding was
13:39:00 25 withdrawn.

1 So there -- again, I would have to go through and check to
2 be sure that it's not zero. It would be fair to say that there
3 might have been a study which found such a thing. But the
4 majority of studies are finding either no improvements or
13:39:17 5 deteriorations, or it's a situation that we call a failure to
6 replicate.

7 Q Sir, I am a little bit confused, because I want to go to
8 two of your studies that you have actually talked about today,
9 the Costa study and the Achille study.

13:39:33 10 Now, as I understand your testimony today, in those
11 studies, there was -- the studies reported that there was an
12 improvement in mental state for adolescents who were treated
13 with medication and psychological treatment in transition that
14 there was an improvement, but in those, you said you can't tell
13:39:58 15 whether it's from the medication or from the psychological
16 treatment?

17 A No. The Costa study and the Achille study associated the
18 improvement specifically with the psychotherapy and ruled out
19 that the effects were due to the medical interventions.

13:40:13 20 Q Okay. Well, let's pull those studies, Doctor, and let's
21 look at those.

22 If you could, there should be a notebook up there that has
23 plaintiffs' exhibits in it. Is that one plaintiff, sir?

24 If you could please, sir, turn to Plaintiffs' Exhibit 34.

13:40:55 25 A Yes.

1 Q All right. Plaintiffs' Exhibit 34, is this the -- do you
2 say Costa or Costa?

3 A I'm sorry?

4 Q Do you say Costa?

13:41:05 5 A My guess is Costa. I have never met the person.

6 Q All right. Exhibit 34 that you have in front of you, is
7 that the Costa study?

8 A Yes, it is.

9 Q All right. So, Doctor, I first want to focus in on --
13:41:18 10 well, let me ask this: This study was aimed at assessing
11 gender dysphoric adolescents' global functioning after
12 psychological support and after puberty suppression, correct?

13 A Yes.

14 Q Bear with me. I am going to take this out so I can put it
13:41:42 15 up on the Elmo, sir.

16 All right, sir. I am going to direct your attention to
17 results that I have highlighted on my copy. Okay? According
18 to the abstract here, the results?

19 A Yes.

13:42:18 20 Q At baseline, gender dysphoric adolescents showed poor
21 functioning with -- it defines the mean scores. So baseline
22 means at the start of the study, correct?

23 A Usually it does. I would have to check that that's
24 exactly how they used the term.

13:42:35 25 Q All right. We will get to the details of that in a

1 minute.

2 Okay. Gender dysphoric adolescents' global functioning
3 improved significantly after six months after psychological
4 support. And then it goes on to say, Moreover, gender
13:42:49 5 dysphoric adolescents receiving also puberty suppression had
6 significantly better psychosocial functioning after 12 months
7 of puberty suppression compared to when they had received only
8 psychological support.

9 Did I read that right, sir?

13:43:07 10 A Yes.

11 Q Do you remember the methodology that was used for this
12 study, sir?

13 A Roughly.

14 Q Pardon?

13:43:14 15 A Yes. Roughly.

16 Q Sorry. I meant to -- all right. And do you recall that
17 the methodology was everybody started at baseline. For the
18 first six months all of the adolescents received psychological
19 counseling. And then for the next 12 months beyond that, one
13:43:36 20 group received puberty blockers, and one group just continued
21 to receive psychological counseling. Do you recall that?

22 A Yes.

23 Q All right. And then I am going to direct you, sir, to
24 page 2211 of the -- if you look at the blue writing on the top,
13:44:12 25 it's page 6 of 9.

1 A Yes.

2 Q All right. And I am going to direct you, sir, to on the
3 CGAS on follow-up?

4 A Yes.

13:44:32 5 Q All right. And I am going to start at the second
6 paragraph where it says delayed eligible. Do you see where I
7 am talking about?

8 A Yes.

9 Q This is talking about there were three follow-ups, right,
13:44:43 10 at 6 months, at 12 months, and at 18 months for this study; is
11 that correct?

12 A That sounds familiar to me, yes.

13 Q And let's read through that together.

14 Delayed eligible gender dysphoric adolescents, who
13:44:55 15 received only -- and gender delayed, GD adolescents, is your
16 recollection that those were adolescents who were eligible to
17 receive puberty blockers, but they delayed them for six months
18 so that they had everybody at a -- doing psychological study?
19 Do you remember this is the group that gets the puberty
13:45:17 20 blockers?

21 A Yes, that sounds correct.

22 Q Okay. The delayed eligible gender dysphoric adolescents
23 who received only psychological support for the entire duration
24 of the study -- excuse me -- I take that back.

13:45:29 25 This was actually the group that just got the

1 psychological -- had significantly better psychosocial
2 functioning after six months of psychological support, okay?

3 However, despite scoring better at the following
4 evaluations, they did not show any further significant
13:45:47 5 improvement in their psychosocial functioning.

6 Did I read that right?

7 A Yes.

8 Q Also, the delayed eligible group continued to score lower
9 than a sample of children adolescents without observed
13:46:04 10 psychological psychiatric symptoms even after 18 months of
11 being in psychological support.

12 So what that's saying is after 18 months, they were still
13 below a group that did not have psychological therapy or
14 issues, correct?

13:46:20 15 A Yes.

16 Q On the contrary, the immediately eligible group, who at
17 baseline had a higher, but not significantly different
18 psychosocial functioning than the delayed eligible group, did
19 not show any significant improvement after six months of
13:46:40 20 psychological support. However -- and this is the key --
21 immediately eligible adolescents had a significantly higher
22 psychosocial functioning after 12 months of puberty suppression
23 compared to when they had received only psychological support.

24 Did I read that correctly?

13:47:03 25 A Yes.

1 Q Then you see at the top of this, there is a chart. And
2 when you look at this chart, the bottom is actually the three
3 different check-ins. Time zero is baseline, when the study
4 started, right?

13:47:18 5 A Yes.

6 Q Time one is the six-month check-in, correct?

7 A Yes.

8 Q And during that six months, both groups are getting just
9 psychotherapy, correct?

13:47:31 10 A Yes, I believe so.

11 Q The rest -- and just to orient us.

12 The red group, the red line is the group of adolescents
13 who only got psychotherapy or psychotherapy through the entire
14 18-month study, right?

13:47:46 15 A Yes.

16 Q The green line that you see that goes up -- goes up and
17 keeps going up, that is the line of adolescents who receive
18 puberty blockers; fair?

19 A Yes.

13:47:59 20 Q And so, Doctor, to get to the ultimate conclusion of this
21 study that you say shows that puberty blockers don't work or
22 don't give any improvement in mental condition over
23 psychotherapy, the conclusion, this study confirms the
24 effectiveness of puberty suppression for gender dysphoric
13:48:37 25 adolescents. Recently, a long-term follow-up evaluation of

1 puberty suppression among gender dysphoric adolescents after
2 that CSHT, which is hormone therapy and GRS, which is puberty
3 blockers, has demonstrated that gender dysphoric adolescents
4 are able to maintain a good functioning into their adult years.

13:49:00 5 This present study, together with this previous research,
6 indicate that both psychological support and puberty
7 suppression enable young gender dysphoric individuals to reach
8 a psychosocial functioning comparable with their peers.

9 Did I read that conclusion correctly?

13:49:17 10 A Yes.

11 THE COURT: Ms. Eagan, when you reach a comfortable
12 spot, let's take a post-lunch break.

13 MS. EAGAN: Perfect. We're good, Judge. We can go
14 ahead and break now.

13:49:35 15 THE COURT: Okay. I will see you in 15 minutes.

16 (Recess.)

17 THE COURT: Go ahead, Ms. Eagan.

18 MS. EAGAN: Thank you, Your Honor.

19 BY MS. EAGAN:

14:09:00 20 Q Dr. Cantor, my understanding from paragraph 63 of your
21 declaration is that the other study that you point to in
22 support of your assertion that testing revealed that puberty
23 blockers did not improve mental health any more than mental
24 health does on its own is the Achille study you mentioned
14:09:29 25 earlier today; is that right?

1 A Yes.

2 Q If you, please, sir, could turn to Plaintiffs' Exhibit 42
3 in that binder in front of you, and this would be the
4 plaintiffs' exhibits that we were looking at earlier.

14:09:42 5 A Yep. Got it.

6 Q All right. Is Plaintiffs' Exhibit 42 the Achille study
7 that we just mentioned?

8 A Yes.

9 Q All right.

14:09:59 10 MS. EAGAN: Your Honor, do you mind if I take this off
11 of this?

12 THE COURT: That's fine.

13 BY MS. EAGAN:

14 Q All right. I am going to -- so this is Plaintiffs'
14:10:15 15 Exhibit 42.

16 And the Achille study, again, was -- in this case if we
17 look at the abstract, the background of the study or the
18 purpose of the study was to examine the associations of
19 endocrine intervention puberty suppression and/or cross-sex
14:10:35 20 hormones therapy with depression and quality of life scores
21 over time in transgender youths.

22 That was the purpose of the study, correct?

23 A Yes.

24 Q And looking down to the results section, between 2013 and
14:10:56 25 2018 -- so this went over a five-year period, right?

1 A Yes.

2 Q And there were 50 participants in the study, correct?

3 A That sounds right, yes.

4 Q All right. And that they received endocrine intervention
14:11:17 5 both -- some were in the form of puberty blockers, and some
6 were in the form of cross-sex hormones, but endocrine -- and
7 over that time period and completed three waves of
8 questionnaires.

9 Is that your recollection of this study?

14:11:30 10 A Yes, roughly.

11 Q Okay. And when that was -- with those treatments, mean
12 depression scores and suicidal ideation decreased over time,
13 which means their depression was -- went down, or they got
14 better. Suicidal ideation went down, which is improvement,
14:11:50 15 correct?

16 A Yes.

17 Q While mean quality of life scores improved over time.

18 And then it goes on to say, When controlling for
19 psychiatric medications and engagement in counseling,
14:12:03 20 regression analysis suggested improvement with endocrine
21 intervention. And then it goes on to say that this reached
22 significance in male to female participants. And the male to
23 female participants, those are ones that were receiving hormone
24 therapy, correct?

14:12:23 25 A I believe they were both receiving hormone therapy. It

1 was not significant in one group, and so they're just reporting
2 the successful in the other and not reporting the nonsuccessful
3 group.

14:12:39 4 Q Well, let's talk about that. Let me pull up paragraph 63
5 of your declaration.

6 When you're discussing this study, here is what you said.
7 You said that upon follow-up, some incremental improvements
8 were noted; however, after -- so, in other words, upon
9 follow-up, they saw improvements.

14:13:07 10 But after statistically adjusting for psychiatric
11 medication and engagement and counseling, quote, most
12 predictors did not reach statistical significance.

13 And that's your basis -- that statement is your basis to
14 say there was not a statistical significance of difference
14:13:26 15 between just counseling versus with meds; is that right?

16 A I'm sorry. Could you say that part again?

17 Q The language that you seize onto, to say that puberty
18 blockers did not improve mental health more than mental
19 healthcare did on its own --

14:13:43 20 A Right.

21 Q -- was the statement in the study that most predictors did
22 not reach statistical significance.

23 A Well, I wouldn't say that I derived that just from that
24 sentence. It's just easier to convey that idea to readers by
14:13:56 25 using the sentence. My evaluation of the study is by those

1 statistics directly.

2 Q All right. Let's go to the language in the study that
3 they talk about, the regression analysis that you were just
4 referencing there.

14:14:11 5 Okay. And this is here in the regression analysis.

6 Let me first say this: The mean changes over time. And
7 it does say, Mean depression scores decreased. Quality of life
8 improved, but did not reach statistical significance.

9 But then when you go on to the regression analysis, here
14:14:39 10 is what it says. It says, Given our modest sample size --
11 which in this case was 50 people, right?

12 A Yes.

13 Q Given our modest sample size, particularly when stratified
14 by gender, most predictors did not reach statistical
14:14:57 15 significance.

16 So one of the contributing factors to that, of course, was
17 the size of the number of participants, correct?

18 A Yes. In statistics, that's a truism. The precision of
19 the statistics is the direct -- direct result of the sample
14:15:20 20 size.

21 Q Okay. And then it goes on to say, That being said, effect
22 sizes values were notably large in many models. In the male to
23 female participants, only puberty suppression reached a
24 significance level. And it gives the number in one of the
14:15:43 25 sample -- one of the tests, and associations with the two other

1 scores approached significance.

2 And then it goes on to say, For female to male
3 participants, only cross-sex hormone therapy approached
4 statistical significance.

14:15:57 5 All right. Statistical significance are not -- on all
6 planes, the numbers improved, correct?

7 A No. That's -- the very meaning of determining --
8 factoring in whether something is statistically significant or
9 not.

14:16:15 10 Q Ultimately, the writers of this study stated, if you look
11 at the next paragraph -- or look on the discussion part if you
12 want -- can you see the screen up here?

13 A Oh, I have the same thing on this screen.

14 Q Oh. You have got one. Okay, good.

14:16:31 15 Our results suggest that endocrine intervention is
16 associated with improved mental health among transgender youth.

17 Did I read that right?

18 A Yes. Those are their words.

19 Q Doctor, to be clear, you agree that the U.S.-based medical
14:17:15 20 association guidelines and position statements are in support
21 for the use of medical treatment combined with mental health
22 treatment for adolescents with gender dysphoria, correct?

23 A I don't think I would phrase it quite that strongly. Most
24 of the associations are using relatively vague terms. And it's
14:17:35 25 not clear when they're talking about adults or children, when

1 they're talking about transition, medical services versus
2 psychotherapy, or a relatively blanket statement of
3 demonstrating respect. I can only accept that they're
4 endorsing a particular treatment when they're endorsing a
14:17:54 5 particular treatment.

6 So is there a specific association or specific statement
7 you have in mind?

8 Q The major medical associations that were involved in this
9 space endorse the use of medications to treat gender dysphoria
14:18:08 10 in children -- excuse me -- gender dysphoric adolescents once
11 they reach puberty when appropriate?

12 A I can think of two medical associations, one
13 interdisciplinary association, and the other -- and all of the
14 others are, as I say relatively, vague words of support, and
14:18:44 15 it's not clear exactly what it is that they're recommending.

16 Q Well, my understanding is what you like to look at is the
17 international standards. That's what you're talking about
18 today in support of your opinions?

19 A Oh, I looked at each of them, and I think I described each
14:18:59 20 of them. I did my best not to leave any out.

21 Q So, and according to you, the Dutch approach is
22 internationally the most widely-respected and utilized method
23 for the treatment of children who present with gender
24 dysphoria?

14:19:13 25 A Yes.

1 Q And the Dutch approach is also, I believe, what you call
2 that watchful waiting approach?

3 A No.

4 Q Okay. The Dutch approach is what is accepted -- I have
14:19:24 5 already said what you said.

6 The Dutch approach says social transition can happen at
7 age 12, puberty blockers may be prescribed at age 12, hormones
8 at age 16, and then resolve other mental health issues before
9 transition. That's the Dutch method?

14:19:43 10 A Yes.

11 Q Do you know how that approach aligns with protocols that
12 are utilized at UAB Children's in Alabama?

13 A I don't know.

14 Q In any event, what you say is internationally the most
14:20:03 15 widely-respected and utilized method for treatment of children
16 who present with gender dysphoria, you would agree that that
17 approach would be a felony in Alabama with this new law,
18 correct?

19 A Yes. It's true that the Alabama law didn't leave an
14:20:26 20 exception for research purposes.

21 Q Okay. So let's talk about the European countries that you
22 mentioned very briefly, the UK, Finland, Sweden and France.

23 When you look at those four European countries, Doctor,
24 not one of them has enacted a ban to puberty blockers and
14:20:46 25 hormone treatments as Alabama has done here, correct?

1 A No.

2 Q That's not correct?

3 A Correct. That is not correct.

4 Q UK has not fully banned puberty blockers and hormone
14:21:00 5 treatments in youth 18 and younger?

6 A That's correct.

7 Q Finland has not banned -- let me ask it this way: Has
8 Finland banned blockers and hormone treatments in youth ages 18
9 and under for gender dysphoria?

14:21:16 10 A Yes, I believe it has.

11 Q It has?

12 A I believe so.

13 Q A blanket ban? Should I refer you to paragraph 131 of
14 your declaration, sir?

14:21:47 15 A Hang on. That's just where I am now.

16 Q Okay.

17 A Oh, yes, they did leave an exception for hormones. The
18 total ban was on surgery.

19 Q Thank you, sir.

14:22:05 20 Sweden, has Sweden put an absolute ban on puberty
21 blockers?

22 A Yes.

23 Q And bear with me. Have they put a ban on puberty blockers
24 and hormone treatments in youth ages 18 and under for gender
14:22:23 25 dysphoria in Sweden?

1 A 18 and under?

2 Q Yes, sir.

3 A No. They allowed exceptions for 16 year olds -- 16 year
4 olds within research circumstances.

14:22:32 5 Q Has France banned the use of puberty blockers and hormone
6 treatments for adolescents ages 18 and under?

7 A No.

8 Q Can you point me to a single country, Doctor, in Europe
9 that has put a blanket ban on the use of puberty blockers or
14:22:50 10 hormone treatments for youth ages 18 and under for gender
11 dysphoria?

12 A Blanket ban in the way you're describing it, no.

13 THE COURT: How about any country?

14 THE WITNESS: No, not that I know of.

14:23:04 15 BY MS. EAGAN:

16 Q I want to turn very briefly to the subject of -- I will
17 use your word desistance.

18 If you turn to paragraph 36 of your declaration.

19 A Yes.

14:23:36 20 Q In that -- you state, Among prepubescent children who feel
21 gender dysphoric, the majority cease to want to be the other
22 gender over the course of puberty ranging from 61 to 80 percent
23 desistance across the large prospective studies.

24 I know that's a point that you also raised earlier today.

14:23:59 25 So I want to ask this question: Of those that number, do

1 you know, Doctor, what percentage of those kids cease to want
2 to be the other gender -- that's using your words -- before or
3 as they enter puberty, in other words, before they actually get
4 into puberty? Do you know how many of those desisters are in
14:24:27 5 that window?

6 A I must not be understanding your question, because it
7 makes me want to say the same number that's in the report, 61
8 to 88 percent. What's different from what I said and what
9 you're asking?

14:24:39 10 Q The 61 to 88 percent, is that children that realign with
11 their birth sex before -- or as they're entering into puberty,
12 that's that number?

13 A Yes.

14 Q Okay. All right. So I want to focus on a different
14:25:01 15 category of youth. Let me ask you this: The medications in
16 the United States, puberty blockers and hormone treatments
17 cannot be given to kids for gender dysphoria until after
18 they've actually entered into puberty, correct?

19 A Very many clinics are doing it as close to the beginning
14:25:23 20 as soon as puberty starts as they are able.

21 Q But it's once they have entered puberty?

22 A Yes.

23 Q So let me ask you about that category of youth.

24 And that is adolescents who have entered into puberty,
14:25:38 25 okay, and who have been -- have suffered from gender dysphoria

1 persistently, consistently, and insisently in childhood
2 leading up to puberty, okay?

3 A Okay.

4 Q Do you have any data regarding what percentage of those
14:25:58 5 individuals desist after they enter into puberty?

6 A No. I don't think that level of follow-up has yet been
7 conducted.

8 Q And, Doctor, in fact, it's your belief that the
9 majority -- that while the majority of prepubescent kids cease
14:26:35 10 to feel trans, you know, to puberty or during puberty, in other
11 words, as they enter into puberty, the majority of kids who
12 continue to feel trans after puberty rarely cease?

13 A That does seem to be the case, yes.

14 Q Okay. Doctor, are you being paid to be here to testify
14:27:10 15 today?

16 A Yes.

17 Q What's your rate?

18 A 400 an hour.

19 Q Who is paying your fees?

14:27:14 20 A The Alabama state -- State of Alabama.

21 Q Okay. Dr. Cantor, have you attempted to recruit parents
22 in Alabama whose children have gender dysphoria and were
23 prescribed or referred to gender-affirmative treatments, have
24 you tried to recruit them to give a witness statement in this
14:27:38 25 case that they believe the treatments are harmful?

1 A No.

2 Q Do you tweet?

3 A Yes.

4 MS. EAGAN: Your Honor, may I approach?

14:27:49 5 THE COURT: Yes.

6 BY MS. EAGAN:

7 Q Doctor, I've marked as Plaintiffs' Exhibit 45 a tweet
8 Dr. James Cantor retweeted. And it's -- let me say this: Is
9 this a tweet that you actually did?

14:28:40 10 A No. I --

11 Q You retweeted?

12 A Retweeted, exactly.

13 Q From a group called Genspect, or what's -- I don't tweet.
14 Would you call that a group? I guess it's a group called
14:28:56 15 Genspect?

16 A It's there is a group called Genspect, and this is their
17 Twitter account.

18 Q All right. And then you retweeted it?

19 A Yes.

14:29:03 20 Q And it says, Urgent. Attention. Alabama parents, if your
21 child experienced gender dysphoria and was prescribed or
22 referred to gender-affirmative treatments and you believe these
23 treatments are harmful, please direct message, e-mail us at
24 once. We are looking for witness statements. Can be anon.

14:29:26 25 By anon, I guess that means anonymous, correct?

1 A That would be my reading, yes.

2 Q All right. Doctor, have you seen a sworn statement under
3 penalty of perjury for any Alabama parent whose kid received
4 puberty blockers or hormones and the parent said the
14:29:50 5 medications hurt their kid more than they helped them?

6 A I'm sorry. Did you ask have I seen such a statement?

7 Q Yes, sir.

8 A Not that I recall.

9 MS. EAGAN: Nothing further.

14:30:05 10 THE COURT: Any redirect?

11 MR. DAVIS: Short.

12 THE COURT: Ms. Eagan, did you intend to offer that
13 into evidence or no?

14 MS. EAGAN: Oh, yes. Thank you, Judge. I offer
14:30:37 15 Plaintiffs' Exhibit 45.

16 THE COURT: It will be admitted.

17 REDIRECT EXAMINATION

18 BY MR. DAVIS:

19 Q Dr. Cantor?

14:30:51 20 A Hi.

21 Q Is it true as a clinician you are not treating anyone who
22 has presented with gender dysphoria as an adult or as a child?

23 A I treat adults with gender dysphoria, not children.

24 Q You are not treating them while they are adolescents or
14:31:09 25 children, you are not currently treating someone who is like

1 under age 16?

2 A Correct.

3 Q Okay. But you are familiar with the research literature
4 on these issues, correct?

14:31:19 5 A Yes, quite.

6 Q And even those that are studying -- or children in
7 adolescents?

8 A Of course.

9 Q You're knowledgeable about the treatment they're
14:31:29 10 receiving?

11 A Yes, very.

12 Q And are you knowledgeable about what the research shows
13 about the efficacy of these treatments?

14 A Yes.

14:31:35 15 Q You had an exchange with Ms. Eagan where you admitted that
16 a fact that is self-reported by a participant may be true?

17 A Correct.

18 Q What's the rest of that sentence?

19 A It is certainly not necessarily true. We need something
14:31:53 20 objective before we can make any decisions upon it.

21 Q Let's turn to the Costa study. That's at Tab 38 of the
22 book of plaintiffs' exhibits.

23 MR. DAVIS: Your Honor, I'm sorry. I left a notebook.

24 May I step over?

14:32:40 25 THE COURT: Certainly.

1 THE WITNESS: I'm sorry. You said Tab 38?

2 BY MR. DAVIS:

3 Q I was mistaken, Dr. Cantor. It was 34.

4 A 34 of the defendants'?

14:33:02 5 Q No. Of the plaintiffs' book.

6 A Yes. Now I'm back there.

7 Q Okay. Now, you have a line in your report in paragraph 57
8 of your report that I will just read to you.

9 It says, Both groups improved in psychological functioning
14:33:25 10 over the course of the study, but no statistically significant
11 differences between the groups was detected at any point?

12 A Correct.

13 Q Okay. Are the three groups represented by the three
14 colored lines -- the three groups you're talking about, the
14:33:41 15 three groups on the three colored lines on this chart I'm
16 showing you?

17 A Part of the information is contained in that graph, yes.

18 Q Okay. Does this table tell us more about the statistical
19 significance or lack thereof shown in the Costa study?

14:34:02 20 A Yes, it does. The results of this table, although much
21 harder to read, indicate that there was no statistical
22 significance between the groups.

23 Q Okay.

24 A What was changing in the groups was change over time
14:34:13 25 within the group relative to the same group previously. But

1 there were no changes -- no significant differences between the
2 groups themselves.

3 Q Okay. What does it mean in a study if a finding lacks
4 statistical significance?

14:34:29 5 A That there was a substantial probability of getting a
6 pattern like that just by random chance.

7 Q And are there any reasons other than puberty suppression
8 that the delayed group did not have the same change over time
9 as the immediately eligible group?

14:34:45 10 A It's not exactly clear if they didn't change just as much.
11 That's one of the ambiguities that, again, comes from
12 statistics. When you look at it in different ways, you can see
13 different aspects, different aspects of it.

14 Q And the authors actually noted statistical significance or
14:35:11 15 lack thereof, did they not, in the language that are bracketed
16 there? It says, this difference failed to reach significance
17 possibly because of sample size?

18 A That is correct.

19 Q Have you said anything about the Costa study in your
14:35:24 20 report that you need to withdraw after your exchange with
21 Ms. Eagan?

22 A No. Everything I said is accurate.

23 Q Okay. Is the same true for everything that you have said
24 about the Achille study?

14:35:39 25 A Yes. Everything I said was accurate. Nothing in the

1 prior discussion changed it.

2 Q The UK is still reviewing these treatments, are they not?

3 A They are in the middle of deciding what to do with what
4 they have now discovered from their comprehensive review of the
14:35:57 5 literature, which showed what they were doing was wrong.

6 Q What did they discover?

7 A They discovered that they said exactly what I said, that
8 there is no evidence to support the medical transition of these
9 children.

14:36:09 10 Q And they have not yet decided how to respond to that
11 revelation, correct?

12 A Correct. They have now taken that report, and they're now
13 reorganizing and deciding exactly what it is that they're going
14 to do.

14:36:21 15 Q And in France, is it not correct that they've said about
16 hormones that the greatest reserve is required for their use?

17 A That is correct.

18 Q And is it true that, quote, they have said that speaking
19 of hormones, they're irreversible nature must be emphasized?

14:36:38 20 A That is correct.

21 Q And in Sweden, is anyone under 16 getting puberty blockers
22 or hormone treatments?

23 A No. That is banned.

24 Q And what about over 16? Youth -- like --

14:36:51 25 A Between 16 and 18, they're permitted to do it, but only

1 within recognized research programs. A regular physician
2 can't.

3 Q And how many such research programs are going on at
4 present?

14:37:04 5 A Oh, in Sweden?

6 Q Are you aware of any?

7 A I am aware of one lab that has two locations. I don't
8 know what its current status is with its current research
9 program.

14:37:20 10 Q Okay. Can you say whether a single child under 18 is
11 currently receiving hormones for the purpose of transitioning
12 in Sweden?

13 A I don't know.

14 MR. DAVIS: Thank you, Dr. Cantor.

14:37:39 15 THE COURT: Any recross?

16 MS. EAGAN: No, Your Honor.

17 THE COURT: May this witness be excused?

18 MR. DAVIS: Yes, of course, Your Honor.

19 THE COURT: All right. You can step down, sir.

14:37:48 20 THE WITNESS: Thank you.

21 THE COURT: All right. Call your next witness.

22 MR. DAVIS: Your Honor, the State calls Ms. Sydney
23 Wright.

24 THE COURT: All right.

14:37:54 25 SYDNEY WRIGHT,

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

3 THE COURT: And we think this will be how long, again?

4 MR. DAVIS: Less than 30 minutes on direct.

14:38:19 5 THE COURT: Good afternoon, ma'am.

6 DIRECT EXAMINATION

7 BY MR. DAVIS:

8 Q Good afternoon, Ms. Wright.

9 A Good afternoon.

14:38:26 10 Q Would you state your name for the record, please?

11 A Yes. It is Sydney Wright.

12 Q Can you pull that mic up a little closer to you?

13 A Yes. Will that work a little bit better?

14 Q Yes. Where do you live?

14:38:36 15 A I live in Cedar Bluff, Alabama.

16 Q And how old are you?

17 A I am 23.

18 Q What do you do for a living?

19 A Me and my wife own a business together.

14:38:47 20 Q What kind of business?

21 A We own a cleaning company.

22 Q Do you have any children?

23 A Yes. We have two.

24 Q What is your biological sex, Ms. Wright?

14:38:57 25 A It is female.

1 Q Did you at any time in your life seek medical treatment to
2 try to appear more like a male?

3 A Yes, sir, for many years.

4 Q How old were you when you first decided to seek some type
14:39:13 5 of transitioning care?

6 A I was 17 when I first started.

7 Q I've put a picture on the screen, Ms. Wright. This, for
8 the record, is page 2 of Defendants' Exhibit 41. Is this you?

9 A Yes, sir, it is.

14:39:37 10 Q How old were you in this picture?

11 A This is my graduation pictures.

12 Q Were you about 17 when these were taken?

13 A Yes, I was. The summer before.

14 Q At the time -- at the time of this picture -- well, is
14:39:52 15 this before you started receiving any cross-sex hormones?

16 A Yes. Yes. Yes.

17 Q To be clear for the record, at some point, you did receive
18 testosterone, a cross-sex hormone in order to transition to
19 male?

14:40:05 20 A Yes, I did.

21 Q What was going on in your life at the time that you
22 decided that you were -- that you wanted to transition or to at
23 least explore that?

24 A In my mind, there was this confusion inside of me that I
14:40:23 25 was not matching with what was in my head, and what I saw in

1 the mirror with how I looked in the mirror. Like I felt like I
2 was not the person I was supposed to be.

3 Q Had you been dating by the time you were 17?

4 A Yes.

14:40:37 5 Q Had you dated boys?

6 A Yes. I had -- I dated one man, yes.

7 Q Had you also dated girls?

8 A Yes.

9 Q Did you decide you would rather date girls?

14:40:48 10 A I sure did.

11 Q Did you at first struggle with coming to peace with the
12 desire you had to date girls?

13 A I did. Both of my parents are very religious, as am I,
14 and I struggled with being seen as being a lesbian and holding
14:41:06 15 my partner's hand and being seen that way, yes, sir.

16 Q When you started feeling that way, did having a feminine
17 body cause you distress?

18 A Yes, sir.

19 Q What clicked for you? What first made you think that you
14:41:26 20 were living in the wrong body? What gave you the belief that
21 you wanted your body to be more masculine?

22 A I first saw -- I never knew much about it until I got on
23 Instagram, and I saw that others were transitioning.

24 And everything that I read up on it seemed to be so
14:41:40 25 positive, in that -- like that would fix the problems that I

1 was feeling inside, and it would fix my current problem of
2 feeling like I shouldn't have been a woman.

3 Q Was it -- was most of what you learned about transitioning
4 and gender-affirming care at first at least from social media?

14:42:03 5 A Yes. Yes, sir, most of it. Uh-huh.

6 Q Where did you turn for treatment when you decided, I
7 really want to look into this?

8 A I turned to a psychologist at first. And then I turned to
9 a gender clinic, as well.

14:42:16 10 Q Let's talk about the psychologist. How many times did you
11 visit this psychologist?

12 A The psychologist, I visited them about six to eight times.
13 I did keep going after I got my testosterone letter.

14 Q All right. How many times had you seen the psychologist
14:42:32 15 before you got the testosterone letter?

16 A I saw her one hour five times.

17 Q Okay. And I guess we need to make clear for the record
18 what a testosterone letter is. What are you talking about?

19 A You have to have a letter to present to your gender clinic
14:42:49 20 doctor in order to be approved for hormones.

21 Q Now, understand I'm asking you to talk only about the
22 experience that you had, not what anybody else going through
23 this has had or what happened in any other clinics.

24 But for you, how deeply did you think this psychologist
14:43:13 25 delved into what was going on in your life before he or she

1 said, let's get you some testosterone?

2 A Looking back, she did not dive in deep. I was -- I
3 went -- I had let known that I had been through trauma and that
4 my parents went through a really bad divorce, and there was
14:43:30 5 some very rough things in my childhood that was not dived into.

6 Q Did she also refer you to a mastectomy?

7 A Yes, she did.

8 Q Now, after you got your letters, did you go to a medical
9 doctor to try to get these treatments?

14:43:46 10 A Yes, I did.

11 Q And where did you go? Is that the gender clinic you're
12 referring to?

13 A Yes. I did go to the gender clinic.

14 Q All right. Tell me about your experience at the gender
14:43:59 15 clinic.

16 A The gender clinic, they want to move you in and move you
17 out as fast as they can with as little as talking to you as
18 they can. The gender clinic I went to -- I went to two
19 different ones, and they both acted the same.

14:44:12 20 The doctor that I gave my hormone letter to never even
21 opened the letter. He kind of scoffed at me. And it was very
22 belittling.

23 And I could tell right off the bat these people didn't
24 care about me. And it -- and then you keep going. And I had
14:44:29 25 read on my blood work on a couple lines, and he told me

1 everything was fine. And I started looking things up, and they
2 were not so fine.

3 Q What do you mean you started looking things up?

4 A My blood work was showing signs that had never been shown
14:44:45 5 in any of my blood work all through my life. And all of a
6 sudden, they're off the charts. Like everything's going
7 everywhere. And I'm starting to panic. I've committed my life
8 to something, you know, and here I am now I -- you don't know
9 what's happening. You're scared. So I was -- I was really
14:45:07 10 scared at the time.

11 Q Did you seek medical treatment for these things that were
12 going on?

13 A Yes. I ended up in the ER like four times.

14 Q Let's -- before we get further into that, let's talk more
14:45:22 15 about these gender clinics. Where were they?

16 A In Atlanta, Georgia.

17 Q Okay. So you have never visited a gender clinic in
18 Alabama?

19 A No. But they do, do them here at Planned Parenthood, and
14:45:34 20 there is a couple of different places.

21 Q You don't have personal knowledge about those clinics?

22 A No, sir. Huh-uh.

23 Q So you saw the two clinics in Alabama (sic).

24 That first time you went, you said the doctor didn't even
14:45:47 25 open your testosterone letter?

1 A No, sir, he did not.

2 Q Did you get the prescription for testosterone?

3 A He gave it to me without opening the letter. He -- I
4 handed it to him, and he goes, great, here. You can go pick
14:45:58 5 your prescription up.

6 Q Okay. What do you do then? What do you do with your
7 prescription?

8 A Well, I asked him, I said, am I -- what do I do? Like how
9 do I -- are you going to give me my first shot today? And he
14:46:08 10 was like -- he kind of laughed at me. And he goes, no, not
11 unless you are going to go pick it up from Rome and drive back
12 to Atlanta, which was two hours, and bring it back to me. And
13 I said, no, I can't do that. And he said, well, you can go
14 home and figure it out. Watch YouTube videos. He said, you
14:46:24 15 can't kill yourself. So...

16 Q But you don't get the testosterone shot at the gender
17 clinic. You get a prescription that you go get filled, and
18 then you self-administer the shots?

19 A You can do it either way.

14:46:36 20 Q Okay. What were you told about the effects of
21 testosterone?

22 A At the time, I was told everything you want to hear is
23 going to happen. And I was told that there was going to be
24 muscle mass increased, and that you are going to get facial
14:46:57 25 hair, and that your voice is going to deepen. You know,

1 everything that you are thinking is going to fix you.

2 Q Did your voice deepen?

3 A Yes, very much so.

4 Q Is it still deeper than it was when you were 17?

14:47:12 5 A Yes.

6 Q Is that likely a permanent effect?

7 A It is a permanent effect.

8 Q What were the other effects on your body from taking
9 testosterone?

14:47:23 10 A Permanently?

11 Q Any.

12 A Any?

13 Q Let's start with when you were actually taking it. How
14 did your body change?

14:47:34 15 A When I started taking it, the first couple things was my
16 voice did drop. I did start to gain slight weight. And then
17 after more months of being on it, the weight gain got very,
18 very excessive. And I became prediabetic from my blood work
19 and from the hormones. And then also my digestive system
14:47:55 20 started to not fail, but they were not working properly.

21 Q This picture, this picture is printed over two different
22 pages, so I am trying to put it together now. Is that you?

23 A Yes, sir, it is.

24 Q And this is for the record pages 7 and 8 of Exhibit 42.

14:48:15 25 Where in the course of your treatment were you about this

1 time this picture was taken?

2 A A little under a year.

3 Q So you said weight gain. And then did you say
4 prediabetic?

14:48:29 5 A Yes. I have become prediabetic.

6 Q And were you told that that was the result of the
7 testosterone?

8 A Yes, sir, it was.

9 Q And this picture is from pages 9 and 10 of Exhibit 41, and
14:48:50 10 I will represent to you that the caption on this picture says
11 that it was after a year on hormones?

12 A Okay. Yes. That one, yeah. That one.

13 Q That's you?

14 A Yes, it is.

14:49:02 15 Q And is that about a year after you were on hormones?

16 A Yes, sir.

17 Q How were you feeling physically?

18 A Physically, exhausted. I felt drained of life. Every bit
19 of it.

14:49:19 20 Q Were you at least at first pleased with your body becoming
21 more masculine?

22 A Absolutely. It was -- it was what I was wanting. That's
23 why I can see both sides of everything.

24 And I was on the complete other side at the beginning. I
14:49:34 25 was all for this. This is everything I ever wanted. That's

1 why I did not want to -- I would have rather died than quit at
2 the time.

3 Q Were you telling people you were a male?

4 A Yes.

14:49:46 5 Q Were you presenting yourself as a male?

6 A Yes. At the time, I worked for a very large corporation,
7 and everybody referred to me as male.

8 Q Did you make any other changes in your life to reflect
9 your change and identity from female to male?

14:50:01 10 A Yes. My driver's license and a lot of documents did
11 reflect.

12 Q At the time, you were sure, weren't you --

13 A Oh --

14 Q -- that you wanted to be a male?

14:50:12 15 A -- 100 percent.

16 Q Were there any changes with your blood counts, like your
17 red blood counts?

18 A Yes. My red blood cell count went sky high. That's when
19 they started warning me of a heart attack or a stroke. That's
14:50:35 20 when things started getting way more intense.

21 Q Other than you mentioned being tired, feeling tired, did
22 any of this -- any of the rest of this just make you feel bad
23 in any way?

24 A Yes. So the red blood cell count -- I had no idea, but I
14:50:48 25 started itching very badly around my legs and my arms. It was

1 from the red blood cell count going up. My blood was starting
2 to thicken. So it was putting me at a risk of heart attack or
3 stroke.

4 They thought at one point I was developing a blood clot in
14:51:02 5 my lung. And I was in the ER. And we had to do a couple of
6 different painful tests. And they came to find out that it
7 wasn't the blood clot, but that it was tachycardia, which was
8 also caused by the hormones.

9 Q After you went to the emergency room, did you decide then,
14:51:19 10 oh, I have made a mistake, I am going to get off these
11 hormones?

12 A No. I was still determined.

13 Q Are you living as a male today?

14 A No, sir.

14:51:28 15 Q Are you a male?

16 A No, sir.

17 Q You are a woman, right?

18 A Yes, sir.

19 Q What changed? What made you at some point decide, I'm
14:51:39 20 going back, and I am going to present myself as a woman and be
21 the woman that I am?

22 A Well, one day my grandfather, who is the most important
23 man in my life, like we had a down-to-earth talk. And we -- he
24 made me realize a couple of things. And he said, if you will
14:51:57 25 just quit, just for three years, just, you know, take a step

1 back, look at this at a couple of things. And so I did. I
2 said, all right. You know what? You are not asking me to quit
3 permanently. You are not asking anything outrageous. So, yes,
4 of course. And so I quit. And that's where we went from
14:52:13 5 there.

6 Q Let me show you the picture that's page 11 of Exhibit 41.
7 Who is in this picture?

8 A My granddad.

9 Q And you?

14:52:27 10 A (Nodded head.) Yes. He -- he is the one that helped me
11 and saved my life. And, gah, he's been a blessing.

12 Q That's you with your grandfather, though, right?

13 A Yes. He's never cared how I looked or anything, as long
14 as I came to see him.

14:52:46 15 Q So he was suggesting that you get off the hormones long
16 enough to look at things clearly?

17 A Yes. He was worried about my health.

18 Q Looking back, when you were going to the gender clinic,
19 what did you need? Did you need medicine to try to make you

14:53:11 20 look like a man? Or did you need counseling?

21 A I needed counseling.

22 Q You gave a written declaration in this case, did you not?

23 A Yes, sir, I did.

24 Q You had a line in there that I am going to read to you.

14:53:27 25 For the record, this is Exhibit 27 and paragraph 23 of that

1 exhibit.

2 A Uh-huh.

3 Q You said, Unfortunately, there are more and more young
4 people like me being deceived every day, being told that the
14:53:41 5 solution to their insecurity and identity problems is to get a
6 sex change.

7 Do you think the people telling those young people that
8 are right, that that's what they need? They need a sex change?

9 A No.

14:53:52 10 Q Why not?

11 A Well, I believe that unfortunately that the doctors are
12 out for the money, because there's a huge market on it.
13 Because once you get somebody hooked on some medicine like
14 this, you can never get off. It is a lifelong commitment. You
14:54:12 15 have a lifelong patient.

16 But I also believe that at the end of every single day, I
17 remember how I felt. At the end of every single day, I was a
18 woman. You can't change it. There's no way -- like I could
19 not change it. I could not escape what I was trying to escape.
14:54:26 20 And eventually, you have to come to terms with that.

21 There's no -- I couldn't -- there was no way. And I lived
22 it. I wanted it to be true. I wanted it so bad. But, no. At
23 the end of every day, it's not.

24 Q What was your biological sex after you had been taking
14:54:43 25 testosterone for a year?

1 A It was a female.

2 Q What was your biological sex when it said male on your
3 driver's license?

4 A It was a female. I mean, every time.

14:54:52 5 Q So how long have you been off the testosterone and decided
6 you're not going to go that course anymore, I am going to live
7 my life as a female?

8 A I think I've been off for about three-and-a-half years, I
9 would say.

14:55:09 10 Q Is there any way that you're different today physically --
11 still today as a result of having taken hormones
12 three-and-a-half years ago?

13 A Yes. Yes. I still have to go to the doctor. I'm still
14 having -- my digestive system is still messed up. I have
14:55:28 15 tachycardia still. I still have to get my blood work done
16 because they're worried about my red blood cell count.

17 And some doctors -- my gynecologist isn't even sure if I
18 am ever going to be ever be able to have children. It took my
19 right away to have children.

14:55:45 20 Q Did you ever consider making a claim against the doctors
21 who gave you these treatments?

22 A I tried to do a malpractice suit. And I couldn't find a
23 single attorney to take the case.

24 Q Why not?

14:56:00 25 A They were afraid.

1 Q Afraid of what?

2 A They were afraid against the standard of code.

3 Q Was there any concern that you heard from any of the
4 lawyers you spoke with about how long it had been since you had
14:56:15 5 received treatments?

6 A They were worried about the statute of limitations.

7 Q How long did it take you to realize that -- bad question.
8 Let me start over.

9 How long did it take, from the day you set off on the
14:56:37 10 course of this treatment, to come to believe that the doctors
11 had mistreated you?

12 A From starting it?

13 Q Yes.

14 A Okay. Half -- I would say around six to seven months I
14:56:51 15 started getting a little shaky feeling because I could -- I
16 could -- I have common sense. I can see when people care and
17 don't care about me. And when you're just being, you know. So
18 I started seeing how they treated people. And I started
19 watching the others at the gender clinics. And I -- it raised
14:57:13 20 more and more concerns as I went on.

21 Q Maybe some inkling. But I mean when you were -- when your
22 eyes were opened --

23 A Oh.

24 Q -- and you realized oh, this was wrong? And you needed to
14:57:24 25 do something about it and possibly even seek recourse against

1 these doctors?

2 A That was -- when I was very much so in the hospital all
3 the time was when I knew that I had to probably do a
4 malpractice suit, or do something, or fight it. Because I
14:57:44 5 didn't want anybody else to go through this at all.

6 Q It wasn't overnight. It took a while for you to come to
7 that realization, right?

8 A Yes. It took months, years, like very, very time
9 consuming. It took time.

14:57:57 10 Q Did you support Alabama's bill that affects these
11 treatments?

12 A Yes, I did.

13 Q In what way did you support it?

14 A I spoke in support of the bill at the committee hearing.

14:58:13 15 Q The committee hearing. You mean the committee at the
16 Legislature?

17 A Yes.

18 Q So you were a witness there?

19 A I was, yes.

14:58:21 20 Q Did you tell them that you hoped they would vote in favor
21 of this bill?

22 A I did, yes.

23 Q What would you tell a young person who is struggling with
24 gender dysphoria, feels like they were born in the wrong body,
14:58:43 25 and they're wondering if the answer to their problems is to see

1 a doctor and get some hormones that will help them transition
2 to the other sex? What would you advise that person?

3 A I would advise them to take a lot of time. Take a lot of
4 time.

14:58:57 5 And you're going to realize in life that there is so many
6 more important things than this. You are going to see that,
7 you know, the people that care and love you. And just time
8 will show you and open your eyes that it's not necessarily --
9 you will slowly see how you'll learn to love yourself. It
14:59:22 10 takes a lot of time.

11 And we can't fix who we are. But we are stuck who we are.
12 And you should just love yourself.

13 And it doesn't matter if you are a girl. You can do guy
14 things. And I can dress like a tomboy if I want. And it
14:59:37 15 doesn't have to be a certain way.

16 I've learned to love myself and love -- hold my wife's
17 hand in front of other people. And it doesn't have to -- I
18 don't have to transition for it.

19 Q Now, you have been through these treatments yourself,
14:59:55 20 Ms. Wright?

21 A Yes, sir.

22 Q Do you think doctors should be allowed to give minor
23 children hormone treatments to try to make that person appear
24 to be the other sex?

15:00:03 25 A Absolutely not.

1 MR. DAVIS: Thank you. I pass the witness, Your
2 Honor.

3 CROSS-EXAMINATION

4 BY MR. DOSS:

15:00:17 5 Q Good afternoon, Ms. Wright.

6 A Good afternoon.

7 Q My name is Jeff Doss. I'm one of the attorneys
8 representing the plaintiffs. We haven't met before.

9 Just to be clear, you don't know which of my clients,
15:00:34 10 Michael Boe, Zachary Zoe, Allison Poe, and Christopher Noe, all
11 of whom are children, you don't know which of those children
12 are, in fact, transgender, do you?

13 A No, sir. I would have no way of knowing.

14 Q Exactly. You don't know any of these kids, do you?

15:00:49 15 A No, sir.

16 Q And so you don't know whether any of my clients have been
17 correctly diagnosed with gender dysphoria, do you?

18 A I don't believe in that diagnosis, sir.

19 Q I appreciate that clarification.

15:01:01 20 So, in your opinion, you don't think any medical
21 treatments should be provided for anyone with gender dysphoria,
22 do you?

23 A I believe that that's your own decision after the age of
24 21 or 18.

15:01:14 25 Q Another good point.

1 When you were testifying on direct examination, you kept
2 using the expression young people, right?

3 A Okay. Uh-huh.

4 Q Now, you wrote an article in October of 2019 for the Daily
15:01:29 5 Signal, correct?

6 A Yes, sir.

7 Q And that's marked as Defendants' Exhibit 41. And I will
8 show you page 3 of that article.

9 You wrote, At age 18, I started seeing a bunch of
15:01:46 10 transgender men's success stories on Instagram, right?

11 A Okay. Yes.

12 Q And you went on to write, I resented that and began to
13 envy the transgenders. I looked into it for myself. Correct?

14 A Right.

15:01:58 15 Q So you were a legal adult at the time that you began
16 considering that perhaps you were transgender, right?

17 A No, sir. I was 17. And then I turned 18 when I got the
18 hormones.

19 Q Well, let's talk about that. On page 4 of the article,
15:02:19 20 you wrote, I soon found a therapist who said she would help me,
21 and I took her -- I told her I wanted to start the hormones on
22 my 19th birthday, which was only five weeks off. She required
23 only a one-hour appointment each week. Right?

24 A Right. Yes.

15:02:33 25 Q So did you start the hormones on your 19th birthday or

1 before?

2 A Started questioning at 17. 18, I started taking action to
3 get a psychologist. And then I wanted to have the hormones by
4 my birthday.

15:02:47 5 Q Okay. Did you, in fact, get your hormones by your 19th
6 birthday?

7 A I was a couple of weeks off, but right at it.

8 Q Okay. So is it fair to say that when you received the
9 diagnosis and you received the hormones, you were an adult?

15:03:00 10 A At the time, yes, uh-huh.

11 Q Ms. Wright, you are not and never have been transgender,
12 right?

13 A I was transgender at some point, yes.

14 Q You considered yourself to be transgender?

15:03:22 15 A Yes.

16 Q Do you believe that you are, in fact, transgender?

17 A I am not now, no.

18 Q But at the time, did you believe you were transgender?

19 A Yes. When I believed it was something that could happen.

15:03:34 20 Q Okay. I believe you received a diagnosis of gender
21 dysphoria; is that right?

22 A Yes, I did.

23 Q But sitting here today, you don't think that you really
24 had gender dysphoria, right?

15:03:44 25 A No. I think it was a mental delusion.

1 Q So you did not think -- sitting here today, you don't
2 think you had a diagnosis of gender dysphoria?

3 A No. I think I had mental problems.

4 Q Okay. And what was the name of the doctor who prescribed
15:03:57 5 the testosterone for you?

6 A Katrina Jensen.

7 Q What practice was the doctor with?

8 A Balanced Living.

9 Q Okay. And that was in Georgia, right?

15:04:09 10 A Correct.

11 Q And, in your opinion, your counselor misdiagnosed with you
12 gender dysphoria, right?

13 A Not that she misdiagnosed me. Because at the time, I did
14 believe in gender dysphoria. That is why I was there.

15:04:22 15 Q Sitting here today, you believe that your counselor
16 misdiagnosed you with gender dysphoria?

17 A Looking back, I don't think it was a misdiagnosis. I
18 think it is a problem with gender dysphoria.

19 Q Okay. So do you think at the time you, in fact, did have
15:04:37 20 gender dysphoria?

21 A You can think that the symptoms are similar and not
22 necessarily the same as -- gender dysphoria, it's a mental
23 problem. Like you don't see yourself as who you want to be,
24 but it's probably caused from other issues coming in your life.

15:04:58 25 So necessarily, gender dysphoria is probably caused from

1 some other things coming from your life.

2 So I mean, I guess that she could have summed it up as
3 that, yes, and whatever she put at the time was what she had
4 thought. I -- I don't want to say I believe in it or don't
15:05:15 5 believe in what she put at the time. She has since resigned
6 counseling.

7 Q Okay. And to be clear, you have had no academic training,
8 in terms of psychological diagnoses, right?

9 A No.

15:05:27 10 Q Okay. You testified that you tried to file a medical
11 malpractice lawsuit against this doctor, but no attorney would
12 take the case.

13 Did you report the doctor who prescribed the testosterone
14 to you to any sort of state regulatory board in Georgia?

15:05:46 15 A I did not -- I reported -- I reported the counselor. The
16 counselor has -- had her license removed, I believe. So that's
17 the only one.

18 And then I tried to handle the doctor, but I could not
19 make progress with the actual gender doctor.

15:06:07 20 Q When you say you tried to handle the doctor, what do you
21 mean by that?

22 A I tried to -- I tried to do a malpractice suit and tried
23 to report him anywhere I could.

24 Q So did you report the doctor to the state regulatory board
15:06:18 25 concerning doctors?

1 A No. At the time, I didn't know how to do that.

2 Q All right. Ms. Wright, because you don't know any of my
3 clients, you can't say whether or not they have benefitted or
4 will benefit from puberty blockers or hormone treatments,
15:06:36 5 right?

6 A Can I give a response? I can --

7 Q That's what I am looking for.

8 A Right. The only thing is I can say that it could harm
9 them in the future if they change their mind. It's permanent.

15:06:48 10 Q But sitting here today, you don't know what benefits that
11 they have experienced as a result of these medical
12 interventions, correct?

13 A I don't know the benefits, but I do know the cons.

14 Q Absolutely. So you don't know what benefits they have
15:06:59 15 experienced, right?

16 A Sure.

17 Q All right. In your article that we looked at a second ago
18 on page 14, you closed with, Until we do something, until the
19 medical community puts up serious guardrails and begins to do
15:07:34 20 its due diligence, and until politicians grow a spine and step
21 in, expect to see more young people scarred for life.

22 Did I read that correctly?

23 A Yes, sir.

24 Q Do you know what guardrails exist at the UAB Children's
15:07:48 25 health clinic?

1 A Please do tell me.

2 Q I am asking if you know.

3 A I don't. I want to know.

4 Q And then getting ready for today, I noticed -- I am not
15:08:00 5 marking this as an exhibit, but I noticed, is this your
6 LinkedIn page, Ms. Wright?

7 A I don't have it any longer, but at one point, yes.

8 Q Okay. And that's a photo of you when you appeared at the
9 Alabama State House while testifying against this particular
15:08:17 10 law, right?

11 A Yes, sir.

12 Q And if we go down a little bit, the about section, you
13 wrote, I also speak as a child advocate in very large court
14 cases all around the U.S.

15:08:29 15 Did I read that correctly?

16 A Yes.

17 Q Other than this case, what other court cases have you
18 testified in?

19 A I have spoken for the VCCAP bills, the Vulnerable Child
15:08:39 20 Protection Act. And I have spoke for South Dakota. I have
21 spoke for Alabama a couple of times. And I think that's all at
22 the moment.

23 Q And let me clarify. You wrote court cases.

24 A Oh, well --

15:08:51 25 Q Have you ever testified in court before?

1 A No. I'm -- I might not be the brightest on lawyer terms.

2 Q Likewise, under volunteer experience, you wrote that you
3 are a public speaker for Compassion Coalition, and you said, I
4 travel and speak at very -- all caps -- large court cases that
15:09:11 5 change laws and standards of care and health, as well as make
6 new laws. Right?

7 A That was what I helped with at one point.

8 I was trying to build my resume to try to look good for a
9 position that I had put some experience that I did on there.

15:09:27 10 So this is what I have experienced, not what I have done or any
11 positions that I hold.

12 Q Okay.

13 A What does my past have to do with -- my past work have to
14 do with the court case -- or not court case, but today?

15:09:44 15 MR. DOSS: One moment, Your Honor.

16 THE COURT: Uh-huh.

17 MR. DOSS: Thank you, Ms. Wright. That's all the
18 questions I have for you.

19 THE WITNESS: Perfect. Thank you.

15:09:53 20 REDIRECT EXAMINATION

21 BY MR. DAVIS:

22 Q Ms. Wright, were you just mistaken when you referred to
23 other events as court cases?

24 A Yes. 1,000 percent. I was -- and that was probably
15:10:10 25 three years ago when I spoke at my first one and was extremely

1 excited.

2 Q Now, you said you do not support medical treatment for
3 folks with seeking to transition. Let's be clear about that.

4 You mean -- did you mean by that like puberty blockers and
15:10:28 5 cross-sex hormones, that's what you're against?

6 A Right. Yes.

7 Q Are you in favor of those folks getting counseling?

8 A Yes, 1,000 percent. I want all the children to be helped.

9 Q Do you consider yourself to have been mature enough to
15:10:46 10 make the decision to transition to male and to take the
11 hormones?

12 A No.

13 Q And you were how old at that time?

14 A At the time, I was 19. I still probably wouldn't have
15:10:56 15 been good by 21.

16 Q Do you think under any circumstances a 13, 14, 15 year old
17 would be mature enough to take these drugs?

18 A Absolutely not. If you would have told me that I could
19 have become an animal or something at 12, you know, you would
15:11:11 20 have taken that leap or something? No.

21 Q Thank you, Ms. Wright.

22 A You're welcome.

23 THE COURT: May this witness be excused?

24 You can step down, ma'am. Thank you.

15:11:23 25 THE WITNESS: Thank you.

1 MR. DAVIS: Your Honor, the State defendants have no
2 other witnesses.

3 THE COURT: Okay. All right. Well, then, why don't I
4 give everybody 20 minutes to get ready for their closing.

15:11:38 5 You know, again, I will give everybody 25 minutes. I
6 think that's probably too long. I'm really interested in you
7 giving me your analysis and tying in your evidence here at the
8 end.

9 You know, to the United States, you know, I would say
15:11:51 10 since you are only arguing one issue and not five, to the
11 extent you can limit yourself to ten, that would be
12 appreciated, as well.

13 Does that sound reasonable to everybody?

14 All right. And by the way, if anybody just, you know,
15:12:04 15 needs five minutes, that's okay, too. So don't be compelled to
16 use all your time.

17 Okay. Well, let's take 20 minutes so you have time to
18 kind of recap, and we will come back and knock those out.
19 Thank you.

15:12:17 20 (Recess.)

21 THE COURT: Please be seated. Thank you.

22 All right. Let's go ahead and get started.

23 Tell me how you think your time usage is going to run,
24 Mr. Doss.

15:33:26 25 MR. DOSS: Hoping well below 25 minutes, Your Honor.

1 THE COURT: Excellent. Excellent.

2 So instead of asking any hypotheticals and putting anybody
3 on the spot too hard, let me just say, you know, and I think
4 you probably will do this anyway, but I would like everybody to
15:33:43 5 directly address how to read Bostock and Brumby together.

6 I get it that Fourth Circuit precedent is not binding
7 here, but I also want to see what you think the interplay is
8 with Grimm. And then anything else you want to tell me.

9 But that would kind of be at the front of my mind.
15:34:05 10 Everybody read those together for me.

11 So all right. Go ahead.

12 MR. DOSS: May it please the Court.

13 First, Your Honor, thank you for your time the past
14 two days.

15:34:22 15 The State has spent the last two days, Your Honor,
16 answering a question that is not dispositive of anything.

17 The State has focused and questioned our witnesses and
18 introduced its own evidence to prove that there exists medical
19 risks associated with the treatments that this particular Act
15:34:45 20 aims at banning. We don't dispute that premise, Your Honor.
21 We haven't disputed it since the beginning.

22 There is no such thing as a risk-free medical treatment.
23 No one has come forward into this courthouse and identified
24 what that risk-free treatment would be.

15:35:03 25 Mr. Bowdre, I thought it was telling when he was

1 questioning the United States' expert this morning,
2 Dr. Antommaria about what if a person has a 40 percent chance
3 of persisting, would it be appropriate to prescribe
4 gender-affirming treatments? But that is simply not how
15:35:22 5 clinical practice works, Your Honor.

6 No doctor in the state of Alabama that Your Honor has
7 heard about is making these sorts of sterile clinical judgments
8 based on statistics alone. It is a three-dimensional
9 assessment that takes into account the parents, the child, the
15:35:41 10 network, the child's background, the history of gender
11 dysphoria that the child may have presented with. All of these
12 issues are taken into account. It's never as easy as opening a
13 book and looking at statistics and basing a medical judgment
14 upon it. It requires individualized attention and
15:36:04 15 individualized treatment.

16 Even Dr. Cantor suggests that multiyear diagnoses
17 preceding medication ought to be the widely-accepted approach
18 in this area. But this Act, Your Honor, strips doctors of that
19 ability, and it strips the parents of the ability to weigh
15:36:27 20 those risks. It is a fundamental freedom in this country, Your
21 Honor, that parents have control over the care and custody and
22 medical matters affecting that parent's child.

23 But the State replaces that right to weigh the risks.
24 With its categorical prohibition, it supplants parental
15:36:54 25 judgment and replaces it with the State's sole unchallengeable

1 without exception judgment that no child should receive these.

2 There was a question this morning by the State to one of

3 the witnesses that if a nine year old with diabetes receives

4 insulin, that would be effective, but if a nine year old

15:37:19 5 without diabetes receives insulin, it would be, quote, very

6 dangerous. That hypothetical illustrates exactly what the

7 problem the State is concerned about. Whether the diagnosis is

8 accurate, and if it's not accurate, the treatment.

9 It makes sense that if you don't have diabetes, you

15:37:41 10 shouldn't be prescribed insulin. In the same way, if you don't

11 have gender dysphoria, it may cause issues if you're prescribed

12 these gender-affirming treatments.

13 That becomes relevant, Your Honor, because of the standard

14 of review applicable to our due process claim on behalf of the

15:37:56 15 parents. Because the State is interfering in a fundamental

16 right, the State must show a compelling State interest, and the

17 State must show that these laws are narrowly tailored to meet

18 that interest. This Act fails on both levels.

19 First, even if the Court were to credit all of the

15:38:22 20 evidence in the State's favor and find that the evidence

21 demonstrates a compelling interest, that alone does not save

22 this law. If we take a step back and look at the evidence

23 offered by the State, the principal concern, as I understand

24 it, is that there's a strong possibility of desistance, as the

15:38:43 25 State says. So this idea of watchful waiting is better than

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1 medical intervention.

2 But that's a problem with the diagnosis, Your Honor. By
3 definition, the obliteration of choice, the obliteration of
4 treatment cannot be narrowly tailored.

15:39:05 5 Perhaps if the State had implemented regulations that set
6 forth concrete guidelines that a clinician must follow before
7 prescribing these medications, maybe that would present a
8 closer question. Maybe we wouldn't be here today.

9 But the State didn't do that. The State took all
15:39:28 10 treatments off the table and made it a felony to follow these
11 widely-regarded medical approaches.

12 A concern for misdiagnosis does not call for the
13 obliteration of choice and treatment. I expect the State will
14 cite to the Carhart vs. Gonzales opinion for the proposition
15:39:56 15 that medical uncertainty gives the government wider discretion
16 in terms of regulating medical treatment.

17 Carhart, Your Honor, was an abortion case. It concerned
18 the federal so-called partial birth abortion ban. And as Your
19 Honor might expect, there's a very different analysis
15:40:17 20 associated when you're considering an abortion regulation, as
21 opposed to when you're considering the deprivation of a
22 fundamental freedom like parental choice.

23 Setting aside that difference, even assuming we can draw
24 some meaning from the Carhart decision, the language that the
15:40:36 25 State is seizing upon, this issue of medical uncertainty, was

1 only part of the analysis. That may have given the State some
2 interest in regulation, but that alone was not the end of the
3 inquiry.

4 The Supreme Court went on to consider whether the
15:40:58 5 regulation imposed an undue burden, including whether the
6 regulation would cause harm. We have shown, Your Honor, that
7 this Act will undisputedly cause harm.

8 Our four plaintiff parents have very similar stories. You
9 heard from one of them live, Ms. Poe. I don't think anyone can
15:41:27 10 hear her testimony and think that she is not sincere, that she
11 doesn't have the best interest of her child in mind, and that
12 she's -- she is seeing positive transformative, amazing
13 benefits from these treatments that the State has dubbed risky.

14 Our other parents share similar stories. And those are
15:41:53 15 reflected in the declarations which we've submitted for Your
16 Honor's consideration.

17 In this case, even if Your Honor were to apply that
18 Carhart standard, which the State seems to be proposing, this
19 law still fails. It undisputedly causes harm to those it is
15:42:14 20 seeking to supposedly protect. It is stripping them of
21 positive medical treatments that exist.

22 Over the past day and a half, Your Honor, we have heard a
23 refrain that these treatments are experimental. We've heard
24 one -- two witnesses now define what that means.

15:42:40 25 Dr. Ladinsky gave an explanation. It doesn't fit these

1 treatments.

2 Dr. Cantor gave a definition I thought was interesting.
3 As Dr. Cantor noted, it's very difficult to say when it no
4 longer is experimental and it's established.

15:42:56 5 Under the State's logic, simply by dubbing a treatment
6 experimental until we've reached some unknowable and
7 undefinable level of certainty, that alone should be sufficient
8 to override parental choice.

9 The problem, though, Your Honor, is that there are risks
15:43:15 10 with every medical treatment, and there are always unknowable
11 risks. That's what makes them unknowable.

12 I can think of many commercials I have seen over the years
13 where medications that have been on the market for years, some
14 studies begin to associate them with adverse risks. And
15:43:32 15 plaintiffs' attorneys are soliciting clients because of these
16 newfound risks.

17 In that regard, Your Honor, if we were to be as risk
18 averse as the State is proposing, I submit with the
19 introduction of antibiotics, the State likely wouldn't have
15:43:48 20 been on board because it had unknowable risks, despite our now
21 knowledge that they are life saving.

22 At some point, medical treatment is going to be new. But
23 newness on its own doesn't make it bad. And it certainly
24 doesn't justify the State's interest in obliterating it and
15:44:06 25 criminalizing it.

1 And that is exactly what the Arkansas -- Eastern District
2 of Arkansas found in the Brandt case. In that case, Your
3 Honor, it didn't criminalize the parents. It only criminalized
4 the physicians.

15:44:26 5 The Arkansas Court there still recognized that the
6 physicians -- because this so intimately implicates parental
7 choice, the physicians even had standing to assert those
8 fundamental protections on behalf of their patients' parents.

9 The Eastern District of Arkansas found that the law in
15:44:47 10 Arkansas, which again didn't criminalize anything, it applied
11 civil penalties. It was less egregious than the law here.
12 Even the Arkansas law violated these fundamental protections
13 and failed at strict scrutiny.

14 But we also challenge the compelling interest piece of the
15:45:13 15 strict scrutiny analysis, Your Honor. The State's compelling
16 interest is, at best, that there's a concern for this
17 desistance. But we have presented evidence suggesting that
18 that concern is overblown.

19 Dr. Ladinsky testified that the standard of care endorsed
15:45:32 20 by every major medical association in the United States
21 recognizes that the use of puberty blockers and hormone
22 treatments can be appropriate in some adolescents with gender
23 dysphoria.

24 Dr. Hawkins testified that the standard of care requires a
15:45:48 25 360 assessment that takes several months, and in some cases,

1 years before prescribing medical intervention such as puberty
2 blockers. The standard of care allows time for adolescents to
3 explore their gender identity, and not all adolescents receive
4 medical intervention.

15:46:09 5 Recall, Your Honor, Ms. Poe's testimony. It took
6 two years from the time that she and her daughter first visited
7 the UAB Children's clinic until any medication was prescribed.

8 It is telling, Your Honor, that the State has been unable
9 to identify a single doctor in the state of Alabama who has
15:46:38 10 ever run afoul of these kind of guardrails. It is equally
11 telling, Your Honor, that the State has identified not one
12 child who has received these treatments ever in the state of
13 Alabama who later regretted them.

14 What we heard this afternoon was from Ms. Sydney Wright, a
15:47:03 15 Georgia resident who was an adult. Even if Georgia had had
16 this exact same law in place, it would not have prevented her
17 from obtaining the treatments she obtained. Ms. Wright's story
18 is an unfortunate one. And if only Ms. Wright had had a doctor
19 like Dr. Hawkins or a doctor like Dr. Ladinsky who was
15:47:31 20 committed to a deep meaningful evaluation of the child.

21 In Alabama, children receiving these treatments from the
22 University of Alabama -- from UAB's clinic, they walk hand in
23 hand with these physicians. That informs their choice.

24 We have introduced into the record, Your Honor, the
15:48:04 25 informed consents that parents are provided with, in addition

1 to loads of information. The parents still sign off on these
2 treatments.

3 As Ms. Poe testified, she is terrified of what would
4 happen if these treatments are prohibited. She knows well the
15:48:26 5 risks, and she's weighed those risks against the benefits of
6 receiving the treatment, and the devastating effects of not.
7 And in light of that constellation, she exercised her freedom
8 as a parent to make that decision in consultation with her
9 child's team of doctors.

10 Indeed, Your Honor, even the study that the defendants
11 have cited as the leading study, it recognizes the benefit of
12 multidisciplinary approaches, including medical treatments in
13 appropriate cases. The Dutch model that we heard about, it is
14 the well-regarded standard nationally. It, too, would be
15:49:19 15 illegal under this law.

16 So to the extent the State expresses some concern in
17 support of its compelling interests, we submit that concern is
18 hollow.

19 Even in the Carhart decision, Your Honor, the Supreme
15:49:37 20 Court acknowledged that a federal court's review of the
21 constitutionality of a state statute looks at that underlying
22 evidence, not just the State's stated concern.

23 In addition, as to the desistance risk, we've put in the
24 Yale statement, Plaintiffs' Exhibit 19. There are two
15:50:06 25 footnotes that are important: 43 and 45. In that statement,

1 which is a literature review, it's a summary of the available
2 scientific literature concerning this matter. It debunks this
3 notion that there's widespread concern about desistance for the
4 children who are receiving or eligible for treatment in the UAB
15:50:30 5 clinic.

6 As I mentioned in my opening, Your Honor, at base, this
7 law criminalizes a parent's concern and love for a child.
8 There can be no clearer example of a violation of fundamental
9 parental freedom.

15:50:57 10 So as to the other compelling interests that the State
11 cites, the kids can't understand because they haven't had sex
12 and don't know if they will want kids. These are difficult
13 questions, Your Honor, admittedly.

14 And if I were a parent of a child going through this, I
15:51:13 15 don't know how I would weigh it. But that's the point. I
16 don't. And it's not my job to weigh it for someone else.
17 These are highly personal, intimate considerations.

18 There are risks of fertility with other medications. A
19 child with cancer going through chemotherapy faces such a risk.
15:51:40 20 Under the State's logic, we ought to ban that. Of course, we
21 don't do that.

22 In the same way, these treatments have proven, as
23 Dr. Ladinsky testified, to be life saving. And they haven't
24 been handed out like candy, as Dr. Cantor has tried to suggest.

15:51:56 25 There's no transition on demand in Alabama. It is not a

1 documented concern. I haven't even heard of it being a
2 documented concern in the last day and a half anywhere in the
3 United States.

4 The studies cited by the defendants in support of this
15:52:15 5 concern for transition on demand, they all originate in Europe.
6 Whereas, Dr. Ladinsky explained, regulation of hospitals,
7 clinics in Europe, very different than it is in the United
8 States.

9 The United States, the standard is clinics will have these
15:52:30 10 robust protocols and procedures in place. They have these
11 professional organizations that are providing this sort of
12 oversight and input. We don't see that in Europe. So perhaps
13 they may have been getting a little lax in Europe. But that's
14 not happening in Alabama.

15:52:50 15 The defendants have suggested another compelling State
16 interest is that the majority of kids ultimately align with
17 their gender identity. But we've disproven that.

18 As Dr. Hawkins testified, gender identity is hardwired.
19 It's unlikely to change. And once an adolescent reaches
15:53:12 20 puberty, it's unlikely that they'll grow out of their gender
21 dysphoria.

22 They suggest that a European pause is better than
23 America's rush to treatment, but they have identified no
24 country in Europe, in fact, no country in the world that has
15:53:32 25 enacted a law like this one.

1 So for being a compelling State interest, I find it
2 interesting that no other country has enacted a solution like
3 Alabama proposes.

4 What does the State propose instead? Do nothing. Counsel
15:54:01 5 them. That's an untested proposal. The State proposes an
6 experiment on a grand scale. All transgender youth in the
7 state of Alabama suffering from gender dysphoria should be
8 guinea pigs.

9 THE COURT: I notice you're rolling through your time
15:54:21 10 pretty good. Are you leaving some time to talk about your
11 legal arguments?

12 MR. DOSS: Yes, Your Honor.

13 THE COURT: All right.

14 MR. DOSS: What's my time so far?

15:54:30 15 THE COURT: I think you are just about there, but I
16 might spot you a little bit.

17 MR. DOSS: In terms of the equal protection, I am
18 going to defer to the government -- the United States because
19 they're arguing that one. But I do want to make a couple of
15:54:44 20 points.

21 The Eleventh Circuit has recognized that a violation of
22 the Equal Protection Clause occurs when you discriminate on the
23 basis of transgender people on transgender status, gender
24 identity.

15:54:56 25 In the State's opening, the argument I heard was that

1 that's in the employment context, and for employment, it may
2 make a difference as to whether someone -- it should make no
3 difference as to whether someone is male or female; whereas in
4 the medical context, it does make a difference, and, therefore,
15:55:12 5 it doesn't ultimately matter.

6 But it's not the Equal Protection Clause for an employment
7 agreement. It's the Equal Protection Clause which ensures that
8 no law forces the discrimination on the basis of sex. That
9 that case concerned an employment issue is not the ultimate
15:55:31 10 disposition. The issue is does the Equal Protection Clause
11 recognize the discrimination on the basis of being transgender
12 is, in fact, a violation? The Eleventh Circuit has said yes.

13 So in light of that ruling, this law does, in fact, do
14 that. It defines the scope of the law, in terms of people who
15:55:49 15 are transgender, of obtaining a medical treatment in order to
16 align one's gender identity with one's sense of self.

17 By definition, the State tries to say not everyone with
18 gender dysphoria is transgender, and not everyone who is
19 transgender has gender dysphoria. But as Justice Scalia once
15:56:10 20 noted, if you put a tax on yamakass, it's a tax on Jews. In the
21 same way, not everybody may who has a yamaka may be Jewish, not
22 every Jewish person may have a yamaka. But these things are so
23 closely related that it's impossible to differentiate them and
24 separate them out.

15:56:30 25 And in that regard, we think it does violate the Equal

1 Protection Clause. The State doesn't meet the standard of
2 review for the same reasons outlined, with respect to the
3 fundamental right to parental choice.

4 In terms of the First Amendment claim, I have appreciated
15:56:47 5 the State's concessions, that they don't think that these
6 things like referrals and mentioning the opportunities violates
7 the First Amendment because of science or requirement.

8 But the problem is if you're making a referral for
9 treatment as a doctor, you know full well what treatments are
15:57:05 10 available, and you could, in fact, be construed as causing the
11 receipt of those treatments. So it does criminalize speech.

12 THE COURT: So, you know, Alabama's criminal statute
13 has a "but-for" in the definition of cause. So you think that
14 overcomes the "but-for"?

15 MR. DOSS: I think the problem, Your Honor, it is not
16 a proximate cause requirement. It's not the closest in time
17 cause of treatment, but it is a "but-for" cause. It is a
18 cause.

19 So had the child not received the referral, Dr. Ladinsky
15:57:39 20 testified that 80 percent of her patients come to her through
21 referrals. Had the patient not received the referral from the
22 pediatrician, it's questionable whether or not the child would
23 have been ultimately seen at the UAB clinic.

24 So it does raise a problematic chain of events. I mean,
15:57:56 25 if it is a "but-for" cause, then that's all the -- alone that

1 is required.

2 THE COURT: I really like your chances in court in
3 front of a jury if it comes down to just that.

4 MR. DOSS: As someone who primarily does criminal
15:58:08 5 defense work, it's a little odd for me to be in court
6 suggesting that something my client may do is a crime.

7 However, for purposes of this, I will say the way the
8 statute's written, it's so broad. As the State argued in
9 opening, a referral is both speech and an act.

10 So it is speech. In the same way the pastor's conduct
11 could be swept under, that's enough to trigger First Amendment
12 scrutiny.

13 As to the preemption claim, Your Honor, I will be brief.
14 It's going to be primarily the same reasons as the Equal
15:58:46 15 Protection Claim. There's at least the Northern District of
16 Georgia case which recognizes that under the ACA,
17 discrimination on the basis of sex can include discrimination
18 due to transgender status.

19 It forces doctors to have to decide between compliance
15:58:59 20 with federal law and compliance with state law. And,
21 therefore, it should be viewed as preempted.

22 As to the void for vagueness argument, Your Honor, I think
23 the State's responses to your questions throughout the past day
24 and a half have illustrated the vagueness of this law.

15:59:18 25 When asked who is the primary defendant that the State

1 would charge, who is defendant number one that the State would
2 charge under this law, the State hesitated. And you asked
3 if -- Your Honor asked if it would only be doctors. The State
4 hesitated.

15:59:36 5 The problem with this law, Your Honor, is no one can read
6 this statute and get fair notice of what is and is not covered
7 by the statute.

8 If I am a parent like the Noes, and I drive my child
9 across state lines to get these treatments in Georgia where it
15:59:52 10 is legal, I've arguably caused. But I don't know. Maybe the
11 State says that isn't covered.

12 If I am a treating pediatrician, if I am a local
13 pediatrician, I make a referral, have I caused it? I don't
14 know.

16:00:07 15 If I am a pastor, and I suggest that these things are
16 available, have I caused it? I don't know.

17 The vagueness undercuts its constitutionality for those
18 additional reasons.

19 Your Honor, we respectfully request that the Court enjoin
16:00:28 20 the enforcement of this Act.

21 THE COURT: Are you going to talk to me about Brumby?

22 MR. DOSS: That was the Eleventh Circuit --

23 THE COURT: Grimm?

24 MR. DOSS: That was the --

16:00:36 25 THE COURT: Bostock?

1 MR. DOSS: Bostock.

2 THE COURT: Three of those.

3 MR. DOSS: Bostock recognized in the Title VII context
4 that discrimination against transgender people would be
16:00:46 5 sufficient to qualify as a violation of Title VII. It's
6 discrimination on the basis of sex.

7 Under Bostock, we think the same logic would apply when
8 you're looking at either the ACA anti-discrimination provision
9 or you're looking at the Equal Protection Clause, which would
16:01:02 10 be consistent with Brumby, which was the Eleventh Circuit case
11 I was referencing. I apologize I didn't mention the name.

12 But Brumby was the Eleventh Circuit opinion where the
13 Eleventh Circuit recognized that both Title VII, as well as the
14 Equal Protection Clause, protected against discrimination on
16:01:20 15 the basis of transgender status.

16 THE COURT: So obviously Grimm is not binding
17 precedent here.

18 And Bostock, the majority said, you know, we shouldn't
19 prejudge what we might say about several other things,
16:01:39 20 including the conduct in Grimm. And yet, they denied cert.

21 Do you want to read any tea leaves on that?

22 MR. DOSS: I don't, Your Honor. Only because I don't
23 know -- it could have been a waiver issue. It could have
24 been -- as to the denial of cert.

16:01:56 25 THE COURT: All right. Anything else?

1 MR. DOSS: That's all, Your Honor.

2 We respectfully request that the Court issue the
3 injunction. We think that we've proven a substantial
4 likelihood of success on the merits, as well as the other
16:02:09 5 factors as laid out in our brief.

6 Thank you, Your Honor.

7 THE COURT: All right. United States.

8 MS. MONTAG: Good afternoon, Your Honor. Can you hear
9 me?

16:02:25 10 THE COURT: I can.

11 MS. MONTAG: I'm Coty Montag on behalf of the United
12 States. I intend to be brief.

13 At the outset of this hearing, the United States posed a
14 single question to the Court. Does criminalizing certain
16:02:39 15 medical treatments for transgender youth and only transgender
16 youth constitute a form of discrimination that's barred by the
17 Equal Protection Clause?

18 The testimony the Court has heard clearly demonstrates
19 that the answer is yes. And failing to enjoin Senate Bill 184
16:02:58 20 before it goes into effect in two days will immediately and
21 irreparably harm youth, families, and providers.

22 The balance of the equities strongly favors preliminary
23 relief.

24 The testimony the Court has heard demonstrates that we
16:03:14 25 have met the requirements for preliminary relief on the Equal

1 Protection claim. And I want to briefly touch on the elements
2 there.

3 First, the testimony set forth by the plaintiffs and
4 United States demonstrates a substantial likelihood of success
16:03:29 5 on the merits. Section 4 of Senate Bill 184 is subject to
6 heightened scrutiny because it discriminates on the basis of
7 sex and transgender status.

8 The law discriminates on the basis of sex by criminalizing
9 gender-affirming care only when that care is being provided to
16:03:46 10 transgender minors. The law prohibits transgender minors from
11 obtaining care that has been well established as medically
12 appropriate and necessary while imposing no comparable
13 limitation on other youth for obtaining these same forms of
14 care.

16:04:01 15 And Your Honor asked us to address *Bostock*, *Glenn*, and
16 *Grimm*. And I just want to be very clear that these cases make
17 clear the discrimination against transgender people is sex
18 discrimination. And as Mr. Doss pointed out, in the Eleventh
19 Circuit in *Glenn vs. Brumby*, this was in the Equal Protection
16:04:21 20 context.

21 So because this is sex discrimination, heightened scrutiny
22 must apply. And the burden is on the State to show that the
23 law serves important governmental objectives, and that the
24 means employed are substantially related to the achievement of
16:04:37 25 those objectives.

1 And I just want to note from Bostock, when Justice Gorsuch
2 said, Treating an individual differently because that person is
3 transgender unavoidably constitutes sex discrimination because
4 it rests on a person having one sex identified at birth, but
16:04:56 5 identifying with a different sex or gender today.

6 Your Honor, defendants' assertion that the law does not
7 discriminate based on sex is incorrect. There is no ambiguity
8 in the law about the class of minors that it targets. It
9 prohibits certain treatments only when used by those whose
16:05:13 10 gender identity is different from their sex assigned at birth.

11 Defendants cannot meet the standard under heightened
12 scrutiny. They cannot show that Section 4 of Senate Bill 184
13 serves important and governmental objectives, and that the
14 discriminatory means employed are substantially related to the
16:05:32 15 achievement of those objectives.

16 And I really want to touch on the substantial relation
17 piece here, Your Honor, and make sure I'm connecting it to the
18 testimony you have heard over the last few days.

19 First, as the Court has heard, the weight of medical
16:05:46 20 evidence confirms that the medical care that Senate Bill 184
21 forbids is widely accepted, safe, effective, and medically
22 necessary treatment for the health and wellbeing of some minors
23 suffering from gender dysphoria based on individualized
24 case-by-case consideration in accordance with well-established
16:06:05 25 guidelines.

1 And for that, Your Honor, I would refer you to the
2 testimony of Dr. Ladinsky, as well as United States Exhibit 7,
3 the declaration of Dr. Antommaria at paragraphs 23 to 38.

4 The Court also heard testimony that the medical research
16:06:22 5 supporting gender-affirming care is substantial rather than new
6 or experimental, and that parents and minors are able to
7 consent or assent to the risks involved.

8 And, again, I would refer to Dr. Ladinsky's testimony, as
9 well as United States' Exhibit 7 at paragraph 16 and 21, and
16:06:42 10 Plaintiffs' Exhibit 6, Dr. Ladinsky's declaration at paragraphs
11 7 and 47.

12 The Court has also heard testimony that individualized
13 treatment is the goal here and that there is no rush to
14 treatment under established guidelines for the care and
16:06:57 15 treatment of transgender youth.

16 Again, this is from the testimony of Dr. Ladinsky,
17 Plaintiffs' Exhibit 6 at paragraphs 9 to 13. It's very
18 important here to emphasize that serious review and
19 reconsideration at every step over a long period of time,
16:07:16 20 normally years, is involved here. And all of the standards of
21 care require a tailored approach based on an individual's
22 needs.

23 The Court heard testimony that the medical care provided
24 improves mental health for many transgender youth and reduces
16:07:34 25 the risk of anxiety, depression, and self-harm. As Dr. Hawkins

1 testified, these youth receiving gender-affirming care not just
2 survive, but thrive.

3 Again, I would refer to the testimony of Dr. Hawkins and
4 Dr. Ladinsky, as well as Plaintiffs' Exhibit 3 at paragraph 27,
16:07:53 5 and Plaintiffs' Exhibit 6 at paragraph 15.

6 The Court also heard testimony as to the many harms if
7 these minors are not treated, including depression, anxiety,
8 suicidal ideation, eating disorders, and substance abuse. And
9 we heard that from Dr. Hawkins and Dr. Ladinsky.

16:08:12 10 As Dr. Antommara testified this morning, the law puts
11 clinicians in the untenable position of either having to follow
12 state law and knowingly harm their patients, or face penalties,
13 including imprisonment and loss of their medical licenses.

14 Your Honor, the standards of care for treating transgender
16:08:37 15 individuals and particularly youth have evolved and will
16 continue to evolve. But at the end of the day, it is well
17 recognized that gender-affirming care can be and is an
18 appropriate treatment for gender dysphoria for some transgender
19 youth based on an individualized medical assessment in line
16:08:56 20 with accepted standards of care.

21 The well-recognized standards of care make clear that
22 these treatments should only be made after extensive
23 consultation with trained and qualified medical professionals,
24 informed consent of the parents and the patient, et cetera.

16:09:12 25 But defendants' response through Senate Bill 184 is to

1 simply criminalize access for transgender youth and only offer
2 counseling.

3 At a minimum, even if there are two sides to whether this
4 care is appropriate and effective and medically necessary,
16:09:28 5 which, of course, we don't concede, that doesn't support a
6 total ban, and a felony one at that. Instead, it supports
7 individualized assessments of patients, which is already the
8 status quo.

9 The State has repeatedly argued in its papers and during
16:09:45 10 oral argument that its legislative judgments are entitled to
11 deference, and that the State is not required to de facto
12 accept or adopt the conclusions or recommendations of a medical
13 association or anyone else.

14 But that's not what is at issue here under the Equal
16:10:01 15 Protection Clause. It is well established that if the State
16 makes the extraordinary decision of making a distinction or
17 classification based on sex, which this law does, the burden
18 shifts to the State to justify why it needs to take such a
19 drastic step and why such a classification is necessary and
16:10:20 20 justified. The weight of the evidence makes clear that the
21 State has failed to meet that standard.

22 Your Honor, I will not go into the other elements. We
23 believe we have shown irreparable injury, the balance of the
24 equities, and the public interests, and that they all justify
16:10:37 25 preliminary relief.

1 The United States seeks to preserve the status quo here
2 and ensure that transgender minors can continue to access
3 medically necessary and appropriate care while the
4 constitutionality of this law continues to be litigated.

16:10:54 5 And I will close by saying the issue before the Court
6 today is not whether someone's gender identity is fixed at
7 birth, or whether minors with gender dysphoria have a right to
8 gender-affirming care in every instance, or whether there's
9 evidence on both sides as to whether and when these treatments
16:11:11 10 are clinically indicated. Rather, the question is whether
11 Alabama can outright ban these treatments in every single
12 instance, and not only that, make it a felony to provide or
13 cause such care. Under the Equal Protection Clause, it cannot.

14 The United States asks this Court to maintain the status
16:11:31 15 quo, and grant its motion for temporary restraining order
16 and/or preliminary injunction.

17 THE COURT: All right. Thank you.

18 Before you begin, Mr. LaCour, let me ask you the one
19 question based on the original plaintiffs' closing.

16:12:03 20 So if a parent drives their child to Georgia for this
21 treatment, does that trip the statute?

22 MR. LACOUR: Your Honor, I think the key is to look at
23 the words "engage in" or "cause, prescription, or
24 administration," not just cause in a vacuum. You always read
16:12:22 25 statutes in context. And "engage in" also "prescribe or

1 administer" are shedding light on cause. I don't think just
2 driving them there would be causing the administration. I
3 think -- another way to think about it is what would be cause?

4 So engaging in the administration of the puberty blocker
16:12:44 5 for the prohibited purposes would be, for example, if a doctor
6 used a needle and engaged in the administration.

7 Now, if the doctor ordered a nurse practitioner to do that
8 instead, the doctor might not be engaging in the
9 administration, but the doctor would be causing the
16:13:03 10 administration.

11 So I don't think buying somebody a bus pass or driving
12 them to the doctor would be that closely related such that it
13 would be causing the administration. This is not a butterfly
14 flaps its wings in the Amazon, as the plaintiff suggested in
16:13:22 15 the reply brief. This is, I think, much tighter to the other
16 key verbs in the statute.

17 THE COURT: All right. Go ahead with your closing.

18 MR. LACOUR: Thank you, Your Honor.

19 Over the last couple of weeks, and the last two-and-a-half
16:13:42 20 days, the Court has heard about children and families facing
21 very difficult situations. But as a matter of law, this is not
22 a difficult case.

23 As mentioned earlier, the State has wide discretion to
24 regulate areas of medical uncertainty. This has long been the
16:14:00 25 law. As the Supreme Court reaffirmed in Gonzalez, at 550 U.S.

1 163, when the State, quote, undertakes to act in areas fraught
2 with medical and scientific uncertainties, legislative options
3 must be especially broad.

4 So when there is competing evidence about benefits and
16:14:19 5 risks, the State can evaluate that evidence and make judgments
6 with all five million Alabamians in mind. That is a
7 well-established role of the State.

8 What this means is that in our federal system, a federal
9 court has an important, but limited role. It is not up to
16:14:38 10 federal courts to make the determination of the best treatment
11 options for any particular individual. Rather, the judge's job
12 is to determine whether the Constitution bars states from
13 regulating in a particular area of medical uncertainty.

14 So plaintiffs have not only failed to bear their heavy
16:14:58 15 burden of showing a lack of medical uncertainty, they have
16 confirmed that SB 184 does not discriminate on the basis of sex
17 or transgender status for reasons I will address in a moment.

18 Now, earlier -- and I apologize, Your Honor. I had
19 suggested that the AMA had supported the partial birth abortion
16:15:15 20 ban in Gonzalez. It does not appear they submitted an amicus
21 brief in this case, but numerous other medical groups did.

22 The California Medical Association, which represented
23 30,000 members, submitted a brief. The American College of
24 Obstetricians and Gynecologists submitted a brief. The
16:15:32 25 American Medical Women's Association, which was a national

1 organization of 10,000 women physicians, surgeons, and
2 physicians in training submitted a brief, as did the American
3 Public Health Association, the Medical Students for Choice, the
4 New York Obstetrical Society, and the University of Chicago
16:15:49 5 Hospital's Department of Obstetrics and Gynecology.

6 Even so, the Gonzalez Court did not hold that Congress was
7 somehow limited in its ability to regulate in an area of
8 medical uncertainty. Quite the contrary.

9 The Court refused to adopt a, quote, policy that would
16:16:09 10 strike down legitimate abortion regulations if some part of the
11 medical community were disinclined to follow the prescription.
12 Considerations of marginal safety, including the balance of
13 risks, are within the legislative competence when the
14 regulation is rational and in pursuit of legitimate ends.

16:16:29 15 Rational and legitimate ends. That is the language of
16 rational basis, Your Honor. That is not the language of strict
17 scrutiny.

18 Mr. Doss suggested it's different because it was an
19 abortion case. Well, abortion is an area of the law where for
16:16:43 20 half a century the Court has recognized a fundamental privacy
21 right. And there is no similar right to gender transition
22 procedures. And these are quite new. They're quite new on the
23 medical scene.

24 So if anything, the fact that abortion was involved in
16:16:59 25 that case cuts in the State's favor, not in favor of the

1 plaintiffs.

2 Plaintiffs' strict scrutiny rule we need to think about.
3 What are the limits of it? I mean, it would destroy the system
4 for FDA drug approval, because anytime a plaintiff could -- who
16:17:17 5 is a parent and has a child who wants some sort of drug that
6 the FDA has decided is still experimental at this point, and it
7 is not -- if the FDA has not decided yet whether the risks
8 outweigh the benefits, or vice versa, the child would have no
9 right to the drug, the parent would have no right to the drug
16:17:37 10 for the parent's use, but the parent would have a right to get
11 it for their child.

12 But, of course, during the last two years of the pandemic
13 as the FDA was considering the safety and efficacy of the COVID
14 vaccine, there was no substantive due process right for a
16:17:53 15 parent to cut in line and sue and say, I think this is going to
16 be really helpful for my kid. My kid is immunocompromised.
17 They really, really need it.

18 That was not -- it's not a Fourteenth Amendment issue.
19 There was not a right. Because what they have done is the same
16:18:08 20 thing the Eleventh Circuit has rejected expressly in the
21 Morrissey case, which we discussed at opening.

22 They have defined the right with broad generality, a broad
23 right to provide medical -- to basically care for your child.

24 But as the Eleventh Circuit and the Supreme Court have
16:18:28 25 recognized, when we're dealing with substantive due process to

1 the extent that's even a thing, you need to really describe the
2 right with great specificity, and then root it in the history
3 and traditions of our nation.

4 And there is no deeply-rooted right in the history and
16:18:45 5 traditions of America that guarantees a parent the right to
6 puberty blockers or cross-sex hormones for their child,
7 particularly when the state of science is so uncertain.

8 If the plaintiffs are right, that this is a strict
9 scrutiny case, then federal judges are going to become medical
16:19:03 10 boards that are going to be adjudicating issue after issue
11 after issue. And it is going to be difficult to imagine what
12 sort of medical judgment is going to be available, what sort of
13 medical judgment a state could still exercise, at least when it
14 comes to parents desiring the drugs for their children.

16:19:24 15 So, I mean, turning to some of the facts, I mean, for
16 years, rates of gender dysphoria in youth had remained stable,
17 as did the patient profile which was typically male. And for
18 years, the standard treatment for gender dysphoria was watchful
19 waiting.

16:19:39 20 And that is not nothing, as Mr. Doss suggested. That is
21 careful therapy with other types of mental health support to
22 help relieve children's distress as they explored their still
23 forming identities. The sort of thing that would have been
24 very helpful to Ms. Wright, who you heard from earlier today,
16:19:57 25 but instead received the fast-track approach.

1 Now, all that has changed, and quite dramatically and
2 quite quickly. If you look at Defendants' Exhibit 7 at page
3 26, there is a very telling chart showing the increase in young
4 people seeking treatment in gender clinics in the UK and
16:20:16 5 Australia from 2010 to 2020. I mean, that data is particularly
6 useful because they have national health-care systems that
7 track all of these patients; whereas, we have a more
8 disaggregated system in the U.S., where a plaintiff -- not a
9 plaintiff -- a patient might go to a clinic and then later
16:20:33 10 never show up again, and you lose track of them.

11 So, if anything, the fact that some of these studies are
12 coming up out of Europe suggest that they should be given more
13 weight because they just have better data on the people.

14 If you look also at Defense Exhibit 7 at page 31, that is
16:20:51 15 two maps. That's the chart, the explosion of gender clinics in
16 the last 15 years. So as of 15 years ago, there were two
17 clinics in the entire country.

18 Now we're into the 50s or 60s. UAB is only seven years
19 old. And, of course, we have heard a lot about UAB, but
16:21:10 20 they're not the only place in Alabama where you can receive
21 these sorts of drugs.

22 Ms. Wright had a different situation in Georgia. But I
23 mean, really any doctor with a script could potentially write
24 for some of these -- for some of these drugs, and there could
16:21:27 25 be other clinics in the future that open up.

1 And in light of this new evidence, many countries are
2 waking up to the grave uncertainty and the risks that this new
3 approach to treating gender dysphoria has for youth.

4 You heard from leaders from two of the prominent gender
16:21:44 5 clinics, Dr. Hawkins and Dr. Ladinsky. Neither of them had
6 substantial familiarity with the careful assessments and
7 conclusions reached by these progressive nations.

8 Hawkins transcript page 39, 1 through 4 said, Are you
9 generally aware of it? Response to one of these studies? And
16:22:03 10 she said she was not.

11 Dr. Ladinsky stated at page 124 through 125, I confess
12 that I am not intimately associated with the position
13 statements of other nations.

14 But listen to what Sweden had to say. Quote, For
16:22:18 15 adolescents with gender incongruence, the board deems that the
16 risk of puberty-suppressing treatments with puberty blockers
17 and gender-affirming hormonal treatment currently outweigh the
18 possible benefits. And the statement further emphasized both,
19 quote, the continued lack of reliable scientific evidence
16:22:35 20 concerning the efficacy and the safety of both treatments and
21 the, quote, new knowledge that detransition occurs among young
22 adults. It's Defense Exhibit 11 at page 3.

23 Similarly, the UK's review went through all of these
24 studies, unlike the AAP's review that the plaintiffs have
16:22:58 25 relied on. Their conclusion was again, quote, Any potential

1 benefits of gender-affirming hormones must be weighed against
2 the largely unknown long-term safety profile of these
3 treatments in children and adolescents with gender dysphoria.

4 And that same review found only five uncontrolled
16:23:14 5 observational studies suggesting any benefit, and it graded
6 those studies as, quote, a very low certainty, closed quote.
7 In other words, medical uncertainty. It's Defense Exhibit 10
8 at page 14.

9 And, again, I implore the Court to look again to the
16:23:34 10 appendix to Dr. Cantor's declaration where he has devastating
11 explanation of all the problems in that AAP report that
12 Dr. Ladinsky, I believe, had referred to.

13 Finland similarly said that in light of the available
14 evidence, gender reassignment of minors is an experimental
16:23:54 15 practice. It's Defense Exhibit 12 at page 8.

16 In France, they said, quote, there is no test to
17 distinguish a structural gender dysphoria from transient
18 dysphoria in adolescents. And because, quote, the risk of
19 overdiagnosis is real, closed quote, treatment should consist
16:24:10 20 only of, quote, psychological support as long as possible for
21 children and adolescents expressing a desire to transition,
22 closed quote. That's Defense Exhibit 13 at 2.

23 France even went on to emphasize, quote, the addictive
24 character of excessive consultation on social networks as
16:24:29 25 harmful to the psychological development of young people and

1 responsible for a very important part of the growing sense of
2 gender incongruence. It's not just the French.

3 We had Ms. Wright here talking about going on Instagram,
4 seeing these images, learning these things, and it, in turn,
16:24:48 5 causing her to feel this dysphoria that she mistook for
6 transgender status with great consequences for her personally.

7 So the evidence -- what WPATH itself has said shows that
8 desistance rates are between 50 and 90 percent. That's Defense
9 Exhibit 18, page 11.

16:25:10 10 Now, Dr. Hawkins, of course, said that unlike any other
11 gender clinic this history they are, quote, exceptional at
12 identifying who is, in her words, truly transgender. That is
13 whose gender dysphoria is going to persist. But they don't
14 have studies to back up this newfound certainty.

16:25:26 15 When asked to respond to evidence that only 25 percent of
16 detransitioners tell their doctors that they have
17 detransitioned, they said that they had read the study, but
18 hadn't noticed that finding. That's Hawkins transcript page 53
19 through 54.

16:25:41 20 And I will try to make sure I'm moving quickly, Your
21 Honor. I do want to get into some of the legal issues.

22 But, I mean, I think it's important that even if
23 plaintiffs could guarantee whose gender dysphoria is likely to
24 persist, there is still great uncertainty about whether these
16:25:59 25 treatments even provide long-term benefits.

1 On the other hand, the risks are potentially quite severe.
2 Recall Plaintiffs' Exhibit 41. This is the informed consent
3 form from UAB. It detailed numerous risks, including heart
4 disease, liver disease, blood disorders, loss of sexual
16:26:18 5 function, and sterility.

6 And there are still other risks that are unknown because
7 the long-term consequences of using puberty blockers and then
8 cross-sex hormones such that a child never goes through natural
9 puberty has simply not been studied with any rigor.

16:26:34 10 So in light of this uncertainty, how could plaintiffs
11 possibly -- or how could -- yeah. How could plaintiffs
12 possibly obtain informed consent from either children or from
13 their parents?

14 The plaintiffs couldn't even explain the difference
16:26:47 15 between the refusal to take consent for a mastectomy or a
16 female circumcision for that matter, and their willingness to
17 take consent for cross-sex hormones that they agree can cause
18 equally, quote, permanent irreversible damage to basic
19 reproductive function. That was Dr. Ladinsky's testimony,
16:27:04 20 pages 133 through 136.

21 And you also heard from Dr. Antommara that he does think
22 that some young people could consent to mastectomy. So even
23 some uncertainty and some conflict between the different
24 witnesses that the plaintiffs have presented.

16:27:22 25 And worse still, even if puberty blockers and cross-sex

1 hormones would help -- and it's not clear that they do help --
2 because we can't know if a child is likely to persist, we
3 really are in a situation like the hypothetical RSV vaccine
4 that was discussed with Dr. Koe that would sterilize 5 percent
16:27:43 5 of its recipients. That treatment would never be approved by
6 the FDA, and Dr. Koe testified quite rightly she would never
7 recommend to that her patients. The risks are just too great.
8 In other words, it would be banned.

9 And here we have sterilizing treatments with far less
16:28:02 10 guarantee of any sort of benefit at the end of the day.

11 So turning to the Arkansas order. I think this will be a
12 good framework for addressing some of the legal issues, and I
13 will try to thread some of the key facts, as well.

14 I am going to get to Equal Protection. I will also
16:28:20 15 address Glenn, Bostock, and Grimm.

16 So first, at the beginning, there are statutory
17 differences between the Arkansas law and the Alabama law. We
18 think the Arkansas law is perfectly constitutional. That case,
19 of course, is up on appeal at the Eighth Circuit. We would
16:28:37 20 recommend Arkansas's briefing to the Court because it can
21 explain in greater detail some of the problems with the Brandt
22 decision.

23 For one thing, the Arkansas law lacks extensive
24 legislative findings that support SB 184.

16:28:51 25 Second, our law is narrower because there is no provision

1 that expressly bans referrals.

2 Third, Alabama's law also expressly leaves open
3 psychotherapy as a treatment for gender dysphoria.

4 And fourth, our law more specifically defines the
16:29:07 5 treatments that are barred by the law.

6 But turning to the opinion, first heightened scrutiny.
7 The Brandt decision said the transgender people constitute at
8 least a quasi-suspect class.

9 What the Court did not do is cite any evidence to back
16:29:23 10 that up. They have said in Grimm, and that was it. Contrast
11 that with the last time the Supreme Court had before it the
12 occasion to determine whether there was a new quasi-suspect
13 class, that's the Cleburne case, 1985.

14 I particularly recommend the Fifth Circuit's opinion that
16:29:42 15 was facially -- or at least the releasing of which was reversed
16 by the Supreme Court. There the Fifth Circuit had a great
17 amount of record evidence of the discrimination against
18 intellectually disabled people from the '80s and going back.

19 Such robust evidence that Justice Thurgood Marshall, who
16:30:04 20 would have concluded that the intellectually disabled were a
21 quasi-suspect class, stated that in his view, quote, the
22 mentally retarded were, in 1985, a group that suffered eugenic
23 marriage and sterilization laws and whose treatment paralleled
24 the worst excesses of Jim Crow. That was the record.

16:30:23 25 And even then, the Supreme Court said, this is not a

1 quasi-suspect class. We are not going to take that very
2 dramatic step in designating a new quasi-suspect class.

3 So plaintiffs have submitted substantially no evidence to
4 try to back up their claim that there's a quasi-suspect class
16:30:40 5 here. I think for that reason, they have not made that
6 showing, and the Brandt Court -- I have not looked all the
7 evidence that was in front of the Brandt Court, but I know the
8 analysis is incredibly thin. That would be one grounds to
9 distinguish.

16:30:53 10 Next, the Court applied heightened scrutiny, because
11 assuming there was suspect class, the Court held that the --
12 Arkansas's law, quote, refers to gender transition which is
13 only sought by transgender individuals, closed quote.

14 Now, that's wrong as both a legal matter and a factual
16:31:12 15 matter. And I mean, I think the facts that we have established
16 here also clearly distinguish that decision from this case.

17 But first on the law, we've discussed it. We've briefed
18 it extensively. The Supreme Court's 1974 decision in *Geduldig*,
19 that was a case where California covered many medical
16:31:33 20 treatments, did not cover pregnancy, however, in their state
21 insurance plan.

22 A group of women sued saying this is discrimination on the
23 basis of sex because only women can get pregnant. And the
24 Supreme Court said this is not discrimination on the basis of
16:31:48 25 sex, because there are two categories here -- people who are

1 pregnant and people who are not pregnant. While it's only
2 women in the people who are pregnant category, there are men
3 and women in the people who are not pregnant category.

4 Therefore, not discrimination on the basis of sex.

16:32:03 5 Now, we can do you one better in this case, Your Honor,
6 because there are certainly -- it's undisputed, there are
7 people who are transgender who do not seek these treatments.
8 And so in that category of people who don't seek these
9 treatments are both transgender and nontransgender persons.

16:32:20 10 But then unlike in *Geduldig*, in the other category, there
11 are also transgender persons and nontransgender persons who are
12 in that category.

13 Dr. Ladinsky testified that at 106, lines 3 through 8,
14 that some of her patients did start puberty blockers, but later
16:32:36 15 stopped and had their gender identity agree with their
16 biological sex.

17 So -- and Dr. Hawkins's -- in the phrasing of Dr. Hawkins,
18 these patients would not be, quote, truly transgender. Thus,
19 as plaintiffs agree, not every person who is diagnosed with
16:32:55 20 gender dysphoria is transgender, and at least some people who
21 are not transgender receive puberty blockers and cross-sex
22 hormones. Indeed you heard from one such person today,
23 Ms. Wright.

24 Justifications for the law. The Brandt Court said that,
16:33:14 25 quote, defendants state that the Arkansas general assembly

1 passed Act 626 in response to a recent judicial ruling of the
2 UK High Court of Justice of England and Wales and in Arizona
3 District Court. And then the Brandt Court found that neither
4 of these authorities were persuasive or precedential.

16:33:37 5 In contrast, as I mentioned earlier, we have extensive
6 legislative findings backing up our law. This was not simply
7 hereto interesting Court decisions. Let's go ahead and enact
8 this new law.

9 Then the Court further found that the reliance on the UK
16:33:53 10 court's ruling was not credible because the State allows the,
11 quote, same treatment for cisgender minors as long as the
12 desired results conform with the stereotype of their biological
13 sex.

14 Now, I don't know all the evidence that was before the
16:34:08 15 Brandt Court, but on our record here, we have shown that
16 puberty blockers for precocious puberty is not the same
17 treatment as puberty blockers for gender dysphoria. I mean,
18 that's the whole premise of the FDA having on-label and
19 off-label distinctions. They're different treatments, even if
16:34:25 20 similar medications might be used.

21 So here -- I mean, in the context of hormones, giving a
22 certain dose of testosterone to a boy with a measurable hormone
23 deficiency to bring him up to normal range is not the same
24 treatment as giving the same dose of testosterone to a
16:34:42 25 biological female to bring her levels up to a range that would

1 be abnormally high for females.

2 As our endocrinologist Dr. Laidlaw explained at
3 Defendants' Exhibit 3, pages 3 through 5, that first type of
4 treatment involves an endocrine diagnosis rooted in objective
16:35:00 5 testing of hormone levels.

6 In contrast, a gender dysphoria is a psychological
7 diagnosis. The fact the treatment for one might bear some
8 passing resemblance to treatment for the other does not make
9 them the same treatment.

16:35:14 10 And further, as discussed in treating gender dysphoria
11 with hormones carries unique and serious risks, including many
12 of those risks listed on the informed consent form from UAB and
13 that are outlined by Dr. Laidlaw on pages 17 through 19 of his
14 report.

16:35:31 15 Dr. Ladinsky herself appeared to recognize this fact when
16 she was asked about two hypothetical boys. As you might
17 recall, one of them had low testosterone and was -- needed some
18 testosterone to get up to normal levels. The other had normal
19 testosterone and wanted more to get to abnormally high levels
16:35:51 20 so he could build more muscle mass. She agreed on page 143 of
21 the transcript that those would be altogether different
22 treatments.

23 A fortiori, when one child is given puberty blockers or
24 hormones for an endocrine disorder, to move them into a normal
16:36:08 25 range for their age and sex, that is an altogether different

1 treatment than using similar doses of those drugs to treat a
2 psychological disorder and move them into abnormal ranges.
3 It's simply not the same.

4 Dr. Koe basically confirmed the same thing on pages 185
16:36:27 5 and 186 of the transcript from yesterday. She stated that she
6 performed testicular exams only on males, but not on females.
7 And when she's treating transgender males for gender dysphoria,
8 she would give them testosterone, but she would not treat a
9 transgender female for gender dysphoria with testosterone.

16:36:46 10 She was asked, Are you discriminating based on sex? And
11 she said no. She was, quote, giving each patient the care for
12 which their sex and gender requires. It's not discrimination
13 to recognize biological realities that you must recognize to
14 perform medicines.

16:37:03 15 For the same reasons, Alabama doesn't discriminate because
16 of sex. This also helps illustrate why our case is much
17 different from Glenn vs. Brumby, Bostock, or Grimm, for that
18 matter.

19 To greatly simplify the Glenn, the Bostock cases, I think
16:37:24 20 a similar analysis would apply to Grimm, although Grimm was a
21 bathroom case and not an employment case. In both Glenn and
22 Bostock, there was a biological male who was fired because he
23 wanted to show up at work presenting as a woman. Even though
24 men and women are both able to wear dresses, only the man would
16:37:43 25 lose his job for wearing one to work.

1 But here there is no way to provide a testicular exam to
2 females. It would be a different treatment altogether. And
3 prescribing testosterone to a boy to get his levels up to a
4 normal boy's levels cannot be done for a girl, because she is a
16:37:59 5 girl and not a boy. It would be a different treatment
6 altogether.

7 Second, Bostock and Brumby were premised on the notion
8 that sex is irrelevant to employment decisions. But sex is
9 obviously relevant to medical decisions. Dr. Koe confirmed as
16:38:17 10 much. Dr. Ladinsky confirmed as much.

11 So either there is no discrimination here, or if there is
12 some sort of discrimination, although the Court has said in the
13 Nyugen decision that recognizing biological realities is not a
14 stereotype, like a law could not be more tailored. Like you
16:38:37 15 have to know the sex to know what the treatment even is. The
16 fit could not be tighter.

17 So moving on. The Brandt Court found that Arkansas's law
18 was not substantially related to the regulation of ethics of
19 the medical profession because gender-affirming treatment is
16:38:54 20 supported by medical evidence that has been subject to rigorous
21 study.

22 Now, the record before Your Honor shows that these
23 statements are simply not accurate, at least on the record here
24 in Alabama. The one certainty in this field is that there is
16:39:15 25 no certainty. There are not rigorous studies, and we have

1 presented ample evidence of medical uncertainty.

2 The Brandt Court did not address similar issues. They did
3 not address the Gonzales decision. They did not address the
4 European reviews. They didn't recognize the weakness of the
16:39:33 5 evidence for these interventions.

6 The Court also said, quote, Every major expert medical
7 association recognizes that gender-affirming care for
8 transgender minors may be medically appropriate and necessary.

9 The Court, of course, never addressed the international
16:39:49 10 literature reviews.

11 And another key distinction, Your Honor, not -- some of
12 these weren't even available at the time the Court was ruling
13 on August 2nd, 2021. There's been more evidence coming to
14 light. As Dr. Cantor said, to the extent the pendulum is
16:40:03 15 swinging, it is swinging in Alabama's direction.

16 Turning again to substantive due process, which I
17 addressed at the beginning, the Brandt Court I think made some
18 of the same errors that the plaintiffs are making here finding
19 that the plaintiffs in that case had a fundamental right to
16:40:21 20 seek medical care for their children and in conjunction with
21 their adolescent child's consent and their doctor's
22 recommendation make a judgment that medical care is necessary.

23 Of course, that, again, defines the right far too broadly
24 and misstates the right. And the Court never identified a
16:40:41 25 history or tradition of that particular right, and similarly

1 ignored the implications of the new right. For example, every
2 FDA decision would be subject to strict scrutiny.

3 Turning to the First Amendment, Brandt -- there was a
4 First Amendment claim in Brandt that the claim there centered
16:41:00 5 on the physician referral provision, which we do not have one
6 of those in Alabama's law.

7 Now, finally, one thing -- another big thing I think that
8 distinguishes our case from Brandt -- an issue we have with the
9 Court's decision, it never once mentioned the risks of these
16:41:23 10 procedures for kids. You will not see them mentioned at all.
11 Not a word about bone health, not a word about heart disease,
12 blood disorders, sexual disorders, or infertility. Not a word
13 about a young women like Sydney Wright and the 13 other
14 declarants who are either detransitioners or the parents of
16:41:44 15 troubled youth, like not a word about any of them. And these
16 people are suffering from having been experimented on.

17 But in this case, Your Honor, you should consider those
18 risks. In this case, the only endocrinologist who has
19 addressed whether treating someone at Tanner Stage 2 will
16:42:02 20 affect fertility is Dr. Laidlaw. This is at page 9 of Defense
21 Exhibit 3, the Laidlaw report. He lays this out.

22 Awareness of the Tanner stage of the developing adolescent
23 is also useful to assess for maturation of sex organ
24 development leading to fertility.

16:42:18 25 For girls, menstruation and ovulation occurs about

1 two years after Tanner Stage 2, and will typically be at Tanner
2 Stage 4 or possibly 3. For boys, the first appearance of sperm
3 is typically Tanner Stage 4. If puberty is blocked before
4 reaching these critical stages, the sex glands will be locked
16:42:35 5 in a premature state and incapable of fertility. His similar
6 statements addressing the problems of sexual dysfunction that
7 come from these treatments.

8 In contrast, you heard from Dr. Antommara today. It is
9 his view that clinics don't need to tell patients and families
16:42:55 10 that puberty blockers will almost certainly lead to cross-sex
11 hormones before kids are started on that pathway. That is
12 their standard of care. And these are half truths to create a
13 false consensus with the health and the lives of children on
14 the line.

16:43:09 15 And to Mr. Doss's assertion, there is no evidence of lax
16 methods in the U.S. They are completely ignoring the 14
17 declarations from -- and the testimony of Ms. Wright, for that
18 matter.

19 There is plenty of evidence of this both in studies and in
16:43:27 20 sworn declarations. There will be more and more of this unless
21 states step forward and protect their children, because the
22 medical community is not doing their job.

23 Now, addressing vagueness. We touched on it briefly.
24 Again, the key language is, quote, no person shall engage in or
16:43:46 25 cause, prescribing, or administering puberty-blocking

1 medication to stop or delay normal puberty. Of course, the
2 cross-sex hormones provision that follows after that.

3 Here's how it works. If a doctor writes a prescription
4 for puberty blockers, that would be engaging in prescribing the
16:44:01 5 puberty blockers. If the doctor orders the nurse practitioner
6 at the clinic to write the prescription, the doctor would be
7 causing the prescription of the puberty-blocking medication.

8 Similarly, if the doctor gave a shot of testosterone for
9 purposes of gender transition, she would be administering. If
16:44:18 10 she ordered the nurse to do it, she would be causing.

11 But if a patient merely posted on Facebook that she had a
12 great experience at the clinic, she would not be engaging in or
13 causing the prescription of puberty blockers, even if a friend
14 read the testimony or reached out to the clinic and later got
16:44:34 15 it.

16 If Reverend Eknes-Tucker tells a congregant that she might
17 receive help for her gender dysphoria at the clinic, he hasn't
18 engaged in or caused the prescribing or administration of
19 anything.

16:44:45 20 And if a parent merely drives his child to the clinic, he
21 hasn't engaged in or caused the prescription of any drugs.

22 Now, if the parent injects the medications, I think he
23 probably has engaged in the administering the puberty blockers.
24 But merely driving him to the clinic, having conversations with
16:45:02 25 their child, being there for them, that is not administering,

1 engaging in, or causing the administration of these drugs.

2 And, Your Honor, I think that's why Reverend Eknes-Tucker
3 wasn't ready to go and file a lawsuit on April 8th like
4 Dr. Ladinsky or Mr. Jeff Walker were. He didn't think that
16:45:23 5 this law applied to him. But when he got a call on Monday,
6 April 16th, from one of Dr. Ladinsky's lawyers, he was excited
7 to -- I believe his phrase -- was make a difference.

8 But as we discussed earlier today, the good news and the
9 bad news for Mr. Eknes-Tucker is that while he did help SBLC
16:45:43 10 and Lightfoot get back into court, and his conduct does not
11 violate the law, so he doesn't have to worry about that, the
12 bad news is he likely doesn't have standing to be challenging
13 this law. So he's going to have to make a difference some
14 other way going forward.

16:45:58 15 Now, one thing to equities I want to address.
16 Dr. Ladinsky stated that she would be concerned that if SB 184
17 goes into effect, her patients --

18 THE COURT: I will say I think you have kind of run
19 through your time, but I was easy with Mr. Doss. I will be
16:46:14 20 with you. But I would say we are close to wrapping it up.

21 MR. LACOUR: Very, very close, Your Honor. I am ready
22 to go home myself. But I appreciate all of the time and
23 consideration you have given to this very important case.

24 I will just say, Dr. Ladinsky was -- stated she was
16:46:30 25 concerned that if SB 184 went into effect, her patients would

1 have to stop taking testosterone cold turkey.

2 Now, going back to language of the statute -- and this is
3 something I have tried to emphasize in the cross-examination --
4 it says, do not engage in or cause the following practices for
16:46:47 5 the purpose of attempting to in effect cause a gender
6 transition.

7 Being responsible and tapering somebody off of these
8 artificial hormones is not for the -- would not be using the
9 hormones for that prohibited purpose. Just like using
16:47:05 10 testosterone for that boy with the low T to get him up to a
11 normal range is not an improper purpose, either. So we don't
12 think that's something that anyone needs to worry about.

13 Now, in closing, Mr. Doss suggested that SB 184 is somehow
14 a grand experiment. Now, with all due respect, I mean, there
16:47:28 15 were only two of these clinics in 2007. UAB has only been on
16 the scene for seven years.

17 In hitting the pause button, Alabama is halting an
18 experiment on our kids, and nothing in the Constitution or
19 federal law requires Alabama to expose children to these
16:47:46 20 unproven and sterilizing treatments. For that reason, the
21 preliminary injunction motions should be denied.

22 If you have any questions, I would be happy to answer
23 them. Otherwise, we rest.

24 THE COURT: All right. I thank you all for your
16:48:00 25 arguments. Let's talk housekeeping just for a minute.

1 Obviously, in the long term, we have got to put together a
2 discovery plan and a trial track. Have the parties talked
3 about that?

4 MR. LACOUR: We have not yet, Your Honor.

16:48:15 5 THE COURT: Do you want to give me your 30-second idea
6 of how long you think how long a track this should be on? My
7 guess is it should be expedited.

8 MR. LACOUR: Your Honor, there is a fair amount of
9 discovery we think we would like to get, including some
16:48:31 10 third-party discovery. Plaintiffs have put at issue the
11 credibility of the AAP, some of these other organizations. We
12 have some questions about donations that the Endocrine Society
13 might be receiving from the prescription drug manufacturers who
14 are profiting off of this use of their puberty blockers and
16:48:49 15 their cross-sex hormones. That might be relevant assessing the
16 credibility of these institutions.

17 I mean, we will certainly move with all deliberate speed,
18 but we would want a chance to fully develop the record.

19 THE COURT: So give me a number.

16:49:06 20 MR. LACOUR: My colleague Mr. Davis is usually a
21 little better at this. I'm just a humble appellate attorney.

22 THE COURT: All right.

23 MR. DAVIS: Mr. LaCour's welcome to correct me, but
24 before we -- we would like the chance to confer about that. We
16:49:18 25 have been so focused on getting ready for this hearing --

1 THE COURT: I get that.

2 MR. DAVIS: -- we really haven't thought about what
3 all we want to do. If we could have until the first of the
4 week to talk about it amongst ourselves and let Your Honor know
16:49:29 5 what our thoughts are.

6 THE COURT: Maybe you can confer with the plaintiffs
7 and y'all can present a joint thought on that.

8 MR. DAVIS: I think we could be ready for like a Rule
9 26 conference the first of the week. Give us a chance to talk
16:49:42 10 internally on each side, then with each other, then report to
11 Your Honor by -- well, by middle of the week or end of the
12 week.

13 THE COURT: Let me say this. Here is all I am trying
14 to accomplish. You know, if we just want to put this on a
16:49:55 15 regular trial track, I will just leave it to y'all, and we will
16 go from there. I was just guessing that somebody might want
17 this to be on an expedited track. And so that's why I am
18 raising the issue.

19 MR. DOSS: That would be our preference, Your Honor.
16:50:09 20 I mean, our thought just right now would be like maybe a
21 six-month discovery window. I mean, I think we are going --

22 THE COURT: That was the number in my mind was
23 six months. So, you know, to the extent --

24 MR. DAVIS: That might be fine with us after we
16:50:23 25 confer.

1 THE COURT: All right.

2 MR. DAVIS: But I would like that chance to talk about
3 that specifically.

4 THE COURT: I get it. No problem. No problem.

16:50:29 5 I will leave it to the parties to talk. To the extent you
6 agree, great. To the extent you don't agree, we can sort that
7 out.

8 All right. Thank you for your arguments. All very good.
9 I appreciate every witness that we've had in the last two days.
16:50:47 10 Thank each of you.

11 Obviously, this was filed on April the 19th. My staff
12 attorneys and I have done nothing since it was filed but work
13 on this case. We will be doing nothing else but this case
14 until we get an order.

16:51:02 15 Just like all of you, I want a well-reasoned order that is
16 right on the law. And so I just ask that everybody be patient.

17 I can't say that it's going to be out tomorrow, or the
18 next day, or the next day, except to say we are not going to
19 work on anything until we get it out and we get it right.

16:51:22 20 So I thank you all. And we're adjourned.

21 (Whereupon, the above proceedings were concluded at
22 4:51 p.m.)

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CERTIFICATE

I certify that the foregoing is a correct transcript from the record of proceedings in the above-entitled matter.

Christina K Decker

05-08-2022

Christina K. Decker, RMR, CRR
Federal Official Court Reporter
ACCR#: 255

Date