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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO

PAM POE, et al.,

Plaintiffs,

v.

RAÚL LABRADOR, et. al.,

Defendants.

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

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

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Attorneys for Plaintiffs

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

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

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

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

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

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

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

EXECUTED ON October 13, 2023.

Respectfully submitted,

/s/ *Alexia D. Korberg*
Alexia D. Korberg

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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO

PAM POE, et al.,

Plaintiffs,

v.

RAÚL LABRADOR, et. al.,

Defendants.

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

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

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Attorneys for Plaintiffs

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

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

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

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

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

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

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

EXECUTED ON October 13, 2023.

/s/ Richard Eppink

Richard Eppink

Exhibit A

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO
SOUTHERN DIVISION
Case No. 1:23-cv-00269

PAM POE, by and through her parents and next friends, Penny and Peter Poe; PENNY POE; PETER POE; JANE DOE, by and through her parents and next friends, Joan and John Doe; JOAN DOE; JOHN DOE,

Plaintiffs,

-against-

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

Defendants.

September 21, 2023
10:04 a.m.

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

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Also Present:

CHRIS HANLON, Videographer

ROB BENIMOFF, Concierge

~oOo~

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

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

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

MR. MAY: Good morning. My name

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

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

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

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

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

JAMES M. CANTOR, the Witness herein, having first been duly sworn by the Notary Public, was examined and testified as follows:

EXAMINATION BY MR. MAY:

Q. Good morning, Dr. Cantor.

A. Good morning.

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

I understand that you have been deposed before, right?

A. That's correct.

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

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

A. I understand.

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

A. Understood.
Q. As I said I am going to ask some questions today. I will do my best to ask clear questions; however, I am not always successful in that goal. If at any time you don't understand my question or you need any clarification, please ask for that clarification, okay?
A. Yup.
Q. And if you don't ask for clarification of any of my questions I will assume that you understood them as posed; do you understand that?
A. Yes.
Q. Is there any reason you can't testify truthfully and honestly today?
A. No.
Q. And you understand that you're testifying today under oath?
A. Yes.
Q. And you understand that oath is the same oath that you would take in a courtroom in front of a judge?
A. Yes.
Q. Since this deposition is

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

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

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

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

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

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

A. I understand.

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

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

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

A. Mine is in the next room.

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

A. That is correct, yes.

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

A. About six.

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

MR. RAMER: Objection to the form.

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

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

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

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

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

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

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

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

associations that have put forth clinical guidelines?

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

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

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

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

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

A. Mr. Wilson and Mr. Ramer.

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

A. Not that I recall, no.

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

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

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

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

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

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

A. Yes, I understand.

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

A. No, I did not.

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

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

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

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

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

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

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

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

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

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

A. I have submitted an expert report, yes.

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

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

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

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

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

A. Yes, I do.

Q. Have you ever publicly spoken about HB 71?

A. No, I have not.

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

A. No, I have not.

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

A. No.

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

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

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

MR. RAMER: Objection to the form.

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

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

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

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

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

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

Q. And yes, that would be the

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

MR. RAMER: Objection to form.

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

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

A. Yes, that's fair.

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

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

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

A. Yes, I have that open.

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

case?

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

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

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

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

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

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

A. No, I am not.

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

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

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

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

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

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

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

But nothing, again, substantive.

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

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

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

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

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

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

Q. So just to make sure I

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

A. Yes, that is correct.

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

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

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

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

A. Yes, I got it.

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

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

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

A. As best as I can tell from the

first pages, yes.

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

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

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

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

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

A. That is correct.

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

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

Q. What is the focus of your private practice?

A. Sex and couples therapy.

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

A. Currently, approximately ages 25 and up.

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

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

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

MR. RAMER: Objection to the form.

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

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

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

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

Q. I appreciate that explanation.

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

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

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

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

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

A. Yes, that's correct.

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

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

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

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

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

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

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

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

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

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

Q. So I just want to understand

that a little bit better.

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

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

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

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

on.

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

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

Similarly --

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

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

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

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

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

A. 50 to 100 per year, perhaps.

Q. Individual patients or individual sessions?

A. Individual patients.

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

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

under the age of 16?

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

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

A. That is correct.

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

A. Roughly two dozen perhaps.

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

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

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

Of the approximately two dozen

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

MR. RAMER: Objection to the form.

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

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

use a wide range of phrases describing their experiences.

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

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

perception of their gender was a pertinent or relevant issue.

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

Q. Let me try this a different way.

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

MR. RAMER: Objection to the form.

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

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

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

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

on by people who for whom it's legitimately said their sexual orientation is about being humiliated or beaten. That is their genuine sexual orientation. To such a person they will often experience humiliation at being called, for example, effeminate, so they find themselves sexually aroused by it. They know it's meaningful. They experience it as core to their being, but it's not actually about gender itself. It's being attributed to gender. But for that person, they actually will become, you know, happier and more fulfilled being able to use the masochism and being able to use the experiences of humiliation within a, for example, kinky setting. So they will sometimes engage in gender atypical behaviors, but not because transition would help them engage in it, but because it provokes from other people in, as I say, in kinky kinds of settings, it gets them the kind of behavior and the kinds of partners and the kind of opportunities that they want.

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

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

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

MR. RAMER: Objection to the form.

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

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

MR. RAMER: Same objection.

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

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

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

MR. RAMER: Objection to the

form.

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

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

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

If it's somebody who just needs

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

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

MR. RAMER: Objection to the form.

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

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

A. Yes, that's correct.

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

Indiana?

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

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

Q. Sure.

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

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

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

MR. BENIMOFF: Exhibit 3 has been introduced.

A. I got it.

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

A. Yes, I do.

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

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

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

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

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

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

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

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

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

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

A. Hold on one second.

Q. Sure.

A. Yes, I am at 59.

Q. Starting at line 21 you were asked:

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

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

about right, yes."

Did I read that correctly?

A. Yes, it would seem so.

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

MR. RAMER: Objection to form.

A. No, that was at that time.

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

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

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

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

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

MR. RAMER: Objection to the form.

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

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

counseling to?

MR. RAMER: Same objection.

A. Again, about another six to eight.

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

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

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

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

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

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

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

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

A. Not regularly, correct.

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

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

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

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

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

A. Again, I can't automatically or

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

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

Q. In the last three months how

many patients under the age of 18 have you seen?

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

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

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

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

to consult without interacting with the patient directly?

MR. RAMER: Objection to the form.

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

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

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

MR. RAMER: Objection to the

form.

A. That is roughly correct. Again, I would have to check my calendar for more precise numbers, but that's roughly it.

Q. Okay.

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

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

(Off the record.)

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

BY MR. MAY:

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

disagree with that assessment?

MR. RAMER: Objection to the form.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

whatever the person's situation is.

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

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

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

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

To say I did not diagnose, in

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

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

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

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

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

question. The question was that the person was unsure and needed help figuring out whatever their situation was -- whatever their situation was. Psychoeducation, as we call it, demonstrating the different possibilities.

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

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

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

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

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

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

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

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

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

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

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

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

Q. You mentioned these patients

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

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

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

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

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

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

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

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

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

Q. Have you ever diagnosed anyone

under the age of 18 with gender dysphoria?

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

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

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

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

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

A. Yes.

Q. How many times?

A. Oh, goodness. Five or six.

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

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

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

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

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

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

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

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

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

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

A. Yes.

Q. How many?

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

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

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

MR. RAMER: Objection to the form.

A. Yes.

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

MR. RAMER: Objection to the form. Vague.

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

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

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

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

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

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

A. The early 2000s.

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

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

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

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

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

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

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

A. That is correct.

Q. And you're not an endocrinologist?

A. That is correct.

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

suppressors?
A. That is correct.
Q. And you've never prescribed hormones for hormone therapy for trans individuals, correct?
MR. RAMER: Objection to form.
A. Or anybody else, that is correct.
Q. And all of these patients that we have been discussing today, these have all been patients that you saw in Canada?
A. Yes, that is correct.
Q. And you have never seen a patient in the United States, correct?
A. Correct. Again, my hesitation -- I am trying to think if there is an exception. I have never had a face-to-face or video -- the cases in the U.S. have been consultations with their clinicians. But I haven't seen a -- myself seen or directly or video directly, had clinical contact with a client in the U.S., with a client in this family of issues in the U.S.
Q. If you can pull up Exhibit 2

again, which is your CV.

A. Got it.

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

A. Yes.

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

A. That looks correct, yes.

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

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

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

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

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

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

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

MR. RAMER: Is there a question?

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

MR. RAMER: Objection to form.

A. That one --

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

Entry number 54 is an article

about gender identity, gender issues; is that fair?

A. Yes, very explicitly.

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

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

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

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

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

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

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

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

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

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

Let's send you into brain surgery. That's not how it works.

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

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

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

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

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

MR. RAMER: Objection to the form.

A. No, I don't think so.

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

Can you explain to how you draw that distinction?

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

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

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

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

A. Correct.

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

A. I'm there.

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

A. That is correct.

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

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

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

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

A. Yes.

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

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

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

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

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

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

A. That sounds right.

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

A. Correct.

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

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

Q. I noticed that does not appear

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

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

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

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

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

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

corporate client I'll call them.

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

A. Correct.

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

MR. RAMER: Objection to the form.

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

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

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

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

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

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

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

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

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

(Off the record.)

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

BY MR. MAY:

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

A. Yes.

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

A. Yes.

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

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

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

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

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

A. Yes, I was.

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

A. Yes, I did.

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

A. That is correct.

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

A. Yes, I have it.

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

struggle on my end now.

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

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

MR. RAMER: Objection to the form.

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

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

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

Do you see that?

A. Yes.

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

A. Yes.

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

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

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

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

Q. Are there circumstances under

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

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

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

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

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

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

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

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

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

no government law saying scientists must investigate this.

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

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

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

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

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

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

MR. RAMER: Objection to the form.

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

Q. Can we turn to --

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

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

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

(Off the record.)

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

Afternoon Session

1:00 p.m.

JAMES M. CANTOR, having been previously duly sworn, was examined and testified further as follows:

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

EXAMINATION (Continued)BY MR. MAY:

Q. Dr. Cantor, if you could please

turn to Exhibit 1, which is your declaration.

A. I have it.

Q. And please turn to paragraph 20.

A. I am there.

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

A. Yes.

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

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

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

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

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

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

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

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

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

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

capture the situation.

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

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

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

patient wants.

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

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

MR. RAMER: Objection to the form.

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

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

in England?

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

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

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

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

Is it possible for an

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

A. Is it possible, yes.

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

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

MR. RAMER: Objection to the form. Vague.

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

Q. So you don't recall whether or

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

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

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

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

A. I am there.

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

Do you see that?

A. Yes.

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

research clinics?

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

Q. Do you speak Finnish, Dr. Cantor?

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

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

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

the conclusions.

Now, of course, the articles that were included in their systematic reviews are written in English. And so, the appendicis of the report that lists all of the studies that were included and all of the studies that were excluded, the lists are in English and I am already familiar with it, with the papers that are in them.

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

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

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

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

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

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

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

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

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

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

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

their criminal codes in order to instantiate the rule.

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

A. I am there.

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

A. Yes, it does.

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

A. They use that phrase, yes.

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

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

Q. I am totally fine with SSS.

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

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

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

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

A. Got it.

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

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

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

MR. MAY: Yes.

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

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

A. Correct.

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

A. Yes.

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

A. Yes, according to its face page.

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

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

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

A. That's how it reads, yes.

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

A. Yes.

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

A. Yes.

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

A. Yes.

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

exceptional cases."

Do you see that?

A. Yes.

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

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

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

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

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

Does Sweden criminalize doctors for providing puberty blockers or

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

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

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

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

A. I am there.

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

A. Yes.

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

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

overapplication of medical interventions.

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

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

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

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

A. Yes, that's correct.

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

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

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

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

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

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

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

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

Q. Okay.

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

MR. RAMER: Understood.

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

A. I believe they included the

same exception, yes.

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

MR. RAMER: Objection to the form.

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

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

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

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

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

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

protocol?

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

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

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

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

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

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

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

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

needing to use their criminal regulations to enforce it.

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

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

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

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

MR. RAMER: Objection to the form.

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

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

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

A. No, I have not.

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

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

Q. Are you aware of how doctors in

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

MR. RAMER: Objection to the form.

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

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

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

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

Q. Fair to say you don't have any

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

MR. RAMER: Objection to the form. Vague.

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

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

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

Two clinicians can be doing completely different things and both declare themselves to be following the WPATH standards -- following the WPATH standards.

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

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

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

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

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

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

such communication.

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

MR. RAMER: Objection to the form.

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

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

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

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

A. When I was initially, initially

started with this case, yes.

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

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

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

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

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

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

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

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

MR. RAMER: Objection to the form.

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

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

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

So far we can't be confident at all. And so it's a matter of, so any decision-maker has to weigh the potential risks against the potential benefits. And even though we acknowledge that there could be exceptions, there is no good way to instantiate that exception, if we can't identify who might be the exception in the first place.

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

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

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

MR. RAMER: Objection to the form.

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

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

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

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

Do you recall that conversation we had?

A. Yes.

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

MR. RAMER: Objection to the form.

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

shouldn't be doing that.

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

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

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

And I was one of the outspoken

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

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

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

A. Yes, that's correct.

Q. Why were you an outspoken

advocate in favor of that -- strike that. Let me ask that question again.

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

MR. RAMER: Objection.

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

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

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

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

MR. RAMER: Objection to form.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(Off the record.)

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

BY MR. MAY:

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

MR. RAMER: Objection.

A. Yes.

Q. Can gender-affirming medical

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

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

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

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

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

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

A. Possible in some under certain circumstances, yes.

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

MR. RAMER: Objection to the form.

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

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

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

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

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

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

MR. BENIMOFF: Marked and renamed as Exhibit 6.

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

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

Q. Do you have Exhibit 6 opened?

A. Yes.

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

A. Yes.
Q. And you reviewed these and discussed these at length in your declaration, correct?
A. Yes.
Q. You would agree that the, although your criticisms of the systematic reviews that were commissioned, you would agree that the Endocrine Society did commission two systematic reviews in the development of these clinical practice guidelines, correct?
A. Well, it's not quite complete. They had two systematic reviews, one for puberty blockers. One for cross-sex hormones. They reviewed safety. But not the effectiveness of either one.
Q. You have some criticisms of the systematic reviews, but you don't disagree with the fact that there were two systematic reviews commissioned in the development of the Endocrine Society Guidelines, right?
A. Yes and no. Again, my

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

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

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

these clinical practice guidelines, right?

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

A. The criticisms I have aren't exactly of the systematic reviews themselves. My criticisms really are about the application and interpretation of the results of the systematic reviews. And again, given -- and given the application is to enact a risk-to-benefit ratio, they weren't systematic reviews of all of the necessary material. But that's not a criticism of the systematic reviews. That's a criticism of the question that was or a limited question that was put to the systematic reviewers and then people over-applying the systematic reviews to pertain to material that wasn't contained in the systematic reviews. And the other part just being the --

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

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

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

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

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

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

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

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

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

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

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

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

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

Q. And the heading is called "Evidence."

Do you see that?
A. Yes.
Q. The last sentence of that paragraph "The task force commissioned two systematic reviews."
Do you see that statement?
A. Yes.
Q. Do you have any reason to disagree with that statement?
A. Yes, it's incomplete.
Q. What is incomplete about the statement that the task force commissioned two systematic reviews?
A. What they reviewed.
Q. Do you see that sentence goes on to say "And used the best available evidence from other published systematic reviews and individual studies"?
A. Yes.
Q. So you would agree -- you won't agree. Let me strike that and let me try that again.
The Endocrine Society, in addition to the two systematic reviews that were commissioned, also relied on

other published systematic reviews and individual studies. "

Do you agree with that?

MR. RAMER: Objection to the form.

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

Q. And those other materials included other published systematic reviews, right?

A. That's what they said, but it's not exactly clear which ones there were, especially given that, given that year.

Q. If we could please go ahead and turn to --

A. Oh, I am sorry. And, of course, missing is the age range. The large, large majority of the information that they reviewed pertained to adults. Of both of those reviews the total number of studies that pertained to minors was one. It was exactly one study between both of those reviews, one study that was

about minors.

So it's only by removing those details that it starts sounding like that there were two systematic reviews. Yeah, one of which included zero studies about minors.

So by taking out the reviews of what removes that the entire process for minors included exactly one study. Which I name in my report and I think it's Table number 1 of my report, compared to the other systematic reviews, which list exhaustively all of the studies that were included in all of the systematic reviews.

So just generically saying reviews, a review of one study is not a review. It's just a study.

Q. So if we can please turn to page 10 of Exhibit 6, which according to the internal pagination is page 3878.

A. Got it.

Q. Do you see there is a table on that page called Table 5?

A. Yes, I do.

Q. And Table 5 describes the criteria for gender-affirming hormone therapy for adolescents, right?

A. That's their title for it, yes.

Q. And it's broken into two sections where the Endocrine Society first provides criteria that makes adolescents eligible for GnRH agonist treatment, right?

A. Yes. And as I say, one study that they reviewed was about cross-sex hormone treatment. The number of studies that they included for the puberty blockers was zero. This is based on zero studies.

Q. And the bottom half of the table is identified by the Endocrine Society as criteria that make adolescents available for subsequent sex hormone treatment?

A. Correct, that was the part that was based on one study.

Q. And when you say it's based on one study, you're referring to those two commissioned systematic reviews, right?

A. Right, the two of them put together found for minors a total of one study.

Q. And you're not considering any of the other articles, references and studies that are cited within the contents of the Endocrine Society Guidelines?

A. The purpose of a systematic review is to apply consistent criteria through all of them.

So the point of those not being included in the systematic review is that they would, you know, they didn't qualify, you know, they didn't meet the criteria for an even-handed identification of the appropriate research.

That isn't to say that one should necessarily ignore them. But one, of course, needs to acknowledge that there is a reason that they weren't of the methodological quality in order to, you know, be included in the systematic review to begin with.

Q. So if we look at the first half of Table 5, the adolescents eligible for GnRH agonist treatment?

A. Yes.

Q. You agree that the Endocrine Society lays out as one of the criteria that the adolescent has demonstrated a long lasting and intense pattern of gender nonconformity or gender dysphoria?

A. That's the text that they wrote, yes.

Q. And another criteria is that they require that the gender dysphoria has worsened with the onset of puberty?

A. Yes, that's the text that they included.

Q. And that any coexisting psychological, medical or social problems that could interfere with treatment, for example, that may compromise treatment adherence have been addressed such that the adolescent's situation and functioning are stable enough to start treatment?

A. Yes, they included that test.

Q. And that the adolescent has sufficient mental capacity to give informed consent to this reversible treatment?

A. That's their text, yes.

Q. Now, I will accept, and I know that you have strong disagreement with the inclusion of the parenthetical phrase "reversible," correct?

A. I think the phrase is being wildly misused and overinterpreted.

Q. You would agree that -- and those four criteria all need to be evaluated by a qualified mental health professional, right?

A. I would add other criteria to that.

Q. And there are other criteria --

A. I mean to the qualifications of the mental health professional. An unfortunate side effect of the polarization that's going on is that it's more than possible to engage in therapist shopping.

If you find, you know, one

mental health person that says, says no or you find a string of them that says no, it's always possible to find another, to find somebody who uses very low stands, to find somebody with an ideology bent, you know, in order to sign off on whatever, on whatever it is the patient wants. So in practice a qualified becomes indistinguishable from a willing.

Q. Are you aware of the qualifications of the various therapists and mental health professionals in the State of Idaho?

A. Only cursorily through the -- only cursorily in order to be able to receive a license or registration in general. But there does not exist a documentation for qualifications specific to being allowed to implement, implement the WPATH or any other criteria.

Q. Do you consider yourself a qualified mental health professional under these criteria?

MR. RAMER: Objection to form.

A. I am not aware of their issuing

criteria for what's qualified. I am not aware of WPATH or any of the other groups having any assessment, regulatory or supervisory powers at all. They merely use the word "qualified" but there is nothing in any of this that prevents anybody from calling themselves qualified. It's being used as a throwaway term.

Q. Do you agree that the Endocrine Society Guidelines say that coexisting psychological, medical or social problems that could interfere with treatment have been -- must be addressed?

A. Again, they include that --

MR. RAMER: Sorry, objection to the form. Sorry, I didn't want to cut you off. Objection to the form, and you can go ahead and answer.

A. They include that text, yes. But it's, as I say, unenforced, unchecked, unoperationalized in the context of the endochronological statement, in practice it's just saying we are not responsible for this. We just

handle the endochronological part and the mental health part, as long as you sign your name to the paper and you're responsible for it, you're responsible for it. Not us. But they issue no guidelines. They don't talk about how they would assess or that they even attempt to assess the qualifications of the mental health professional who is signing off on the medical transition.

Q. What qualifications would you want the mental health professional to have in order to make these determinations?

MR. RAMER: Objection to form.

A. That's tough to say in the current context. It's exactly because these questions have become as polarized and as controversial that they have that we, the healthcare professions and we the democratic societies require an objective evidenced means of making these decisions in order to be fair to people who disagree. Disagree in a healthy way, I mean.

Because that necessarily includes an empirical evidence-based means of deciding what the criteria for the patients are, that pretty much requires that the same empirically demonstrated, tested criteria be applied for the decision for which clinicians are qualified to do that.

So if somebody asked me that question 15 years ago, you know, I could relatively fluently suggest the basic parts of my field and the knowledge that's in it in order to say this is the kind of stuff a person needs to know in order to come to an educated clinical decision.

But because of the situation that's bringing these questions forth today, I would need to, and I think one would need to say, how do you know that those are effective. My best guess isn't good enough anymore as it would have been before these controversies emerged.

So I am still able and willing to describe the areas of the field that a

person needs to be able, needs to be fluent in in order to be able to assess the multiple possibilities that, of what might help a patient expressing gender dysphoria. But there hasn't been a test to demonstrate that, my hunch, my view, my opinion, for what the qualifications should be are, as I say, themselves empirically validated.

The one exception to that is the more general finding that has been shown in research about healthcare providers is that actual clinical experience in this or other relevant questions does not help. It does not improve clinical decision-making and level of clinical care. It increases the confidence of the clinician. But it does not improve actual clinical care, which is exactly the opposite of how most lay people think of it and including most of the legal systems where people kind of have this prejudice, hunch, myth. That more experience at performing this kind of care makes one better at this care.

The research does not support that.

Q. Are you a qualified mental health professional who would be able to make these determinations listed out here -- sorry, let me strike that and start over. I realize I am asking my question slowly.

Are you a qualified mental health professional who is able to make the assessments laid out in, under number 1 of Table 5 of the Endocrine Society Guidelines?

MR. RAMER: Objection to the form.

A. Again, without an objective set of what those criteria are it's hard to be definitive. At the same token, it's difficult to think of a set of criteria that wouldn't approve me while still being legitimate criteria at all.

I mean, there are people who would want to disqualify me, accusing me of whatever myth or stereotypes they have about me. But for objective criteria, again, it would be difficult to say which

ones I wouldn't -- what kind of criterion I wouldn't meet. Again, I'm limiting my own opinions to adults.

Q. You agree that the Endocrine Society lays out in its criteria for gender-affirming hormone therapy for adolescents that a qualified mental health professional has to confirm these points under number 1 in Table 5, right?

MR. RAMER: Objection to form.

A. Yes. As I say, it's an expression that that is essentially the coverage they are giving themselves. If it turns out the person's mental health status doesn't improve this is the opportunity for endochronologists to say, that wasn't our job.

Q. The Endocrine Society as part of that wants to ensure that -- strike that.

The Endocrine Society Guidelines lay out that a patient's coexisting psychological, social or mental problems that can interfere with the treatment have been addressed, right?

MR. RAMER: Object to the form.

A. Well, again, it's the same thing. They are saying if they have not been addressed, that wasn't our job. That's the fault of a clinician who sent the patient and cleared the patient before they came to our door.

Q. Unless a mental health professional -- unless a qualified mental health professional has confirmed that the patient doesn't have coexisting psychological, medical or social problems that could interfere with treatment or any such problems have been addressed, then the Endocrine Society Guidelines say that person is not eligible for GnRH agonist treatment, right?

MR. RAMER: Objection to the form.

A. Yes, that's what provides them the coverage.

Q. And the Endocrine Society Guidelines say that GnRH agonist treatment should not be started before 10 or stage 2, right?

A. That's a throwaway kind of requirement, because you can't block a puberty that hasn't happened. So the presence of that line is correct. But as I say, it's a pretty vacuous claim.

Q. You can't administer puberty blockers to pre-pubertal children, right?

MR. RAMER: Objection to the form.

A. There is no point to it. So as I say, it's a vacuous, it's a vacuous claim. It shouldn't be interpreted to indicate some sort of a conservatism on their part. It's an empty rule. Don't give medicine to a person who doesn't need the medicine. Okay, fine. As I say, it's an empty -- it's an empty rule.

Q. If a patient satisfied all of the criteria laid out in the first half of Table 5 under the heading of "Adolescents Are Eligible for GnRH Agonist Treatment If," if there were a person under the age of 18 who satisfied all of those criteria, should that person be able to obtain puberty blockers?

MR. RAMER: Objection to the form.

A. Well, to me able is a conclusion of what's a risk-to-benefit ratio. We have grossly insufficient information about the risks, and especially the benefits. The Endocrine Society did not include in their systematic reviews either the risks or the benefits of puberty blocking medication. So we simply do not know if they are able. We simply cannot assess the risk-to-benefit ratio. And they cite no evidence suggesting that they have it. It's an unanswerable question. We have slightly more information now than when they first wrote this.

I included in my report, in my response to a Dr. Baker, I included a table that had the exact year of this and the list of all of the studies, you know, by year, in order to, you know, demonstrate that at the time of this, the studies we had didn't exist. These criteria, indeed I think expire this

year. And they, I assume, are planning to update and reengage it.

The current set of the Endocrine Society -- their policies automatically give out, I think every five years, I think. So this is as out of date as their criteria.

I take that back. It's the AAP that just announced a redoing of it. But as I cite, the years on which this is based on the lack of research on which these statements about GnRHs are applied are all still true. So they came up with a policy, but it is not based on any research at all.

Q. Do you think that GnRH agonist treatment is appropriate under any circumstances for purposes of treating gender dysphoria?

MR. RAMER: Objection to form.

A. It can be, as we were discussing before. It has to have the caveats of it's possible, but mostly unknown, which is the whole trouble. We need to do the research in order to be

able to identify, assuming it's possible at all, to identify which people for whom it might be beneficial or at least give us a favorable risk-to-benefit ratio. If we can't identify which persons they are, that it's possible, is the question.

Q. I think you mentioned this earlier, if we can go back to your declaration, Exhibit 1, and look at Table 1, which I believe occurs right after paragraph 78. Or right before paragraph 78, I am sorry.

So the studies that you listed in this table, under Endocrine Society, the only one that you have listed is Klink?

A. Yes, that is the one study that their systematic review found.

Q. So to be clear, this table is discussing what was included in systematic reviews, right?

A. Correct.

Q. This table does not indicate what studies were relied on by the Endocrine Society in providing their

guidelines in addition to the systematic review?

A. That's correct. That's the job of the systematic reviews to apply that criteria to everything going on. Things that are excluded by a systematic review are excluded for an explicit reason.

Now the part that needs to be answered is that if this study didn't qualify for your systematic review, exactly why are you including it in your policy at all. If it wasn't good enough for the systematic review for the policy, what makes it good enough for the policy.

Q. This table also doesn't include other systematic reviews that were relied upon by the Endocrine Society except for the two that they commissioned, right?

A. The great majority, really, except for this one study, everything else in their systematic review is about adults.

So the other systematic reviews that they included were systematic reviews about outcomes and risks for

adults, not adolescents.

Q. And you applied the same criteria for what you included in the column for the WPATH?

A. Yes.

Q. And so just to be clear on that, because I thought that was a terrible question, personally. So in the column for WPATH, the articles listed there, are just the articles that were included in the systematic review commissioned by WPATH, right?

A. Correct, that's the point of the systematic review is to exclude everything with the explicit criteria, which says, these are the studies good enough to, you know, be in.

If you say, oh, the studies after setting your criteria, finding that, oh, I don't like the studies that meet my criteria, so let's include these other studies that I wanted to include all along. That's now gaming the system. The entire purpose of the systematic review is to disallow that kind of cherry

picking.

Once you add or read studies that were excluded by a systematic review, as I cite, that's spoiling the whole point of trying to be objective and avoid cherry picking. That's merely claiming that you're avoiding cherry picking and then throwing more cherries into the basket after the fact.

Q. If we can turn to paragraph 143 of your declaration.

MR. RAMER: Sorry, Philip, did you say 143?

MR. MAY: Yes.

MR. RAMER: Thank you.

Q. The first sentence of this paragraph reads "The social media voices today loudly advocate 'hormones-on-demand' while issuing hyperbolic warnings that teens will commit suicide unless this is not granted."

Did I read that correctly?

A. Yes.

Q. What do you mean by the phrase

"hormones-on-demand" in quotation marks?

A. That there should not be an assessment or gatekeeping process. That obtaining, obtaining these medications is itself a civil right rather than an assessment of risk-to-benefit ratios.

Q. The Endocrine Society does not endorse providing hormones-on-demand, correct?

MR. RAMER: Objection to form.

A. They don't use that phrase.

Q. We just looked at the criteria for the Endocrine Society for providing hormones, and there are specific criteria that should be met before gender-affirming medical care is provided, right?

MR. RAMER: Objection to the form.

A. Yes and no. The language that they use lacking any objective means of assessment allows for absolutely anything to happen with no comeuppance. There is nothing to stop anybody from calling anybody qualified.

So saying that it needs to be a qualified person, but you give no way of determining, assessing or supervising who counts as qualified, well, that's not a rule at all anymore.

Q. Are you aware of any doctor in Idaho providing "hormones-on-demand"?

A. I can't imagine a licensed healthcare provider making such a statement publicly. As I say, it's typically social media voices, people who refer to themselves as activists referring to engaging in such procedures as a civil right, and so on, who are expressing, without using the phrase, but expressing what is indistinguishable from operationally hormones-on-demand. But such voices and advocates don't have a license or insurance coverage to enable it.

It's people with nothing to lose and for whom it's very easy to say out loud in an anonymous social media account. It should be people deciding for themselves, and that's that.

But the clinicians themselves again -- there is one potential exception, but not in, not in Idaho. As I say, I am not aware of a licensed clinician describing themselves with such language.

Q. Are you aware of a licensed clinician in Idaho whose practices conforms as what you describe as hormones-on-demand?

A. No, I never looked.

Q. And the sentence here refers generally, to social media voices. There is no citations for that sentence, right?

A. Correct. I didn't try to find -- again, for example, specific quotes of specific tweets or -- do we still call them tweets -- posts on social media where somebody said so.

Q. So you're relying on your expert opinion for that, right?

A. I don't know really if it's an actual -- I don't know if I would call it my expert opinion. It's just, you know, like more than once it's a pretty

ubiquitous -- it's pretty ubiquitous.

Q. All right. Let's go ahead and shift gears just a little bit. In terms of assessing research literature, you believe that GRADE is the most widely used methodology for assessment of, for assessment of studies?

A. For clinical, clinical outcome studies, yes.

Q. And you're familiar with the literature underlying GRADE?

A. Yes, basically.

MR. MAY: Rob, we can go ahead and mark tab 19 as the next exhibit, which I believe will be 7.

(Exhibit 7, Article entitled "GRADE Guidelines: 3. Rating the Quality of Evidence by Balshem, et al.", was so marked for identification, as of this date.)

Q. What has been marked as Exhibit 7 is an article entitled "GRADE Guidelines: 3. Rating the Quality of Evidence by Balshem, et al." Do you see that?

A. Yes.
Q. You're familiar with this paper?
A. I can't say this specific paper. At least I would have to check my own notes to remember exactly which reference, which version of this it came from. But I know roughly the contents of it.
Q. Why don't you turn with me to page 2 of Exhibit 7 to the heading number 4.
A. I see it.
Q. You see the heading says "A particular quality of evidence does not necessarily imply a particular strength of recommendation"?
A. That's correct.
Q. And in the first paragraph underneath that section, the last two sentences read, "Although higher quality evidence is more likely to be associated with strong recommendations than lower quality evidence, a particular level of quality does not imply a particular

strength of recommendation. Sometimes, low, or very low quality evidence, can lead to a strong recommendation."

Do you see that?

A. Yes.

Q. Do you disagree with that statement?

A. That it can happen sometimes, no, I don't disagree.

Q. You can go ahead and turn to page 3 of Exhibit 7, section 5.

A. I am there.

Q. All right. And if we look at the very last paragraph of that section over in the right-hand column, the second to last sentence. Quote, "Although the processes for assessing quality are the same, authors" --

A. Hang on. Hang on.

Q. Yes.

A. I am sorry, redirect me to that sentence.

Q. It's about halfway through to the spillover of the paragraph on the right-hand column.

A. I got it. It's a couple of lines above the 6. Got it.

Q. It reads "Although the processes for assessing quality are the same, authors of systematic reviews and authors of guidelines will apply the criteria differently."

Do you see that?

A. Yes.

Q. Do you agree that's an accurate representation of how authors of systematic reviews and authors of guidelines can apply the GRADE criteria?

A. Again, removed from its contexts, it would suggest that it's more arbitrary as opposed to back in context, recognizing that it's necessarily a fault with the system and, therefore, something which we need to do our best to mitigate by having as objective as possible, you know, the determinations of what, you know, how quality is assessed.

Q. If you can go ahead and turn with me now to page 6, excuse me, page 5 of Exhibit 7. The internal pagination is

page 405.

A. I am there.

Q. The heading 10, "Conclusion."

A. Yes.

Q. The first sentence the authors note "In closing, we caution against a mechanistic approach toward the application of the criteria for rating the quality of the evidence up or down."

Do you see that?

A. Yes, I do.

Q. Do you agree with that statement?

A. Yes, essentially.

Q. The last sentence of that paragraph goes on to say "Fundamentally, the assessment of evidenced quality is a subjective process and GRADE should not be seen as obviating the need for or minimizing the importance of judgment or as suggesting that quality can be objectively determined."

Do you disagree with that statement?

A. No, not really.

Q. You say not really. What's the really part?

A. Well, it's the missing part of the obvious application of those specific sentences to, you know, to the particular conclusions relevant to this case.

What they were pointing out, perfectly legitimately, is that sometimes there is some wiggle room and some exceptions.

Well, what's missing is, of course, the rest of that argument. There is absolutely no evidence whatsoever to suggest that this is one of those exceptions.

Nobody has listed any of the, here is what the systemic reviews say and here is the part where we think they apply versus not. They simply ignore the systematic reviews.

So that -- well, I suppose, actually it's exactly the same as when discussing that there are potential theoretical exceptions among patients. Okay.

There can be exceptions. But if we don't have a means of justifying which exception identifying those exceptions, how do we know that, in that example, a given particular patient is, is an exception.

The identification that exceptions can exist doesn't mean that this patient is such an exception. For this document, it indicates that there are potential exceptions for when rating particular studies or particular literature.

Well, what's missing is any evidence to suggest that the particular studies that are being used in the systematic review are such exceptions. The insinuated argument is that if they can never exist an exception, therefore, this is one.

Well, no, wait a second. Demonstrate or show evidence that the studies that are being concluded, that are being involved in the systematic reviews of outcomes of a medicalized

transition are such exceptions. They are not.

Also missing from the argument is exactly as I listed in my table. There have been multiple systematic reviews of this literature. And they all came to the identical conclusion. The only groups coming to a different conclusion are people who are the managers of the clinics and are in a financial conflict of interest over the results.

So what exactly is the evidence that, you know, it's that the subjectivity here is on the part of several public healthcare systems versus the commercial system in the U.S.

So as I say, my really is the insinuated argument of where that's going to lead, because there can exist exceptions, therefore the rule doesn't apply to the present circumstance. No, what we are missing is the evidence that this is one of those exceptions. There is no such evidence.

Q. Okay. So I want to -- you said something towards the end there that I want to follow-up on.

"The only groups coming to different conclusions are people who are managers of clinics and are in a financial conflict of interest over the results."

What's your basis for that statement?

A. Primarily I'm referring to the sets of experts whose reports I have been evaluating and comparing to the literature itself. Again, for this particular case there is only Dr. Baker itself. But in the back of my mind it's the series of the same experts over and over again that I have been encountering in several different cases. I am including them. And, of course, the various professional societies which are, they are in charge of defending guild interest and defending guild interests, period. Such as groups such as the endochronological society, whose members

and funding come from the dues which are people who perform these procedures.

So, as I say, they are not being done by people or associations that lack a conflict of interest. They are coming from people and groups with a conflict of interest.

Q. Okay. So let's focus on -- you refer to Dr. Baker, but it's Dr. Brady?

A. I am sorry. Thank you very much.

Q. Let's talk about Dr. Brady. Dr. Brady is not the manager or director of a clinic, right?

A. Correct. She said in her report that 100 percent of her practice was these patients. So, again, a conflict of interest.

Q. She's not a manager or director of a clinic, right?

A. That is correct. She's an exception. As I say, in my head I am thinking of them as a large group and the important part is that they are in a conflict of interest. I refer to them as

directors, because the majority of them are. But that is correct, she is an exception. She's in the same conflict of interest, even though she's not the director of the clinic.

Q. Dr. Brady is a psychiatrist, right?

A. I don't remember if she said psychiatrist or psychologist.

Q. And sorry, and thank you for correcting me, she's a psychologist. She's not an M.D. Dr. Brady does not provide gender-affirming medical care, right?

A. Correct. She doesn't provide medical care. She conducts the mental health assessments which then enable the medical care.

Q. She does not herself provide medical care, right?

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

Q. Let me strike that and ask it differently. She herself does not perform gender-affirming medical care,

right?

A. Again, my hesitation is really just a quibble over words. The services she provides are not directly hormonal or surgical. But because these decisions are being made on a team basis include, and the team includes medical interventions, that, again, that is part of a hospital, you know, in a meaningful way everything in the hospital counts as medical. And there is many of the activists, you know, start including, refer to the entire process, including the assessments as medically necessary. But still require mental health assessment, as I said, what counts as medical, what counts as medical or not. And if she does it versus a psychiatrist doing it, it could be exactly the same report, but one counts as coming from one it's medical. And coming from the other, it's not medical, even though it's the identical service. As I say, it starts becoming quibbling over what counts.

Q. Sure. My question was really

directed toward prescription of puberty blockers and cross-sex hormone therapy.

A. Correct, she's a psychologist and would not be directly prescribing the hormones or performing the surgeries.

Q. And it's your belief that psychotherapy should be the first line of treatment, correct?

A. That is what the research is most consistent with, yes.

Q. So shouldn't Dr. Brady be advocating for more psychotherapy?

MR. RAMER: Objection.

Q. Under her conflict -- sorry. According to your logic, shouldn't Dr. Brady be advocating for more psychotherapy and advocating against gender-affirming medical care?

MR. RAMER: Objection to the form.

A. I don't know about should be. But -- I don't know what I could add to that. I'm not sure if it should be. If 100 percent of her clinical time is already accounted for, it's moot.

Q. You think a source of compensation can have an undue influence on a person's perspective?

A. It certainly can, yes.

Q. And I believe that you've estimated that about 80 percent of your current income comes from expert services like this?

A. Last year and this year. I have no control over it. This is really up to the American legislatures, how quickly they pass these regulations and then how quickly they get sued. And then, you know, for many of them I get a phone call. I have no reason to think that this is permanent. I can't help but point out that I am a scientist. Nobody becomes a scientist for the money. If money were my motivator, then I would have gone into, you know, clinical work to begin with. But that, you know, I am a scientist.

By pure coincidence, you know, relatively late in my career, even though I have always, my entire career, just

given away to whoever would ask, you know, whatever information about my field I could. This very bizarre, unpredictable wave in society has just changed how things work.

So I've, essentially, put my private practice primarily, most of it, on hold for as long as this lasts. And then, you know, presumably I will switch back when this is over, which could be anytime, which could be anytime.

Q. Would being paid by an advocacy group influence an opinion?

A. Again, it certainly can. But I haven't said anything, you know, in any of these cases that I haven't been saying for many years. In fact, the thing that brought me to the attention of these groups was my fact-check of the AAP, now five years ago, on my own time. Perfectly free. Just because the material, I could see what was going on. I could see that it was dangerous. What the public needed was the actual information.

So just on my own time, because I am interested in the material, I just ran a fact-check. Well, at the time, it was the first, really, peer-reviewed publication on the subject, on the subject matter.

So when the various cases started coming forth, presumably, the various legal representatives needed to find an academic who knew the material, and there weren't many. There continue not to be many. I am one of the few, because, exactly because I am already on record. I have nothing to lose. I have nothing to defend. I have nothing really to gain. I just switch what it is that my, my time is allocated to. And presumably, whenever this round of cases finishes, things will switch back.

Q. Dr. Brady could just as easily change her practice in the same way, right?

MR. RAMER: Objection to form.

A. I have no idea. I have no idea what her other interests, expertise,

alternatives are.

Q. You have never practiced in the U.S. medical care system, right?

A. I volunteered for parts of it. I was a research assistant doing medical research at Boston VA Hospital. And then came to Canada.

MR. RAMER: If there is a good breaking point coming up, we have been going about an hour.

MR. MAY: I am coming up to one.

Q. Being compensated by a group that advocates for the provision of puberty blockers and cross-sex hormone therapies could influence a person's opinion, right?

A. Could, yes.

Q. And similarly being compensated by a group that advocates against the provision of puberty blockers and cross-sex hormone therapy could also influence an opinion, right?

A. It could.

MR. MAY: We can go ahead and take a break.

THE VIDEOGRAPHER: Thank you. This is the videographer. The time is 3:17, and this ends media file 4.

(Off the record)

THE VIDEOGRAPHER: We are back on the record. The time is 3:25. This begins media file 5.

MR. MAY: We can go ahead and mark tab 25 as the next exhibit. Maybe we should have done that during the break. I believe that will be Exhibit 8.

(Exhibit 8, Article entitled "GRADE Guidelines 4, Rating the Quality of Evidence, Study Limitations (Risk of Bias)" by Guyatt, et al., was so marked for identification, as of this date.)

BY MR. MAY:

Q. Dr. Cantor, let me know when you have that up.

A. Got it.

Q. Exhibit 8 is an article entitled "GRADE Guidelines 4, Rating the Quality of Evidence, Study Limitations

(Risk of Bias)" by Guyatt, et al.

Do you see that?

A. Yes, I do.

Q. Are you familiar with this document?

A. Roughly.

Q. If you can turn with me to Section 8 of this article, which is page 410 by the internal pagination.

A. I am there.

Q. The first paragraph, second sentence reads that "First, empirical evidence supporting the criteria is limited. Attempts to show systematic difference between studies that meet and do not meet specific criteria have shown inconsistent results. Second, the relative weight one should put on the criteria remains uncertain."

Do you see that?

A. Yes, I do.

Q. And this is in a section titled "Limitations of GRADE's Approach of Assessing Risk of Bias in Individual Studies," right?

A. Yes, and again, acknowledging their use of bias as not the synonym for prejudice.

Q. Absolutely. This is bias in a very specific context, right?

A. Yes, it's in the scientific method version of bias meaning how close it is to a pressure pushing in a single direction.

Q. Absolutely. Do you agree with GRADE's statements here in that first paragraph?

A. For at that time. I would have to go and look and see what's happened in the decade since. I also think it's fair to say that, again, with that sentence taken out of the broader context, something is missing, something gets lost.

The sentence by itself, you know, would suggest that, therefore, it ought not be itself used where that's not the alternative. What's missing is if somebody can come up with a better system, great, let's test them. The

alternative is not, therefore, do what you want. This is, this is the best we have until, you know, but we need to fine point and tweak and change criteria but nobody has found anything better yet.

Q. If we can turn to page 413 with the internal pagination of Exhibit 8.

A. Yes.

Q. And in the bottom right-hand column, the first full paragraph, it starts with the sentence "The possibility of discrepant judgments between intelligent and well-informed review authors is more than theoretical."

Do you see that?

A. Yes.

Q. Do you agree with that that it's possible for discrepant judgments between intelligent and well-informed review authors?

A. Yes, that's the reason why these assessments have to be done by several people and for them to be able to hammer out where there are disagreements.

Q. And the paragraph goes on to

discuss different studies of deep vein thrombosis in airline passengers taking long flights. And if you turn to page 414. At the top of the page, the end of the spillover paragraph, it says that "Even after direct contact and discussion each group adhered to its own position, and it's possible that either group is correct."

Do you see that?

A. Yes.

Q. So possible for there to be reasonable disagreement among review authors even applying GRADE criteria, right?

MR. RAMER: Object to the form.

A. Yes. It is indeed possible.

Q. Okay. You can put this aside for now. I want to turn back to your declaration, Exhibit 1 and go to paragraph 108.

A. I am there.

Q. Here you're discussing the term "gender identity" in this paragraph, correct?

A. Mostly, really I am discussing people's common, a popular definition of gender identity using a non-scientific one, and trying to attribute to it all kinds of scientific attributes.

Q. You disagree with the idea that gender identity could be defined as a person's inner sense?

A. It can't be scientifically defined as an inner sense.

Q. What do you mean by scientifically defined?

A. Objective, verifiable and falsifiable.

Q. And you say that it's increasing popular to do this. Are you saying this is a new phenomenon?

A. That what's a new phenomenon?

Q. Defining gender identity as a person's inner sense?

A. Yes and no. It's use and application for decision-making is pretty new. It's been used before as just a general description to kind of characterize a phenomenon, generally at a

time earlier in mental health, where all of mental health was really just a series of metaphors and general descriptions. But again, now, in the social media age and when being used to justify medical transition of minors, it's being given the weight and consideration, not merely of a general description, but as a concrete objective criterion to justify physical interventions.

Where, as I say, it was used, it was originally just used as a general metaphor. But it's no longer being treated as a general metaphor. It's being treated as a physical objective unquestionable truth. That's what's new.

MR. MAY: If we can please mark tab 31 as the next exhibit. I believe that will be Exhibit 9.

(Exhibit 9, Article titled "The Recalled Childhood Gender Identity/Gender Role Questionnaire, Psychometric Properties" by Zucker, et al., was so marked for identification, as of this date.)

MR. BENIMOFF: Exhibit 9 marked and renamed.

A. Got it.

Q. If you can go actually to the second page of Exhibit 9, which is the first page of the real article.

A. So internal page 470?

Q. No, internal page 469. Just the cover page of the pdf is the cover page?

A. The cover page with the abstract, yes?

Q. Yes. So this is an article titled, "The Recalled Childhood Gender Identity/Gender Role Questionnaire, Psychometric Properties," by Zucker and others including yourself that was published in 2006, right?

A. Correct.

Q. Do you recall this article?

A. Really only vaguely. My participation was for the statistics.

Q. If you go to the second page of the article which on the internal pagination page 470 --

A. Got it.
Q. -- you'll see here that it says, the first, the very first full sentence "Gender identity has been defined as a person's basic sense of self with regard to maleness and femaleness" and then it cites articles from 1965 and 1968; do you see that?
A. That's right.
Q. Do you disagree with that statement?
A. Again, it depends on the context in which it's given. It's useful as a general descriptor of what's going on. And in back of those days that was perfectly appropriate. But it's inappropriate to use that as a literal statement of a basic scientific truth that would justify, you know, objective and physical interventions which is how it's being used now.
Q. I am not really understanding what you mean by -- I am having trouble understanding what you mean by a basic scientific truth.

A. Objective, verifiable, falsifiable.

Q. And isn't that the point of your design of the questionnaire in this article, in order to assess gender identity?

MR. RAMER: Objection to the form. And object, again, to not allowing the witness to finish his answer.

A. Yes, that was the purpose of the questionnaire.

Q. And that's to make gender identity verifiable and objective and falsifiable?

A. Towards that direction, yes. It wouldn't change the definition of gender identity. It would be a measure that would -- so that if two different clinicians in two different clinics in two different countries for that matter administered the same questionnaire, we would expect them to get the same set of answers. Therefore, we would be able to compare the outcomes of one clinic with

the outcomes of the other clinic, because they are both using the same, the same instrument.

But the instrument would not, no instrument can provide us with a definition of the construct that we're trying to measure.

Q. So you can use a survey in order to assess a person's gender identity; is that fair?

MR. RAMER: Objection to the form.

And, doctor, before you start to answer. Allow me to be able to interject the objections, thanks.

A. This isn't a survey.

Q. Apologies, a questionnaire.

MR. RAMER: Same objection.

A. And what was the question again?

Q. Is it fair to say that you can use a questionnaire in order to assess a person's gender identity?

MR. RAMER: Objection to the form.

A. That's what we call an empirical question. We can only find out if it's possible by trying to do it and seeing if we're successful.

Q. The purpose of this 2006 article here was to design such a questionnaire, right?

A. To contribute to the design of such a questionnaire in order to address some of the issues that are pertinent to the creation of such questionnaires.

Q. Has such a questionnaire been successfully designed?

MR. RAMER: Objection to the form.

A. I can really only compare it to my, to my prior analogy about asking does surgery work. There are many different kinds for many different purposes and there are many different possible answers. It works for this but not that. It has high quality for this purpose, but not for that purpose. It can pick up on certain things, but not on other things. It may have, you know, strengths and

weaknesses in different contexts.

Any one, any, pretty much any one study is unlikely to unravel a complicated set of questions ranging from determining how valid a construct is all the way through finding a valid way of measuring that construct. So it's a contribution to that literature. Well, it's one paper contributing to that literature. But it's very, very rare for, you know, any one study to single-handedly establish that kind of validity.

Q. You said that it's ranging from determining how valid a construct is all the way through finding a valid way of measuring that construct. Do you disagree with gender identity as a construct?

MR. RAMER: Objection to the form.

A. That's kind of a circular question. There are, for as long as people use different -- people use the phrase to mean different things in

different ways in different circumstances, and they can vary in the ways and circumstances in which it's valid.

So it's the -- so the unpacking is about is gender identity as being used in a given circumstance valid, but somebody else using it in another way in another circumstance, I guess, there can certainly be valid applications, applications of it that are valid in one circumstance, but not valid in another circumstance.

The identification of whether a construct is valid is -- my headphones are giving out. Hold on, I am just switching speakers. Can you still hear me?

Q. Yes.

A. But can I still hear you? Say something clever and devastating.

Q. I hope you can still hear us.

A. Try again.

Q. Can you hear us now, doctor?

A. Thank you. That was clever and

devastating, perfect.

So the research questions about, for establishing whether a construct is valid and for establishing how to measure a construct, go hand and hand. One begets the other. The better our measures get, the more we can validate a construct. The more valid a construct is, the more directly we can establish a way to measure it.

So as I say, each one study kind of contributes to that cycle. But there is nothing about it that really allows us to say gender identity is valid. That's part of that whole, part of that research we find and often do find it's valid in this way and this circumstance but not valid in that way or that circumstance. And it's from that theories of research that we find out what gender identity is.

But when the initial definition is merely an inner sense, well, you can't test an inner sense. It can't be used to determine the validity of a construct

and, as I say, you can't measure it. So that's what makes it not a valid scientific definition, even though some people find it an adequate descriptor when somebody's, when the phrase was first getting used, when somebody's main purpose was really to differentiate it from sexual orientation.

Q. So just looking back at this article, this defines gender identity as a person's basic sense of self.

Do you view a basic sense of self to be different from an inner sense of self?

A. Largely overlapping but not identical. And the same issues apply. Again, when we wrote this paper, you know, these kinds of issues were not, were not controversial. The main purpose to defining gender identity was to differentiate it from, from sexual orientation. But it wasn't getting used, you know, to make the kinds of dramatic physical objective decisions to which it's being applied now. In order to

justify, you know, objective physical dramatic interventions we need equivalent high level of research. A metaphor and analogy doesn't cut it in the way that it does in just getting a basic description.

Q. And while the goals in this article was to develop or contribute to the development of a questionnaire to measure and assess gender identity as defined as a basic sense of self, right?

A. I am hesitating on the "as defined." Because to say as defined is to add that, and we know that this is the correct definition, and anything outside of that definition we would exclude, which is --

Q. I am just taking from what's in the paper.

MR. RAMER: Objection to the form. And objection, again, to counsel interrupting the witness's answer.

A. It's not just in the paper. The paper is one piece of a larger puzzle, together with all of its

references, the conversation going on around it and absent the current controversies around it. It was and theoretically still is always possible that during the development of such questionnaires that we find that, oh, it was the definition that we were using that was preventing us from coming up with whatever reliable or valid questionnaire as opposed to this, each one feeding the other kind of information.

But we can't in that cycle of measures and validity just say this is the definition and now our choice is to find something to measure that. No, no. We are giving this our best guess given what we have. We might have to tweak the questionnaire or the instrument or we might have to tweak what we are using as the definition. Each of these feeds what we know about the other.

Q. Does this paper, which has been marked as Exhibit 9, does it advocate for changing the definition of gender

identity, away from what's written in the beginning of the paper as a person's basic sense of self?

MR. RAMER: Objection to the form.

A. No, not that I recall.

Q. And in the next paragraph it starts with "Over the years various assessment tools have been developed to measure both gender identity and gender role in children."

Do you see that?

A. Yes.

Q. Do you agree that gender identity is measurable?

A. Again, that's the same interrelated set of questions. There is nothing in this questionnaire or in my report that challenges the validity of gender identity itself. It challenges defining gender identity in a way that cannot be tested at all.

Q. This paper, though, defines gender identity as a person's basic sense of self with regard to maleness and

femaleness, right?

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

A. No, not exactly. It acknowledges and describes that, you know, in the conversation, you know, in the literature to which it was contributing, that's the basic idea we were aiming for.

But that's not how the phrase is being used today which is to take that basic description and to accept it as a literal truth.

This paper was trying to find ways to tap into it but that's different from defining, concretizing, making unquestionable, leaving out the possibility that the definition was wrong:

This is a decent definition of gender identity, then we would be able to, and now we have a series of questions and the actual construct is the correlation matrix we call it, is the interrelatedness amongst each of the

variables that we have identified as associated with each other.

But to use a phrase such as inner sense and say, therefore, it cannot be, a person reporting it can't be questioned, that there can't be any physical evidence for it that we must take as literal truth, the person's self-report.

No, that's not a scientific. That is take a non-scientific or pre-scientific construct and switching from, in this paper, we would be taking something that was untested, with the way the phrase is being used now is to, as I say, express something as untestable.

Q. Your paper does not conclude that the definition laid out at the beginning of the paper is incorrect; does it?

A. Correct, in the context of the paper we were not -- it required only a general description of the phenomenon we were going after. There was nothing in the paper that was along the lines of

"because this is an inner sense, therefore," and then assuming the validity, the validity of it. It was asking questions. If this is what it is, then a person should give whatever series of answers.

For example, with a questionnaire, you know, once, after developed, one can administer questionnaires to groups of people which would in turn allow us to say these people are expressing this about their gender identity and those people are expressing that about their gender identity.

But if one simply stops and says that's a person's inner sense, well, then it's no longer possible to disagree with what somebody says their inner sense is.

Q. So I just want to redirect you back to my question, however. The paper does not conclude that the definition of gender identity that you laid out at the beginning of the paper is incorrect,

right?

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

A. That was not the subject of the paper and not an indication of any of the results.

Q. If we can turn back to your declaration, Exhibit 1.

A. Got it.

Q. And I want to go to paragraph 139, please.

A. Yes.

Q. So in this section of your report you distinguish between suicidality and suicide, correct?

A. Well, the research literature on them does, and I am just summarizing it.

Q. Sure. You agree that suicidality is a serious issue, right?

A. Yes.

Q. And you agree that suicidality is something that should be addressed --

A. Yes.

Q. -- in a patient presenting?

Sorry. You agree that suicidality is something that should be addressed in a patient that presents with indicators of suicidality?

A. Yes, absolutely.

Q. You go on to discuss, if we turn to paragraph 148, you discuss a systematic review in paragraph 148 by McNeil.

A. Yes.

MR. MAY: I want to go ahead and pull that up. So if we can please go ahead and mark tab 29 as the next Exhibit, Exhibit 10.

(Exhibit 10, Article entitled "Suicide in Trans Populations: A Systematic Review of Prevalence and Correlates," by McNeil, et al., was so marked for identification, as of this date.)

MR. BENIMOFF: Exhibit 10 marked and renamed.

A. Got it.

Q. So Exhibit 10 is an article entitled, "Suicide in Trans Populations:

A Systematic Review of Prevalence and Correlates," by McNeil et al, right?

A. Yes.

Q. And this was published in 2017, and it's the same article that you cite in paragraph 148 of your declaration, right?

A. Yes, it is.

Q. I want to go ahead and skip forward to the discussion. And turn to page 8 of the article which is 348 by the internal pagination. And I apologize, this isn't skipping ahead to the discussion, this is still the results.

A. I am there.

Q. Do you see the heading for most of this page is entitled "Trans-Related Variables and Suicidality"?

A. Yes.

Q. And if you look to the bottom of the left-hand column basically towards almost the end of the column, McNeil reports that "In contrast, however" --

A. I am sorry, I thought you were reading from it, go ahead.

Q. I am reading from the article, I apologize, if that's not clear. The left-hand column, bottom paragraph, and it's four or five lines from the bottom?

A. Yes.

Q. "In contrast, however, Bauer, et al (2015), reported less suicidal ideation for those undergoing a medical transition compared to those who were considering it."

Do you see that?

A. Yes, I do.

Q. And you don't disagree with that assessment by McNeil of the Bauer article?

A. I don't disagree with their describing the result. But again taking that out of context it's easy to misinterpret what it means or its indications, I should say.

Q. And if you go to the right-hand column, staying on this same page, the first full paragraph. And it starts with "In terms of the specific medical interventions that people might undergo,

Colton Meier, et al (2011), found a small but nonsignificant decrease in lifetime prevalence of suicide attempt among a group of trans men who were taking hormones compared to those who were not."

And then, "E.C. Wilson (2015), found that hormones related to a significantly lower rate of suicidal ideation in trans women receiving them compared to those who were not. Overall, Bauer, et al 2015, reported that receiving hormones was associated with decreased suicidal ideation in a mixed group compared with those who had not started hormone therapy."

Did I read that correctly?

A. Yes, that's what those say. But as I said, you know, when you kind of remove it from its context, that's easily misinterpreted to mean that there was a causal association between the two where they hadn't yet, none of those studies had yet ruled out the more mundane, the more parsimonious explanation.

As we were saying before the

successful transitioners are the ones that get through the real life experience, and so on, and are otherwise mentally healthy.

When you take a sample of people who have transitioned, you get a sample of people who were screened for mental health. When you compare them to people who have not yet gone through that screening, the people with lower mental health are still in the sample.

So if you just compare one group with the other, you get a group from whom the mental health issues have been removed, compared to a group of people for whom the mental health issues had not yet been removed.

So, of course, there is a difference between the two, even though there is absolutely no evidence that it was the transition itself that caused the change in the levels of mental health between the two.

Q. All right. We can go ahead and put McNeil aside. Can we turn to

paragraph 58 of your declaration, Exhibit 1.

A. I am there.

Q. So in paragraph 58 you say that "People's self-reports do not represent objective evidence"?

A. That's correct.

Q. Are there any circumstances where subjective self-reporting could be the basis for medical interventions?

A. Sorry, say that again.

Q. Is there any circumstance in which subjective self-reporting could be the basis for some medical interventions?

A. Sure. If it's a low risk intervention.

Q. What else besides when it's a low risk intervention can subjective self-reporting be the basis for medical intervention?

MR. RAMER: Objection to the form.

A. I can't think of any.

Q. Are questionnaires evaluating an individual's subjective self-reporting

or objective evidence?

A. It depends on the content of the questionnaire and the method by which one obtains the sample. A survey typically consists of a series of face valid we call it, just direct open-ended questions, what you see is what you get. The question being asked means the question you're being asked. The person taking the survey takes a poll of who is going to vote for whom in whatever election tomorrow. As I say it's a face valid, obvious and easily manipulated series of answers. And anyone that wants to take the survey can take the survey, which leads itself to all kinds of problems, who has time for the survey or not.

People who feel more strongly about an issue can take it, and people who don't care are people who don't care. So when you get X percent think whatever it is they think, it's difficult to come to a conclusion, because anybody who wants to take the survey can take the

survey.

Questionnaires in the field, the sub-field or part of my field that does these calls them psychometric instruments, psychometric instruments, where it's not so obvious what the answer is and the investigator is looking for patterns amongst the answers to the question. And there really is no correct answer, there is no correct answer at all. And it's the way the questions cluster unto themselves in order to reveal an underlying pattern across them, is what's of interest.

And such questionnaires need to be what we call psychometrically valid. They need to have been independently determined to actually tap into whatever construct it is that that questionnaire is aiming at.

And a questionnaire would be applied in a specific circumstance to a particular kind of sample that was ascertained by the researcher in a specific way.

So they can look similar in that it's a person answering questions, but the kinds of questions and the way the questions are administered and to whom it's administered are independent -- are independent. Where the questionnaire, the more formal and the more scientifically valid method allows us to come to more specific concrete observations.

Q. So you mentioned that there could be kind of a bias, you didn't use the word "bias," but I am going to ask you, is it appropriate to describe the way that -- strike that question. Let me start it over.

You mentioned the way that anyone who wants to take a survey can take a survey, can lead to all kinds of problems. And is one of those problems bias in the sample?

A. Yes, we would call that a selection bias or ascertainment bias, typically.

Q. And then beyond the scientific

term of bias, can the individuals who are deciding to take the survey have a bias one way or another towards their perceived outcome of the survey?

MR. RAMER: Objection to the form.

A. Possible, yes, certainly.

Q. And is that itself a different kind of scientific bias?

A. Different from?

Q. Or is it a subset of selection bias or ascertainment bias?

MR. RAMER: Objection to the form.

A. That's a good question. That wouldn't be the terms I would use to describe that kind of a problem. Usually we would describe that as a problem with, with the validity of the survey. Usually ascertainment and selection bias refers to who is taking the survey rather than the behavior of the people once they are taking the survey.

Q. If a survey were exploring topic X, and that survey were advertised

to people primarily pro-topic X, how would that be described in terms of scientific bias?

MR. RAMER: Objection to the form.

A. Usually we would call that a selection bias.

Q. Is that a problem if a survey exploring topics X is advertised primarily to people who are pro-topic X?

A. It depends on the content of the survey and how it's being, how it's being applied and interpreted.

There can theoretically exist -- if one has a bias sample but you're not asking questions -- but you're not coming to conclusions that depend on that bias, it's not going to make as much of a difference.

For example, to make up a generic example, if one used one's church group to do a survey, well, if you ask them about, you know, the nature of religion, you're not going to -- it wouldn't be valid from that to take that

percentage of Americans are this religious. We have no reason to think that, because they would be biased in that specific way. But if we asked them other kinds of questions -- if we asked of the survey results or if we analyzed the survey results for a conclusion that people who get up early in the morning tend to have whatever kinds of jobs, well then the selection bias is less likely to be relevant, it's less likely to be relevant.

Even if we found that for example, churchgoers were more likely to wake up early in the morning. Fine. But we would have much less of a reason to suspect that that would change the relationship between time of morning and recreational interest, and so on.

So such surveys are not automatically meaningless. But the amount of validity we could have, depends on how it's being analyzed, the questions that are being asked of the survey.

Q. I believe you previously

testified to this statement, but you agree that it's easier for advocates for people with one or another political persuasion to be able to effect a survey, right?

MR. RAMER: Object to form.

A. In general, the transparency of the questions allows for that, yes.

Q. And advertising a survey on a particular website can mean that the results would reflect that website's bias, right?

A. Again, it depends on the content of the survey and the questions being asked. It can be perfectly legitimate to advertise on a listserv of people who have an experience with whatever that experience is, because it's people with that experience or what you're trying to find out about.

A generic example if you want to know people's experience on cooking, you can run a survey on people who cook whatever it is that they cook. Well, that's perfectly fine, because that's the

thing that you're trying to measure.

But in a, again, in the context of these particular questions, you know, where there is a large controversy or a polarized debate going on, then surveying a group, you can't really say, you can't from surveying one side of that group and being able to conclude that whatever percentage of the public think whatever it is that you got from surveying from that, from that one side. So it depends.

MR. MAY: Why don't we go ahead and take a break now before I go ahead and switch gears a bit.

THE VIDEOGRAPHER: Thank you, the time is 4:15, we are going off the record.

(Off the record.)

THE VIDEOGRAPHER: The time is 4:25, we are back on the record. This begins media file 6.

BY MR. MAY:

Q. Dr. Cantor, in your declaration you cite an article by Littman from 2018, right?

A. Yes.
Q. And you're familiar with that article?
A. Yes.
MR. MAY: So if we can go ahead and pull up what's been marked as Exhibit 11.
(Exhibit 11, Document titled "Correction: Parent Reports of Adolescents and Young Adults Perceived to Show Signs of a Rapid Onset of Gender Dysphoria", was so marked for identification, as of this date.)
MR. BENIMOFF: Exhibit 11 is marked and renamed.
A. Got it.
Q. All right. Exhibit 11 is a document titled, "Correction: Parent Reports of Adolescents and Young Adults Perceived to Show Signs of a Rapid Onset of Gender Dysphoria."
Do you see that?
A. Yes.
Q. And this is a correction of the Littman article and a notice of the

republication of that article with the corrections made, correct?

A. Yes. It's the editorial standard in that journal to call that corrections but one from that shouldn't apply the usual phrase correction that there was a mistake in error or something false in the original version. It's just that the editorial standard is that when there is any change to an article it's just called a correction.

Q. If we stick on the first page of Exhibit 11, under the heading "Emphasis That This is a Study of Parental Observations Which Serves to Develop Hypotheses."

The fourth line down, the sentence reads "Rapid onset gender dysphoria is not a formal mental health diagnosis at this time."

Do you see that?

A. Yes, correct.

Q. You agree with that statement, right?

A. Yes.

Q. And a few lines down the sentence reads "Furthermore, the use of the term 'rapid onset gender dysphoria' should be used cautiously by clinicians and parents to describe youth who appear to fall into this category."

Do you see that?

A. I recall that that was a basic idea in here. I am not seeing that sentence. Where is it again?

Q. About halfway down the paragraph.

A. And what was the first word of the sentence?

Q. "Furthermore."

A. Yes, got it.

Q. So the statement "Furthermore, the use of the term 'rapid onset gender dysphoria' should be used cautiously by clinicians and parents to describe youth who here fall into that category."

Do you agree with that statement?

A. Yes.

Q. All right. If we can turn to

page 3 of the correction notice, Exhibit 11?

A. Got it.

Q. There is a heading called "Clarification of Study Designs, Methods and Related Limitations."

A. Yes.

Q. The last sentence of that entire section states that "For the current study selection bias may have resulted in findings that are more positive or more negative than would be found in a larger and less self-selected population. Subsequent studies should address these issues."

Do you agree with that?

A. Yes.

Q. You agree that selection bias may have impacted Littman's findings?

MR. RAMER: Objection to form.

A. May have, yes. Again, my hesitation really is about the lion's share of that caution really applies to how one is going to -- this is what I was saying before, you know, about surveys in

general. It depends on exactly what it is that one is going to conclude from those results.

For example, one would not want to use a survey like this to say, you know, X-percentage find whatever, characteristic or whatever somebody wants to pull out of it. But if one says, oh, my goodness there is a pattern of people who show more of this also show more of that. Oh, that's interesting because we were expecting, whatever. Therefore, we need to ask more questions.

So it is indeed, because surveys are cheap and easy, you know, it's very often the first line, the first line of research. So again, with surveys and everything else, one wants neither to overinterpret nor underinterpret the potential implications.

Q. The next heading in the correction notice, Exhibit 11, is "Updated Information About Recruitment."

Do you see that?

A. Yes, I do.

Q. And towards the bottom of page 3, there is a sentence that starts with "This means that parents participating in this research may have viewed the recruitment information from one of at least four sites with varied perspectives. Specifically, three of the sites that posted recruitment information expressed cautious or negative views about medical and surgical interventions for gender dysphoric adolescents and young adults and cautious or negative views about categorizing gender dysphoric youth as transgender."

Do you see that?

A. Yes, I do.

Q. Does that go along with the selection bias that we were discussing a little bit earlier?

A. Yes, essentially.

Q. Do you think it's a problem that this study was advertised, in the three out of four sites in which this study was advertised had cautious or negative views about medical and surgical

interventions for gender dysphoric adolescents and young adults and cautious or negative views about categorizing gender dysphoric youth as transgender?

MR. RAMER: Objection to form. Compound.

A. I would hesitate with the word "problem." It's a problem, it's more or less of a problem depending on what, you know, one wants to derive from it. It would be a huge problem if one is going to, as I say, you know, claim that the results are representative of the entire population. That would be a problem. That would be a large problem. But to identify that, oh, this is not so rare, there are a chunk of people saying this not very obvious kind of thing. We should follow that up. That is perfectly -- that is perfectly legitimate.

Also, missing, also missing and what gets lost when this study is pulled out from the other studies and when individual sentences are pulled out from

this study. One -- how does the saying go -- mistakes the forest for the trees. This is one piece that's consistent with, you know, several other different kinds of findings, all of which are pointing in a similar direction. No one of these studies provides any kind of a firm conclusion.

It's extremely rare outside of physics for any one study to definitively decide anything. It's the overall pattern throughout many different studies, looking at several different things in several different ways and then having a tendency, all pointing in one direction and then somebody comes up with an explanation that best explains the entire set.

For this particular -- I hesitate to say finding, but the most relevant part of this finding was that parents were reporting that the kids started reporting feeling gender dysphoria after a relatively profound increase in uses of social media. Okay,

fine. If that were the only piece we had, we really don't know what it means.

But, for example, in my report I included, you know, several very large representative epidemiological samples which showed all at exactly the same time, right around 2012, skyrocketing rates of depression, suicidality, anxiety disorders. And it corresponds exactly to the large increases in gender dysphoria and to social media culture having taken on to youth.

So these are each completely independent, unrelated sources of information, all pointing in exactly the same year. Year? Era? Within a year or two of each other. As I said, you could almost overlay each of these graphs on top of each other.

So when put together, what we see is no matter which way we look at it, no matter who looks at it, both here and in Europe, we keep finding the same thing. Social media has revolutionized, not in a positive -- I guess I don't

really want to assign it positive or negative -- but in a dramatic way things have, the social interaction and social variables have drastically, drastically changed for youth. All at the same time. All coincident. Not coincidental, but I mean all at the same time with the introduction of social media.

So in the context of all of these other findings the observation that parents of gender dysphoric kids noticed or say that they notice that the kids started reporting gender dysphoria after enormous amounts of use of social media.

As I was describing several other findings, all of these are pieces of the same puzzle and it's really difficult to come up with a better explanation to this pattern of findings. And as I keep saying, it's a pattern of findings. If one just considered one finding at a time, in isolation from all of the others, there is no such thing as a perfect study. We will always be able to find, you know, shortcomings of any

study. It's a human endeavor. But put together, there is a very, very consistent pattern. All associated with the onset of social media. So that presents, you know, a very, again, I don't want to call it proof, but it provides people could legitimately debate over the word "compelling evidence," but very strong evidence or evidence that says that we need to take this possibility extremely seriously, that social media is driving all of this.

Nobody has presented, nobody has presented any theory, hypothesis, idea, explanation that explains nearly as well such a wide range of these otherwise completely independent observations.

Q. These are all correlative conclusions not causative conclusions, correct?

A. That's correct. There is no real good way to test causality in this one. But as I say, nobody has come up with a better, with a better explanation.

Q. But you can't say that social

media exposure causes this presentation of gender dysphoria in adolescents that Littman reports on, right?

MR. RAMER: Objection to form.

A. Correct. We don't have a way to measure the causality of this one. The level of evidence for which we have is, as I say, it's the going theory. Nobody has a better one. No one has a better one, period.

Q. The Littman study does not tell you how common it is for adolescents to experience gender dysphoria based on exposure to social media, right?

A. Correct. It's not a representative sample.

Q. The Littman study doesn't actually survey adolescents, right?

A. It surveys their parents.

Q. And Littman himself agrees that there may be aspects of the adolescent's life that the parents do not have full visibility into, correct?

MR. RAMER: Objection.

A. Yes, that is possible. Again,

not just in this study. That's the nature of the study in youth, is that it's very common, very common, almost ubiquitous that the surveys are done of the parents. We always try -- the field tries to get as many different sources of information as possible. One would, you know, do a survey of parents, of teachers, of their pediatricians, of the youth themselves when they are old enough. And it's appropriate to the questions. The research, the findings that are the most compelling are the ones where, as I said before, where we keep finding the same pattern no matter whom we ask.

Q. You would agree that LGBT youth often keep their sexual orientation and/or gender identity from their parents for some time, right?

MR. RAMER: Objection to the form. Compound.

A. That was very clearly true before the social media age. I am not aware of analogous research repeating

that in a rigorous way of the post-social media onset.

Q. What do you define as the onset of the social media age?

A. 2011-ish, 2012-ish is when all of these variables seemed to have exploded.

Q. So if a person -- if an adolescent -- let me strike that and start over.

If an adolescent who is say 16-years-old in 2004?

A. So they were born in --

Q. '88.

A. Okay.

Q. You would expect that -- you would not be surprised by a finding that that individual hid their sexual orientation or gender identity from their parent, if it was not heterosexual or cisgender?

MR. RAMER: Objection to the form.

A. I don't think I would ever be surprised if somebody told me that they

hid it, hid their sexual orientation from their parents. But again in the social media age and in the current environment, there is not a lot of any report that I would find surprising. It's exactly because so many youth are so strongly influenced by social media that -- I am skipping a step.

In sex research, which I have been at, you know, I want to make a joke about it, since they invented sex, we kind of take for granted that when you ask a person about their sexualities, their sex lives, their desires, their erotic backgrounds, their masturbation habits, and so on, we take for granted that what they tell us may not be the whole truth. It doesn't necessarily mean they are lying, but it's hard to escape the social pressures, the self-delusions and stories that we tell ourselves that what they are telling us, especially in a first assessment meaning may not be the whole story. That's always been true. Especially when it comes to any kind of

atypical sexuality, including atypical gender identities.

The methods that we have objectively to tell us about people's sexualities verify what we always took for granted that the objective variables do not always match what the person tells us about their sexualities. That was all before social media.

Social media itself has brought with it a culture that has only further increased, again, that has greatly increased the social pressure, the desire for people to tell the right answer, the focus on how somebody looks or will appear. And so I, we, an objective sex researcher, is that much more in doubt that a self-report is the whole story or is accurate or can be taken at face value.

So as I say, now, if somebody tells me that they hid something from their parents, didn't hide something from their parents, there really is just about nothing that somebody can say that will

surprise me but by the same token, I, and I think anybody should take that much more of a -- I am not even sure if I should say critical or cynical -- that we can't take for granted, especially from a youth, especially from people, you know, with their own social vulnerabilities and mental health issues going on, that what they are telling us is the literal truth as opposed to how they want to be thought of, how they want to think of themselves.

So we have both problems. We have people who will, because of perceived social stigma, hide information from their parents, families, therapists, doctors, friends, whoever. But by the same token, other people who will exaggerate situations in order to gain from the sympathy of the people around them. So in which cases is it being overestimated and in which cases is it being underestimated, we don't have an objective way to check all of these subjective reports.

Q. Dr. Cantor, do you recall what

my question was?

A. That's a good question. You were asking something that followed from the Littman study. That was it. Would it be surprising if somebody said -- would I be surprised if somebody said that they were hiding their sexual orientation from their parents.

Q. In 2004. So I want to redirect you back to my original question?

A. I apologize, I don't know if I heard the 2004 part.

Q. If I can redirect you back to my original question, you would not be surprised by a finding that an individual who was 16 in 2004, born in '88, hid their sexual orientation or gender identity from their parent, if that person was not heterosexual or cisgender?

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

A. I wouldn't be surprised about that.

Q. Is it fair to say that teenagers and adolescents may conceal

their sexual orientation from their parents?

A. Sure.

Q. And it's fair to say that still holds true today as much as it did in 2004?

A. No, that's where I insert my long answer is how much has changed between then and now is that we can't so easily generalize habits from then or experiences from then to now.

Q. Do you think -- is it still a likelihood that an adolescent will conceal their sexual orientation from their parent?

MR. RAMER: Objection to the form.

A. That's a good question. I don't think anybody knows. I am not aware of that kind of a question, those kinds of questions really being asked in contemporary surveys. Different kinds of questions have become, for lack of a better word, fashionable.

Q. Would it surprise you if a

teenager or adolescent came to you and told you that they were concealing their sexual orientation from their parents?

MR. RAMER: Objection to the form.

A. If a person said that today, no, that would not be surprising.

Q. Would you be surprised if a teenager or adolescent today told you they were concealing their gender identity from their parents if that gender identity was not cisgender?

MR. RAMER: Objection to the form.

A. Again, I wouldn't be surprised if they said that. But I still would not be sure that it's the whole story, either.

Q. Okay. So in this hypothetical a 17-year-old comes to you and says I've been feeling like I may not, that my gender identity may not align with my biological sex. I haven't told anything about this to my parents. But I am feeling strongly that I may be

transgender. Do you have any reason to suspect that this hypothetical individual would be lying to you?

MR. RAMER: Objection to the form.

A. Lying wouldn't be the right -- I would not readily use the word "lying." Much more common and, therefore, my first set of, you know, next pile of assessment questions would be whether the person is mistaken in labeling what it is that they are experiencing.

If they, for example, use the terms you did which are the terms ubiquitously going around the, around social media, I still don't know what this person's actual experience is and what it is that they are using those terms to describe. So I would actually skip all of the popular buzz words and conclusions and jump right to exactly what it is that you're feeling. How long have you been feeling it. Under what circumstances. And then I would start presenting that some people say, some

people say, there are other people who say, in order to broaden the other possibilities in order to start getting an idea of, you know, what the person's actual experience is and then, you know, what happens, what we know about other people who describe those kinds of experiences.

If I start out with I think I am transgender, at this point those words aren't meaningful anymore. They are just kind of a generic stamp at this point that people use for many different purposes. But they are not lying. In general, they are using the only vocabulary that they have to describe it. They are using terms that they see everybody else using.

But my clinical or any standard clinical assessment actually would be to jump over that secondary vocabulary into, all right, what's going underneath the surface.

Q. Okay. So with that same hypothetical patient. After you have

seen them for a couple of sessions or as long as you need to make an appropriate assessment, you come to the conclusion that they meet the criteria for gender dysphoria under the DSM.

Would you still believe them if they said they had not told their parents that they were, that they had feelings of a gender identity, a gender identity that did not align with their biological sex?

MR. RAMER: Objection to the form.

A. Again, there are a couple of things built into that question, one of which is that the DSM-5 would actually not be relevant to such a, such a case. The DSM-5 criteria predate all of the outcome studies on adolescent onset gender dysphoria.

The research that was available in 2013, there existed one outcome study of kids who transitioned. We didn't have the information. We didn't have the information. We didn't get have this, you know, explosive increase in

adolescent onset cases. So its validity for diagnosing adolescents is zero. As I say, the DSM doesn't cover adolescent onset cases.

Now I am kind of working in the assumption that this is an adolescent onset case because they are today the great, great majority of the adolescents who are coming in. Before 2012-ish, before the DSM-5, there were basically none. We had the prepubescent kids coming in and we had middle-aged adults coming in. Barely anybody in between. That's why we had the adult or late onset cases or the childhood or early onset cases.

So if somebody comes in at 17, really, my initial questions are about when did this start. Is this new. Is this something that just began. You know, is it adolescent onset or is this a kid who was always ridiculed, bullied, who is very clearly different from his or her peers, really since childhood. Is it a childhood onset case. And knowing the

difference between those, you know, keys in, you know, very, very different parts of the literature as relevant.

If it were an adolescent onset kind of case, again, nope, nothing would surprise me, including that they didn't tell their parents.

If it were a childhood onset case, the question becomes moot. Even if they didn't say anything out loud to their parents, their parents very likely would have, you know, already figured this out, even before the kid did. As I say, the childhood onset cases stick out for better or for worse.

To back up a step, therefore, whether they meet DSM-5 criteria is not really pertinent because the DSM-5 criteria aren't what was used in the research that we have about the outcomes for most of these, most of these youth.

Q. One of the things you mentioned that even if they didn't say anything out loud to their parents their parents very likely would have already figured that

out?

A. For childhood onset cases, yes.

Q. You agree that's still different than the child coming out to their parents as having and revealing that they recognize they have a different gender identity than what aligns with their sex from birth?

A. Yes.

MR. RAMER: Objection to the form.

THE WITNESS: Sorry.

MR. RAMER: Objection to the form.

Q. So that adolescent who had been -- strike that.

That adolescent who had been displaying signs of gender congruence, gender dysphoria going back to childhood, could still be themselves concealing their gender identity from their parents?

MR. RAMER: Objection to the form.

A. Yes, that again wouldn't, would not surprise me.

Q. Turning our attention back to the Littman paper, but not specifically the correction. I want to turn to your declaration in paragraph 136, your declaration being Exhibit 1.

A. Yes.

Q. Paragraph 136 you discuss the Littman paper, right --

A. Yes.

Q. -- among other articles, fair?

A. Yes.

Q. And you have a footnote 5 there about the corrections to the Littman article.

And you say that the relevant results were unchanged between the original article and the revised article, right?

A. Yes.

Q. Are you familiar with both versions of the Littman article, both the original and the revised?

A. No.

Q. Were there any new hypotheses or conclusions that Littman laid out in

the revised article that were not in the original one?

A. Sort of. The range of potential explanations was expanded. As I say, the findings themselves were unchanged.

MR. MAY: If we can go ahead and mark tab 27 as the next exhibit, which I believe will be Exhibit 12.

(Exhibit 12, Research article titled "Parent Reports of Adolescents and Young Adults Perceived to Show Signs of a Rapid Onset of Gender Dysphoria" by Littman, was so marked for identification, as of this date.)

MR. BENIMOFF: Exhibit 12 marked and renamed.

A. There it is.

Q. So Exhibit 12 is a research article titled, "Parent Reports of Adolescents and Young Adults Perceived to Show Signs of a Rapid Onset of Gender Dysphoria," by Littman.

A. Yes.

Q. That was the revised version of

the Littman article, right?

A. That's a good question. I would have to compare both in my, in my notes to double check. But I have no reason not to take your word for it.

Q. I will represent to you that it is the revised one.

A. Okay.

Q. If we can turn to page 34 of Exhibit 12.

A. I am there.

Q. It's going to be the sections spanning pages 34 and 35. Do you see this hypothesis, "Two parental conflict may provide alternative explanations for selective findings"?

A. I see the section, yes.

Q. And I will represent to you that this is new in the revised version of the article.

A. Okay.

Q. Is this one of the range of potential explanations that was expanded that you referenced earlier?

MR. RAMER: Objection to the

form.

A. I can't say and I don't remember saying exactly which of the hypotheses were kind of alternative explanations were there. But that, again, is not pertinent, I don't want to say that I even have a conclusion. It's that the scientific term that we have is the principle of parsimony.

For any correlation there are necessarily several different explanations. So when we look at any one correlation, there is always any number of possible ways to explain it.

What, as I was describing before, the part that's, that makes this strong evidence is that one of these hypotheses, the association with social media, is consistent with several others of these findings entirely independent of this, looking at entirely different variables investigated by, as I say.

So if we line up the, oh, this from this study goes together with that study, with that study, with that study,

with that study. So that one hypothesis, this is written by social media, explains a wide range of very diverse findings. That's what makes a compelling, strong, important theory and the theory to beat. When we isolate to one of the papers or one set of correlations, yeah, no, we can add as many alternative possibilities for that one finding as we want.

But these others, parental conflict might provide alternative explanations. That doesn't explain the coincidental timing of things exploding for the entire generation for all of these other variables, all happening at exactly the same time.

Is it theoretically possible that each of these things has its own independent cause? Sure, that's theoretically possible. But the scientifically superior explanation is, as I said, the principle of parsimony, is that the more you can explain with one theory, makes that the theory to beat.

And so the idea that this is

driven by social media explains not only one of these hypotheses, but all of those others. So, yeah, no, we can add as many other hypotheses as we want, but the principle of parsimony points us to one of them.

Q. So redirecting you back to Hypothesis 2 about parental conflict might provide alternative explanations for selected findings, Littman reports that almost half of the -- if you go to the second and third lines -- "almost half of the AYAs" -- which I believe is an abbreviation for adolescents and young adults -- "withdrew from family, 28.5 percent refused to speak to a parent and 6.8 percent tried to run away."

Do you think it's still reliable to rely on parental reports from parents whose children refused to speak with them.

MR. RAMER: Object to form.

A. If that were the only variable available, then it would be hard to choose amongst the potential

hypotheses -- well, explanations rather than hypotheses.

Q. These are all hypotheses, right?

A. These are evaluations of those hypotheses. Again, I wouldn't have called them hypotheses. I would have reserved that term in the traditional way.

The hypothesis is the idea that you have, you know, before conducting the study and the idea that you're trying to either falsify or, you know, gather, gather support for.

These are, you know, hypothesized explanations for data that were already gathered. I wouldn't use the word "hypothesis" for that. But again, that's within the journal's editorial discretion.

Q. Let me take you back to Exhibit 11, which was the correction notice for the Littman study.

A. I am there.

Q. Sticking with page 1, the first

bold heading that we looked at earlier is this is an "Emphasis That This is a Study of Parental Observations Which Serves to Develop Hypotheses."

And she explains that the study serves to develop hypotheses that rapid onset gender dysphoria is a phenomenon, and that social influences, parent-child conflict and a maladaptive coping mechanisms may be contributing factors for some individuals, right?

A. Yes.

Q. The purpose of surveying the data is to generate hypotheses; do you agree with that?

MR. RAMER: Objection to form.

A. I would hesitate to narrow down the purpose to a single one. Usually that expression is used in order to, as a reminder of how non-conclusive surveys are when, you know, trying to investigate or flesh out a theory and that it's purpose is not to be conclusive, it can't be conclusive. It's to help develop, oh, look, these are associated. We should

look at that, look at that more.

Q. You can put this aside for right now. Let's turn back to your declaration, Exhibit 1. And if we can go ahead and turn to paragraph 245.

A. I am there.

Q. Would you agree that desistance is less likely to occur past the age of 12, right?

A. In childhood onset cases, unfortunately a lot of people kind of use that for anyone over 12, you know, and including people for whom it only just started when really that phrase only, that conclusion only applies to people for whom it was prepubertal onset and persisting into adolescence, not just anybody in adolescence.

Q. So for a child that presents prepubertal with symptoms consistent with gender dysphoria, once puberty, once puberty has begun, and that child continues to display signs of gender dysphoria, you would agree that that child is likely not to desist?

MR. RAMER: Objection to the form.

A. Close. The part that's not exactly accurate is to say once puberty has started. There is no such sharp line. It's not, you know, last month was prepubertal. This week is, this month is pubertal. Therefore, you know, this kid is going to persist. As these studies were coming out, it was generally over the course of puberty and a sex drive kicked in, the kids generally started figuring out that they were gay or lesbian, because they were experiencing sex drive and their first crushes and masturbatory fantasies, and so on. But even though the studies were, you know, just referring to puberty as the general era, people with a motivation to, that medicalized transition should begin as quickly as possible, started just saying the beginning of puberty where none of these studies really said the beginning of puberty.

But as I said and you almost

said, a kid with prepubertal, before puberty, generally it's from the get-go and continue after, after most of puberty and into adolescence. Those are unlikely at that point, it seems to desist for that minority for who that happens. Most of them desist, but not all of them.

Q. And for those who do not desist, do you think that prescription of puberty blockers can be appropriate for some of those individuals?

MR. RAMER: Objection to the form.

A. That's the open empirical question for which we have, you know, only mixed evidence. You know, so there are some cases for which it appears to be the case. But we can't figure out, we haven't found a way to figure out for which cases. And there are some, several studies, and again I summarize them each in my report, that it doesn't make a difference to their mental health. Some get better. Some don't. And it doesn't seem to be strongly related to a

medicalized transition. So we can't say it's impossible. But we can't say, you know, for the cases for which it does seem to be legitimate, we haven't yet figured out how to predict which of those it is, which leads us, of course, to the policy question is, well, if we can't identify which ones it is, and it is interfering with the healthy development of healthy functioning tissue, now we're at the risk/benefit ratio. It's how much risk to how much harm relative to how good is the evidence to how much benefit.

And by and large we have, exactly, as I elucidated in my report, we don't have any evidence that it does any good -- it does any better on average than mental health treatment and psychotherapy.

Q. If we can turn to paragraph 114 of your declaration, Exhibit 1.

A. I am there.

Q. I actually want to talk about the heading above that, it says that 11 cohort studies follow children not

permitted social transition, all showing the majority to desist feeling gender dysphoric following follow-up after puberty.

How do you define the phrase "social transition," as you use it here?

A. That really wasn't pertinent to the studies themselves because there was no in-between or partial status in those studies. The kids were still being treated. Had the name. Used the gender and pronouns of their biological sex. These weren't cases where it was ambiguous or there were certain circumstances where they presented one way, and in other social areas where they presented another way.

The contrast is between these 11 studies and the Olson study where the kids had already socially transitioned. There might have been a handful of exceptions, but they were nearly 100 percent of them. But again, it was not particularly ambiguous that those kids had socially transitioned. They had a

new name. New set of pronouns. And so on. But there hasn't been any study amongst the prepubertal onset cases where anybody was looking at particular aspects of social transition, amounts of social transition, pockets of their lives in which they did versus did not transition.

All we have are the results from this now 12 studies and the one which did have transition was a pretty complete social transition. And the ones that didn't transition, essentially, didn't transition in any way before puberty.

Q. So I am just trying to make sure that we are all talking about the same thing. I am trying to understand what's your definition of social transition?

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

A. I am not giving a definition of social translation. I am describing what happened in these studies.

Now, of course, I have no

trouble acknowledging that, as I said, there are mixes and ambiguous circumstances where a person can do this in different ambiguous ways or in different ways, in different pockets of their life. But in describing this set of studies, none of that ambiguity was, was present.

Q. This is not a trick question.

A. I didn't know there was such a thing.

Q. You may be thinking about it a little too hard. I am just trying to understand, to make sure we are all discussing the same thing. What are you describing as a social transition?

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

A. I am not describing anything. I'm reciting and summarizing what the studies contained.

Q. So what I am trying to understand is using a different name than the name given -- strike that question.

Is using a different name than

the name that was given to you by your parents an aspect of social transition?

MR. RAMER: Objection to the form.

A. It can be.

Q. Is using different pronouns than aligned with biological sex a form of social transition?

MR. RAMER: Objection to the form.

A. Again, it can be. But just as with, you know, several of the other questions, no one of those is ah-ha that's the line. It's the accumulation of, you know, several of them and it becomes more and more ambiguous, you know, in between and then less and less ambiguous at the other extreme. When going from none of the options are being used by the kid to every option available to the kid is being used. And then in between are the different pockets, different circumstances, different ways or the use of ambiguous pronouns or an ambiguous name. And which of them

defines social transition? That's one of the empirical questions which remains uninvestigated.

So I don't have, I am not using a definition, a definition of social transition and these studies also, it became moot because none of them had an in-between status, they were all pretty much all untransitioned or pretty much all entirely transitioned. So I don't need to generate a definition that I am not using.

Q. So what are the various factors that could be considered in whether or not there has been a social transition?

MR. RAMER: Objection to the form.

A. I am still back to that being an empirical question. When most people discuss it, they are generally referring to some combination of changing names and changing pronouns, but there are also sometimes unspoken assumptions that go along with it, such as how the kid thinks of themselves: How they are being

treated by the different people that they, that they interact with. Those are legitimate associated ideas, but in order to know which of those really counts is one of our validity questions. We need to be able to test which of those or the combination of those or accumulation of exactly which of those choices helps us predict the trajectory that the kid is on.

If we find that a certain number of the choices or a certain combination of the choices is more versus less likely to lead to a successful outcome or unsuccessful outcome in one direction or the other direction, now we have an objective way of knowing which ones do and do not count. But we don't have such research allowing us to reliably predict that trajectory. So we only have our, scientifically we only have a best guess. But in communicating with, you know, society, experts, policy makers, other scientists, parents, families and so on, again my usual

question is how do they want to use the phrase. What do they mean by it, so I can understand what they're saying.

Q. Right. Which is why I am trying to understand what you're saying when you wrote the words "social transition."

A. I am using --

MR. RAMER: Objection, objection to the form. Asked and answered.

A. I am using what those scientists did, which didn't -- because everything was so far from the line, they didn't need and, therefore, I don't need and can't offer more detailed definition that could be applied to who was over and under that line.

MR. RAMER: If you have a breaking point coming up, we have been going about an hour.

Q. If you go to paragraph 120 of your declaration?

A. 120 you said?

Q. Yes.

A. I am there.

Q. And the heading says "One Cohort Study Followed Children Who Were Permitted Social Transition in Contrast With Children Not Permitted to Transition Socially, Most Persisted in Expressing Gender Dysphoria."

Do you see that?

A. Yes.

Q. And in the next, the first sentence of paragraph 120, you describe Olson as discussing a cohort study of children who had already made a complete binary rather than intermediate social transition, including a change of pronouns.

A. Yes.

Q. Okay. What do you mean by a complete binary social transition including a change of pronouns?

A. I am repeating what, how Olson described it. Again, change in hair. Change in clothes. Change in pronouns. Sometimes a change in name and they weren't, as I said, I am just reflecting what, what they said and because it was,

you know, complete and dramatic and exactly the reverse of the other 11 studies, the questions or definitions about do pronouns matter, well, because one changed and nobody else did, it was part of it, but pronouns weren't the only thing that changed either.

So it doesn't the contrast in those results doesn't tell us anything about any one of the components of social transition. All we have is the contrast between people who used every option available to them and the kids that didn't use any such option.

Q. So is it fair to say that in the context of your declaration, when you refer to social transition, you're referring to, you're adopting the definition from Olson?

MR. RAMER: Objection to the form.

A. I am not adopting anyone. I am summarizing and reiterating the content of those studies as given by those study authors.

THE REPORTER: I need to take a break.

THE VIDEOGRAPHER: This is the videographer, the time is 5:27, we are going off the record.

(Off the record)

THE VIDEOGRAPHER: We are back on the record. The time is 5:37, this begins media file 7.

BY MR. MAY:

Q. Let's turn to your declaration, Exhibit 1, and go to paragraph 114, the heading right above it.

So you said 11 cohort studies followed children not permitted social transition. So I want to understand the verb there.

Is it that they were, is it the children expressed an interest in doing that and they were told they could not. Is that what you mean by not permitted?

A. No. Again, these are studies that go back, you know, some many decades. They didn't report that level of detail. They were just describing the

cases themselves.

So it was the only word that I can think of that would accurately capture all 11. But they weren't, as I say, in the earlier studies they didn't give enough detail, they didn't give enough detail. And by the same token in the 1970s, it wasn't the option that it is today.

Q. Do you think it's fair to say in those 11 studies, it's just that the children have not socially transitioned or did not socially transition as opposed to the not permitted?

MR. RAMER: Objection to the form.

A. I would have to go back and see if there is an exception I am not immediately recalling. But in the Zucker samples, the youth that were in treatment with him, the purpose of the therapy that the kids were undergoing was to develop comfort in their natural bodies. And his philosophy was that allowing a social transition would work exactly against

that.

So part of the process was in order to help somebody become comfortable in a situation where they are not comfortable was exposure to that situation. The same as trying to get somebody uncomfortable with the fear of heights. If you give them at every opportunity permission to move into the basement, and so on, you're not going to be helping them get over their fear of heights.

So part of the therapy that Zucker was offering, again, required that the person develop and, therefore, be in the situation that they start therapy as uncomfortable with. And that meant not, not socially transitioning.

I use the word "permit," again, kind of relatively generically but I don't, I can't, especially without checking each of the original studies directly, to see what kind of -- enforcement isn't the right word, but exactly how that situation was handled.

If a parent or family, you know, didn't want to engage in that kind of a therapy, then, you know, they wouldn't be in therapy with Ken Zucker. They would pick a different therapist or clinic, you know, trying to do, trying to do something else.

But my use of the term, as I say, was as accurately as possible to pick a word that covered, that covers all 11 studies.

Q. Which Ken Zucker study, is that the one in Table 2 of your declaration, that's the one, the last study listed with the first author Singh?

A. And Drummond.

Q. And Drummond, okay.

For these 11 studies, was a desire to be the opposite sex an inclusion requirement?

MR. RAMER: Objection to the form.

A. It varied over the course of the studies. The DSM criteria changed. Some of these used the 3. Others the 3R.

Others the 4. Other the 4R. And some of them used a more generic description of the kid, regardless of what the DSM criteria at the time was. So it varied.

Q. Did all 11 of these studies require the child to identify with a transgender -- strike that.

Did all 11 of these studies require the child to have a transgender identity in order to be included in the study?

MR. RAMER: Objection to the form.

A. That question assumes a certain definition and validity of what identity means. And how that term is used and what it means has changed over time and in different situations.

But as I said, these used several different DSMs over several different decades in several different countries. And every single one of them came out with exactly the same result.

So to the extent that there could be an exception -- then, of course,

there could always indeed be an exception -- but the onus of proof then belongs to whatever, whoever it is that wants to say "But if you use this definition, you will get something different." Okay. That is always possible. But there has never been any such indication. It will eternally remain possible, but nobody has ever demonstrated any evidence that any one of the symptoms or components that lead to a diagnosis of gender dysphoria, that any one of them is, makes a difference or how much of a difference.

Q. So I appreciate that. Redirecting back to my question.

For all 11 of these studies was a transgender identity an inclusion criteria?

MR. RAMER: Objection to form. Asked and answered.

A. I don't know if I have another way to express it. To answer that question is to say that we have a reliable way of knowing what the gender

identity is, and we don't. We have what the kids say. We have what their families say. How accurately does what they say reflect their identity? We have no idea. How valid is the concept of identity in this context? We don't know that either. So as I say, that level of abstraction can't really be answered. All we have is the various self-reports, and then the observations of the behaviors.

Q. Okay. Social transition is not banned by the Idaho law HB 71, right?

A. That's my understanding.

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

A. Sorry. That's my understanding, yes.

Q. Social transition is not a medical procedure, you would agree with that?

MR. RAMER: Objection to the form.

A. Again, we're falling into a level of ambiguity where, you know, the

assumptions are the insinuations used by the term, can't always be accepted at face value.

Q. So let me try and maybe help you definitionally then and rephrase the question and ask a better question. Social transition does not encompass -- strike that. Let me try one more time.

A prescription of puberty-suppressing hormones is not an aspect of social transition?

MR. RAMER: Objection to the form.

A. Not directly, no.

Q. And cross-sex hormone therapy is part of medical transition, not social transition; you agree with that?

MR. RAMER: Objection to the form.

A. Again, not in a simple, direct way. But there are caveats to it that are inescapable, that are pretty inescapable.

The best analogy I have is that going on a diet is not a medical

procedure, but having a really bad diet has profound medical implications. So these don't fall apart -- these aren't completely independent either.

Q. Are you familiar with Daniel Weiss?

A. I am not getting an image of a particular person with that name, but I have to acknowledge I am terrible with names to begin with.

Q. I will represent to you that Daniel Weiss is another one of the experts that the state has submitted a declaration from in this case. Do you know him?

A. No, I don't think so.

Q. Have you read his declaration?

A. No, I haven't.

Q. Have you read his CV?

A. No, I haven't.

Q. Have you read his declaration from any other cases?

A. No, not that I recall.

Q. I will also represent that the state has submitted a declaration from a

doctor named William Malone; are you familiar with this individual?

A. Yes, a bit.

Q. How are you familiar with Dr. Malone?

A. Mostly over social, social media and some of the essays that he's, that he's written on the topic.

Q. Did you read his declaration that he submitted in this case?

A. No, I haven't.

Q. Have you reviewed his CV?

A. I don't think so. If I did, I don't really recall any of the details from it.

Q. Do you think Dr. Malone is an expert on the treatment of gender dysphoria?

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

A. He knows the material as thoroughly really as a person can. Of course, emphasizing on its medical aspects.

Q. Do you think that Dr. Malone is

a credible expert with respect to gender affirming medical care for minors?

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

A. Yes, from my point of view, that's, you know, a matter of having the appropriate knowledge of the relevant research, which he very much does.

Q. Have you ever spoken with Dr. Malone?

A. We've been in group conversations together. If we've ever had a one-on-one conversation, I am not remembering it.

Q. What were the contexts of the group conversations that you had with Dr. Malone?

A. There is a set of researchers who want to conduct what is, essentially, a systematic review of systematic reviews evaluating how the various of the systematic reviews of the safety and effectiveness of the medicalized transition of minors and how well each of those reviews have stuck to the

appropriate protocol for the conduct of systematic reviews.

Q. You mentioned earlier that the certainty of the benefit of puberty-suppressing and cross-sex hormone therapy is less clear as the patient gets younger and younger. Do you recall us discussing that?

MR. RAMER: Objection to the form. Mischaracterizes prior testimony.

A. Sort of. I think really the, what I was suggesting is that the farther away we go from what's actually established, you know, the less confident that we can be that the information generalizes to it. But at the same time, not to make any kind of a, you know, perfect, you know, line, once 18, all of the sudden everything is going to be different than the day before.

Q. Do you think that doctors, families and patients are best positioned in order to make a case-by-case determinations for the medical treatment

for the patient?

MR. RAMER: Objection to the form.

A. I don't think that's how the lines are drawn. The quality of the decision-making, as best as we can measure, is how well it matches the evidence we have. So different people, you know, with different relationships with the kid, you know, can be applying, you know, different kinds of information.

If it's the parents who's following the science, then the parents are in the position. If the parent is opposing the science, then the parent is not in the best position and the same for everybody else, you know, including the kids themselves in their environment.

So it's not -- the people of course factor in, but what actually will be the best decision follows from how well their input matches the science, not really their relationship with the kid.

Q. If a patient -- if a parent -- strike that and let's start that over.

If a parent and an adolescent go to their doctor and they say that we have read all of the literature. We are familiar with Dr. Cantor's views on puberty suppression and cross-sex hormone therapy. We are well-versed in the risks and the benefits and the relative information or lack thereof, knowing all of this, we would like to proceed with cross-sex hormone therapy.

Do you think it would be appropriate for that individual to receive cross-sex hormone therapy?

MR. RAMER: Objection to the form.

A. I can't resist the gut reaction. What 16-year-old can tell me how the analyses are done, what a systematic review is? What's known and unknown is a profoundly complicated kind of question. And I am having trouble, you know, finding M.D.s and Ph.D.s properly applying the basics of the scientific methods.

Again, I would have to balk a

bit at the hypothetical to begin with. If a person tells me that they know this information, again, I have my usual critical thinking. I am not going to take at face value that their description of their knowledge is true. I have questions for them: What did you think of this; what did you think of that; what else did you try; how did you -- how did you read what it is.

It's the kind of stuff that I said and if you decide to go, you know, go ahead with it anyway, all right. So what was it that convinced you that I'm -- it's not clear to me if they are saying I am wrong or if they think they are going to be one of the exceptions.

Again, my clinical nose immediately is not to take it at face value. Scratch beneath the surface. And figure out how, how they got there.

And then after that, the assessment would be pretty much as the others, that they know this material. All right. That's the primary component

of informed consent. Great. But the rest of the clinical questions are still the same. What other less risky stuff have you tried already. You know, what are the alternatives, and so on.

So although nothing in that says, excludes them, it's not sufficient either. The information we have, knowing that we can't, we the professionals are no good at predicting who would and would not benefit from this, well, we can't do it. Neither can the kids nor families. We have no evidence suggesting, giving us an idea of how accurate their predictions are either.

And, of course, it's never, we could never be too sure that what they are saying is all we get. Are they just saying whatever it is, if I am the clinician or somebody else is the clinician or are they just saying what they think the clinician needs to hear in order to sign off on the paper.

Q. So the same hypothetical. The patient with the additional

characteristics of this patient has been displaying gender dysphoric behavior prepuberty. Has persisted through puberty, and has been seeing a therapist or a qualified mental health professional since the age of five. Do you think that that person should be categorically excluded from being able to receive cross-sex hormone therapy?

MR. RAMER: Objection to the form.

A. As I say, we're no good at predicting who will and won't benefit. The flip side of that same coin is that we can't categorically conclude in a situation, you know, that matches the cases of a couple of existing studies.

It is indeed possible that, that this person would be an appropriate candidate. But the nature of the research doesn't allow us to make a definitive conclusion. If they were in a jurisdiction where that kind of research was being done, that would be exactly the place to send that person because they

would be one of the people from whom we might be able to learn something -- that we might be able to learn something. But, of course, participating as part of a clinical trial comes with a very different set or comes with a much more detailed, advanced deeper set of just what the person is consenting to.

Now, they are consenting to a situation that by definition acknowledges how much of this is really just unknown, and this is our best guess which is different from the kind of informed consent to say this is the established practice. These are the pluses and minuses. This is how much risk you're taking on and you can either sign the paper or not.

When it's a research protocol, like I say, the documentation that goes along with it and that even if it doesn't, no matter what the results are, society at large benefits from it, because it's part of a data set that gets analyzed and can help the next cycle or

generation of people going through it.

So as I say, because we can't predict who would and would not benefit, we can't categorically deny in the same way that we can't automatically assume success.

Q. So you would agree that that individual should not be categorically denied access for the possibility of receiving cross-sex hormone therapy?

MR. RAMER: Objection to the form. Compound.

A. I don't think I can say -- your rephrasing is a bit broader than what I think I am saying.

I am just acknowledging that the current state of the science doesn't allow us to do that. But we can't say it more broadly or with a more permanent -- there is no ideological block to it. We are just very limited still in our ability to provide estimates of the potential risks and potential benefits as a part of, you know, a person coming to their decision about it. Even WPATH

itself, as I have in my report, is just long lists of unknowns.

Q. Turn back to your declaration. If you can turn back to paragraph 215.

MR. RAMER: Was that 215?

MR. MAY: Yes.

MR. RAMER: Thank you.

A. I am there.

Q. In this paragraph you talk about an elevated risk of Parkinsonism in adult females.

A. Yes.

Q. Are you an expert in Parkinsonism?

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

A. Well, I am a neuroscientist studying the role of sex in the brain and as part of -- Parkinson's patients resemble the control patients that we used when I was at the Boston VA doing research on the brain and memory. So I am certainly very fluent in the relevant information in assessing this kind of research.

Q. And is this a study that you cite in this paragraph of adult women without gender dysphoria?

A. That's right.

Q. There is no children included in this study?

A. That's correct.

Q. And there is no gender dysphoric individuals included in this study?

A. That's correct.

Q. There is no transgender people included in this study?

MR. RAMER: Objection to the form.

A. That's correct.

Q. You think this is a relevant study to consider for risks for transgender youth?

A. Yes, absolutely.

MR. MAY: Let's go ahead and take a break for about -- let's go ahead and take a break.

THE VIDEOGRAPHER: Thank you, this is the videographer, the time is

6:06, we are going off the record.

(Off the record.)

THE VIDEOGRAPHER: The time is 6:16, we are back on the record continuing media file 6.

BY MR. MAY:

Q. Dr. Cantor, we were discussing earlier today the practices of some different countries over in Europe; do you recall those discussions we had?

A. Yes.

Q. And I want to turn your attention specifically to Sweden. Would you -- would you be comfortable -- strike that.

Turning your attention, specifically to Sweden, would you support adopting Sweden's policies in Idaho?

MR. RAMER: Objection to the form.

A. Essentially, yes. And I would have to emphasize that a large chunk of that is associated with Idaho. The entire country of the U.S. needs a public healthcare system like Sweden. And that

given that kind of a situation, you know, where decisions then are made with, on an appropriate basis. And like Sweden, based on systematic reviews of the relevant evidence.

Q. Would you support Idaho adopting Sweden's policies towards the treatment of transgender gender dysphoric, gender nonconforming youth, even absent a public healthcare system?

MR. RAMER: Objection to the form. Compound. Vague. Calls for a legal conclusion.

A. I'm not quite sure that those can be separated. A major distinction and what's making, what's associated with the U.S. going in such a very different direction than the other countries we discussed is, again, it's unavoidable that the basic difference is that in the U.S. these decisions are being made by professional guilds with a conflict of interest whose decisions are reflecting not the science, but the broader principle of opposing a government

telling doctors what to do.

So when the science is, so when the professional associations are saying, oh come to our members because our members are doing the right thing, we know they are doing the right thing because it's right for our members and the decisions are being made by a group with a conflict of interest. Where in a public healthcare system, the government is supposed to be directing and limiting what it is that the medical profession does.

At the moment the question about, you know, the government telling doctors what they may or may not do happens to be about the medical treatment and medicalized transition of minors, but the U.S. is only in this position exactly because the decisions are being made by the providers rather than by a public healthcare system which has the public health as its primary concern. Profession associations have as their primary concern, the professionals.

As I say, at the moment the question happens to be about medicalized transition of minors, but that's just the current situation. We're here, the U.S. is here exactly because the decisions are not being made by the appropriate people on the appropriate basis, serving the appropriate public interest.

Q. Would you support a system in Idaho that allows for the prescription of puberty-suppressing hormones and cross-sex hormone therapy in the context of formally-approved research studies?

MR. RAMER: Objection to the form.

A. As a basic, as a basic principle as we were saying before, yes, again, as a scientist I do believe that free scientific inquiry needs to be, a society, a state, any group is better off, you know, when scientists have a freedom of inquiry.

If ever it is possible for us to figure out or come up with a method of accurately or reliably identifying who

would benefit from medicalized transition versus who would be better off with a different intervention, it's going to be by increased research.

But in saying that, again, I don't want to overstate it either. It remains eternally possible that the, it remains possible that the research may show that it is very, very few people and we're not able to identify such -- not able to come up with a method to identify these kids. And so even though there is a, you know, theoretical exception made for research, if there are no research questions to be answered, then, again, it becomes moot, it becomes not available.

Q. During the course of your deposition today, did you speak with anyone during any breaks or anything like that?

A. No.

MR. MAY: Okay. Then I have no further questions at this time. And I will pass the witness.

MR. RAMER: And I have no

questions for the witness. And we just ask to review and sign.

THE VIDEOGRAPHER: Thank you, counsel. This is the videographer. The time is 6:23, we are going off the record. This ends media file 6 and that concludes this deposition.

(Time noted: 6:23 p.m.)

ACKNOWLEDGMENT OF DEPONENT

I have read the foregoing transcript of my deposition and except for any corrections or changes noted on the errata sheet, I hereby subscribe to the transcript as an accurate record of the statements made by me.

_____

JAMES M. CANTOR

SUBSCRIBED AND SWORN before and to me this ____ day of _____, 2023.

_____

NOTARY PUBLIC

My Commission Expires:

CERTIFICATION

I, DAWN MATERA, a Notary Public for and within the State of New York, do hereby certify:

That the witness whose testimony as herein set forth, was duly sworn by me; and that the within transcript is a true record of the testimony given by said witness.

I further certify that I am not related to any of the parties to this action by blood or marriage, and that I am in no way interested in the outcome of this matter.

IN WITNESS WHEREOF, I have hereunto set my hand this 22nd day of September, 2023.

DAWN MATERA

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ERRATA SHEET
VERITEXT

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Subscribed and Sworn To
Before Me This______Day
of_______________, 2023.

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Notary Public
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Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

VERITEXT LEGAL SOLUTIONS

COMPANY CERTIFICATE AND DISCLOSURE STATEMENT

Veritext Legal Solutions represents that the foregoing transcript is a true, correct and complete transcript of the colloquies, questions and answers as submitted by the court reporter. Veritext Legal Solutions further represents that the attached exhibits, if any, are true, correct and complete documents as submitted by the court reporter and/or attorneys in relation to this deposition and that the documents were processed in accordance with our litigation support and production standards.

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Exhibit B

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF IDAHO
SOUTHERN DIVISION
----------x

PAM POE, by and through her parents and next friends, Penny and Peter Poe; PENNY POE, PETER POE; JANE DOE, by and through her parents and next friends, Joan and John Doe, JOAN DOE; JOHN DOE,

Plaintiffs,

Case No.

v.

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

Defendants.

----------x

10:00 a.m.

September 22, 2023

VIRTUAL DEPOSITION of DR. DANIEL WEISS, an Expert Witness in the above entitled matter, pursuant to Notice, before Stephen J. Moore, a Registered Professional Reporter, Certified Realtime Reporter and Notary Public of the State of New York.

DANIEL WEISS

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DANIEL WEISS

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ATTORNEY KORBERG	8

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DANIEL WEISS

THE VIDEOGRAPHER: Good morning, we are going on the record.

The date today is September 22, 2023, the time is 10:02 a.m. Eastern time.

This is media unit 1 of the video recorded deposition of Dr. Daniel Weiss, taken in the matter of Poe, et al. versus Labrador, et al., filed in the U.S. District Court for the District of Idaho, Southern Division, case number 1:23-CV-00269.

My name is Christopher Hanlon, I'm a certified legal videographer. Our court reporter today is Steve Moore.

At this time I would ask participating attorneys to please state your appearances for the record.

All other attorneys will be noted on the stenographic record.

Attorney Korberg?

DANIEL WEISS

ATTORNEY KORBERG: Good morning. My name is Alexia Korberg. I am with the law office of Paul Weiss Rifkind Wharton & Garrison, and I am going to be taking today and representing the Plaintiffs in this case, Pam Poe, Penny Poe, Peter Poe, Jane Doe, Joan Doe and John Doe.

ATTORNEY DROZ: Good morning. This is Rafael Droz. I am an attorney for the Idaho Attorney General, and I am a Deputy Attorney General, and I am representing Dr. Weiss in the deposition.

THE VIDEOGRAPHER: Thank you, counsel.

At this time I would ask our court reporter, Mr. Moore, to please administer the oath and we can proceed.

D A N I E L W E I S S, called as a witness, having been first duly sworn by

DANIEL WEISS

the Notary Public, was examined and testified as follows:

EXAMINATION BY
ATTORNEY KORBERG:

Q Good morning, Dr. Weiss. How are you?

A Good morning.

Q We haven't met before, but my name is Alexia Korberg and I represent the Plaintiffs in this case.

Do you understand that I'm going to ask you questions today for use in a legal case?

A Yes.

Q And do you understand that in certain circumstances your testimony can be used in court?

A Yes.

Q And do you understand that you are under oath sworn to testify truthfully, right?

A Yes.

DANIEL WEISS

Q Are you aware of any reason today that you cannot testify truthfully or accurately?

A No.

Q If you want to take a break at any point, please just let us know and we can do that.

So, I understand you've been deposed before, so I'm really only going to briefly review how this works.

But if you don't understand a question, I'm going to ask that you ask me for clarification.

Can we agree that if you do answer a question I pose to you it means you understood the question?

A Yes.

Q Great.

And are you aware that you are not allowed to speak to counsel either during the deposition or during the breaks about the substance of the case or your testimony?

A Yes.

DANIEL WEISS

Q So, do you agree that you're not going to have any e-mail, texting or messaging functions available to you today?

A During the deposition?

Q Exactly, during the deposition.

A Yes.

Q Can we agree that if you do communicate with counsel during the breaks about the substance of your testimony that you will alert me to the fact that you have done so?

A Yes.

ATTORNEY DROZ: Objection. I don't know if that's the rule or not, but I just want to put it out there that I can talk with Dr. Weiss if necessary and we can take it from there.

But I don't think we have to disclose any substance of any conversation.

ATTORNEY KORBERG: I would disagree with that, but we can cross

that bridge if we do.

ATTORNEY DROZ: Yes.

Q Is there anyone in the room with you today, Dr. Weiss?

A No.

Q Are there any papers or notes in the room with you?

A Only my declaration.

Q Great.

A On my desk. There is probably something behind me, but --

Q Does your declaration have any notes on it, or is it a clean copy?

A No notes on it and it does not -- I do not have my CV, by the way, on my desk.

Q Okay.

So, Dr. Weiss, you're here today to testify as an expert witness, right?

A Yes.

Q On whose behalf are you appearing as an expert?

A For the State of Idaho,

DANIEL WEISS

Attorney General's Office.

Q And who is paying your fees in the matter?

A Idaho.

Q Have you ever personally spoken with any of the Plaintiffs in this matter, either the minors or their parents?

A No.

Q Have you ever personally spoken with Plaintiffs' physicians?

A No.

Q Have you ever personally spoken with anyone who has firsthand knowledge of Plaintiffs?

A No.

ATTORNEY DROZ: Objection. What is firsthand knowledge?

Q Dr. Weiss, have you ever spoken to anyone who has told you anything about the Plaintiffs other than that which is in the Complaint?

A No.

Q When did Defendants first contact you about the case?

DANIEL WEISS

A I don't remember.

Q Do you know, do you recall roughly when?

A Perhaps a few months ago, but I do not remember.

Q When you were first contacted about the case, perhaps?

A Two months ago or something or sometime thereabouts.

Q What did Defendants ask you to opine on?

ATTORNEY DROZ: Objection to the extent it calls for attorney-client privileged information.

You can answer, Doctor, to the extent it doesn't reveal any conversations.

A On the matter related to the Plaintiffs' response to the Idaho law.

Q When you say you were asked to opine on the matter related to the Plaintiffs' response to the Idaho law, do you mean you were asked to opine on

DANIEL WEISS

Plaintiffs' Complaint in the matter, or some other document?

A The Plaintiffs' Complaint.

Q Prior to being contacted by Defendants in this case, had you read Plaintiffs' Complaint in this matter?

A No.

Q And were you asked to generally give an opinion on Plaintiffs' Complaint in the matter, or were you asked to offer some more specific opinion?

ATTORNEY DROZ: Objection, just calls -- it's confusing.

A I don't understand the question.

Q Sure.

So you said you were asked that the opinion you were asked to provide in the matter was a response to Plaintiffs' Complaint, right?

A Yes.

Q So, I'm asking were you asked to respond to the Complaint generally or were you asked to provide some more specific

opinion or response?

ATTORNEY DROZ: I'm going to object just to the extent it calls for confidential communications, privileged, expert witness privileged communications.

I mean, it's pretty clear what's going on here.

Q You can answer, Dr. Weiss.

A So, I was asked to opine on the -- on bans on hormonal interventions on minors, and to the extent I was provided information on the minors in this case, to also comment on that.

Q When did you first perform work in relation to this case?

A It would have been shortly after I agreed to assist in the matter.

Q Roughly how many hours of work have you personally put into the matter?

A I don't remember.

Q Roughly, ballpark?

A Maybe 20 hours.

DANIEL WEISS

Q In relation it to this case have you performed any work not directly related to either preparing your declaration or preparing for today's deposition?

A I don't understand.

Q Sure.

So you said you performed roughly 20 hours of work in this case, right?

A Yes.

Q And the work you performed included preparing your declaration in this matter, right?

A Yes.

Q And presumably the work you performed included preparing for today's deposition, right?

A Yes.

Q Outside of those two things has any of the work that you have performed in this matter --

ATTORNEY KORBERG: Withdrawn.

Q Have you done any work in this matter that is unrelated to either the

preparation of your declaration or your preparation for the deposition today?

A No.

Q So, you understand this matter relates to an Idaho law, right, HB 71?

A Yes.

Q Have you taken a public position on HB 71 either before or after its passage?

A I do not recall having done so, no.

Q Has anyone asked you to take a public position on HB 71 at any point?

A Not that I recall.

Q From between the time that HB 71 was being conceived of, drafted and then ultimately passed, did you speak to anyone about it, other than the attorneys in this case?

A So, I have taken -- I have provided statements for many states related to bans on hormonal interventions in minors with gender dysphoria, and I may have

provided such a statement for Idaho, but I don't recall.

Q Did anyone in the Idaho legislature or otherwise consult with you on the drafting of HB 71?

A No.

Q Have you expressed concerns to anyone about any element of HB 71?

ATTORNEY DROZ: Objection.

Just concerns?

A I would have spoken to counsel about it, so.

Q Sure. So other than counsel in this case, have you expressed to anyone any concerns, critiques, questions about the provisions of HB 71?

A No.

Q Have you expressed concerns to anyone --

ATTORNEY KORBERG: Withdrawn.

Q What did you do to prepare specifically for your deposition today?

A I had a meeting with counsel beforehand, but not today, and read through

my declaration.

Q And how many hours did you meet with counsel?

A Less than an hour, 45 minutes, maybe.

Q Was anyone other than counsel for the State of Idaho present for that meeting?

A No.

Q Did you speak with either Dr. Cantor or Dr. Malone in preparation for today?

A No.

Q Prior to your retention in this case had you ever spoken to Dr. Cantor or Dr. Malone before?

A Yes, I have spoken to Dr. Malone once about -- well, I will stop there. Yes, one time.

Q Tell me the circumstances in which you were introduced to Dr. Malone.

A Dr. Malone had written a commentary about hormonal interventions in minors with gender dysphoria, and I sent him

an e-mail praising him on the lucidity and the soundness of his points.

He then responded to me and we chatted on the phone.

Q. When was this?

A. About two years ago.

Q. Have you been in touch with Dr. Malone since that time?

A. No.

Q. Other than counsel for the State of Idaho, have you spoken to anyone about your deposition today?

A. I spoke with -- I spoke with, let's see John Reimer.

Q. And who is John Reimer?

ATTORNEY DROZ: John Reimer is an Attorney for Idaho, so --

THE WITNESS: Okay.

Q. So, other than Mr. Reimer and other counsel for the State of Idaho, did you speak to anyone about your deposition today?

A. No.

ATTORNEY KORBERG: Can we

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please pull up tab 1, which I believe has already been marked as Exhibit 1.

(The above described document was marked Exhibit 1 for identification as of this date.)

THE CONCIERGE: Shall I be sharing it on screen, counsel?

ATTORNEY KORBERG: Sure.

THE VIDEOGRAPHER: I have a question about that, counsel, this is the videographer.

If he is sharing on screen, would you like that included in the video on a split screen or the witness only?

ATTORNEY KORBERG: I don't think we need to show it.

THE CONCIERGE: Do you need a second, Chris, before I share it?

THE VIDEOGRAPHER: No, we are good.

Q Do you agree that this is the declaration that you submitted in this case?

A Yes.

Q And to the best of your knowledge is -- does this, does Exhibit 1 reflect the full and complete declaration you submitted in this case?

A Yes.

Q And are the opinions that you espouse in your declaration your own?

A Yes.

Q Did you have assistance drafting this declaration?

A No.

Q So nobody helped you draft this declaration, is that correct?

A The contents are solely my own. I did show it to my wife for formatting only.

Q Understood.

Does your declaration represent a complete statement of the opinions that you are offering in this case?

ATTORNEY DROZ: Objection.

A I might offer additional opinions during this deposition, but I agree

with all the opinions expressed -- I continue to agree with the opinions expressed in this declaration.

Q Okay, so let's take that in parts.

So first, there is nothing you would like to correct or amend in your declaration, right?

A Correct.

Q And as you sit here today, at this moment, the opinions expressed in this declaration are all those you intend to offer, but it is possible that over the course of this deposition you might offer additional opinions, is that right?

A Yes, that's correct.

Q All right. Can we turn to page 50 of Exhibit 1.

It says, references at the top are these the materials you relied on in reaching your opinions expressed in your report?

A Yes, and my experience in rationality.

DANIEL WEISS

Q Did you personally read each of the references listed --

A Yes.

Q -- here?

A Yes.

Q And you think each of the representations you listed here is reliable?

A What do you mean by reliable?

Q Well, am I correct that you formed the opinions expressed in your report in reliance on among other things these -- the references that you list here?

A I think we need to define the word reliance. I used -- critical analysis, my experience, my ability to analyze studies and all of that in careful review of each of the references.

Q Understood.

But you believe in the accuracy, the methodology, et cetera, of the references that you list here on page 50 of your report, is that correct?

A I don't think it's a matter of belief.

DANIEL WEISS

ATTORNEY DROZ: Objection. There is numerous references. I'm not sure if you want to go through each one. I suppose we could do that.

But you can answer, Doctor.

A Certainly. So I don't think it's a matter of belief. This is not -- we are not talking about belief, we are talking about analysis, thinking, evaluation, careful evaluation of each of the references, and I think the declaration speaks for itself.

When I refer to a reference, I might comment on appropriate or inappropriate, flaw or quality type methodology.

So I might refer to something, and it doesn't mean I agree to everything that that reference says.

Q Do you have any concerns about the accuracy of any reference that you list here beginning on page 50 of your report?

DANIEL WEISS

A I think the word accuracy in this context is unclear.

Q Is there any reference that you listed in your report that you think is unreliable in some way?

ATTORNEY DROZ: Objection, in terms of reliability.

A I think the word reliable is not -- it's not an absolute term, so -- medicine and science is not always clear-cut.

So I think you need to be more specific, and we can look at a particular reference and then you can tell me about it and we can analyze it.

Q Are there any references -- what does it mean to you, why did you list these particular references in your report?

A I think the declaration speaks for itself. Let's go to a particular reference and I'll tell you why I listed it.

Q As a whole, what does it mean for you to list a reference?

What does a reference mean in

this context? What role did it play in the formation of your opinions?

A So, in the declaration I would list a reference because it solidifies, clarifies or supports a statement I make.

Q And is there any reference about which you have a concern about the methodology employed in that reference?

ATTORNEY DROZ: Objection, any particular reference, or what are we talking about?

ATTORNEY KORBERG: No, I am directing him to all the references, and these speaking objections are really, they are inappropriate, you are directing the witness, and I would ask you to stop.

ATTORNEY DROZ: I am just trying to -- I don't want to say I'm trying to help you, but I am just trying to move it along in terms of what we are talking about here.

ATTORNEY KORBERG: I hear

you. I don't need any help, please just stick to the standard forms of objection.

ATTORNEY DROZ: Objection, vague.

A I have no problem with the question. I think that we still have to drill down and look at particular references.

I might have cited a reference, for example, by Dr. Turbin, who is basically a statistician who finished his psychiatry training like a year or two ago.

He's very well known in the field of gender dysphoria. I might have cited one of -- cited one of his papers here, I don't recall, among all my references, that are about 160 references. If I cited his paper, it likely has very flawed methodology.

And so that would be an example of, yes, a reference I would have concerns about.

But we can look through each

reference.

Q So, it's your belief that some of these references that you list in your report you do think have very flawed methodology, is that correct?

A I said there may be one or two. We would have to look through each.

I have to look at them and tell you that one has a particular problem. That one doesn't.

And I will mention that so the declaration again it speaks for itself.

It will refer to a reference and say, for example, the Dutch protocol, I referred -- that's in there -- that subsequent study, the late study after surgical reassignment, had very flawed methodology, and I discuss that in the declaration.

Most of the other references, however, I think are sound, but we have to look at each individual one.

Q Okay.

So, some of the references

have methodological and other flaws that you identified in the declaration, right?

A Yes, and some of them may have other flaws that I might not have identified.

Q Okay, so some of the references, none of which you can identify specifically as you sit here today, but you relied upon in forming your report, may be flawed, methodologically or otherwise, right?

A No; I don't think that's accurate.

If we look through the references today, sitting, and we go through each one, I may tell you of flaws in them.

But right now, without going through each individual one, I can't by memory, tell you which ones are flawed.

We can look at each one, we can go through all 163 or so of them, if you would like.

Q So I understand that you can't by memory identify now which ones are

flawed in ways that you haven't already outlined in your report.

But it is your testimony that there is some number of references that you rely upon in your report and list here that are flawed in some way, whether methodological or otherwise, that you do not identify as flawed in your report, right?

A No.

ATTORNEY DROZ: Objection to form.

A I would not agree with that.

You're using the word relied upon in a very misleading way. I may have mentioned it, I may have referred to it, but I would not have relied upon a report that was significantly flawed.

So, by using the word rely, it sounds like I'm basing my statement or declaration upon flawed references, and I'm not.

I might have referred to a reference that was flawed, but I'm not basing an opinion or conclusion based upon a

flawed reference.

Q In reading your report, how am I supposed to know which references you are relying upon and which references you are referring to for some other reason?

A The declaration is fairly clear in that, is very clear in that regard.

Q For every reference it is your -- it is your testimony that your declaration is clear as to whether you are relying on that reference or not?

ATTORNEY DROZ: Objection to form, vague.

A I don't know what you mean by relied upon. I don't use that terminology when describing a scientific or medical conclusion.

I may consider a study, a paper, but to rely upon implies that it's a foundation for a decision.

There is no single reference here that provides a sole foundation for my decision.

It's the overall scientific

literature, my clinical experience, my ability to evaluate that literature, and rationality or common sense.

Q We will return to that.

ATTORNEY KORBERG: Let's pull up what I understand has already been marked as Exhibit 2.

(The above described document was marked Exhibit 2 for identification as of this date.)

Q Would you agree with me that this is your CV that you submitted in this matter?

A Looks like it, yes.

Q And is the CV that you submitted in this matter currently accurate?

A I'm not sure when it was submitted, but it should be accurate, yes.

Q Do you have anything that you would like to add or amend to your CV?

A Not that I can think of, no.

Q Starting at page 92 of your CV, you list legal experience, then three cases.

DANIEL WEISS

Do the cases that follow reflect all of your legal experience?

A Can we go to page 92, and let's look at 93. Back to 92.

Yes, that's all.

Q Did you submit a declaration in Van Garderen v. Montana, a challenge to a Montana law banning gender affirming care for transgender adolescents?

A Yes.

Q Why wasn't that case included on your CV?

A It came after the submission of the CV.

ATTORNEY KORBERG: Can we please mark tab 4 as Exhibit 3, which is your declaration in that Montana case.

(The above described document was marked Exhibit 3 for identification as of this date.)

THE CONCIERGE: Sorry to bother you. I see 4.1, et cetera. Which tab?

DANIEL WEISS

ATTORNEY KORBERG: This is actually tab 3.

THE CONCIERGE: Got it, thank you.

Q Is this a, to your knowledge, a complete and accurate reflection of the declaration that you submitted in that Montana case?

A Looks like the first page.

Q Have you ever been disqualified to serve as an expert for a case in which your expertise has been offered?

A No.

Q Have you ever given any testimony, either written or in person, on any issue that a judge has ultimately declined to credit or consider?

A No.

Q Turning back to Exhibit 2, which is your CV in this case, page 24.

Q Does it sound right that your bibliography lists 23 publications?

A I don't remember that. We

can scroll down, it will tell you that.

Q Sure.

Do you have any writing or presentations not reflected in your CV?

A I think it's complete in that regard.

Q In your report you suggest you participated in 100 clinical trials, but you only list 90 here.

Do you know what the ten clinical trials that you didn't include in your CV are?

A Let's look through and see what that number is here. Let's see what the last states.

Q I will suggest that you -- I will represent to you they are not numbered here, so we just counted them.

A I may have miscounted.

Q So it's your belief in your report when you say you participated in 100 clinical trials, you actually meant to say that you participated in the 90 clinical trials that you listed in your CV, is that

right?

A If you --

ATTORNEY DROZ: Objection.

A If you counted them and you got 90, and my declaration says 100, and -- you can quibble over the ten.

Q Sure, but what I'm asking is was your assertion that you participated in 100 clinical trials in your declaration incorrect, or are there ten clinical trials that you participated in that are not reflected on your CV?

A So I did want to see the last one listed, because it's possible I may not have listed a few other trials.

Can we scroll down to the end?

Q That would be page 108, I believe.

A That looks complete, and if the total is 90, then, I thought I said approximately 100, but if I said 100 I was off by ten.

Q Do any of the 590 total

publications and presentations that you reflected in your CV relate to gender dysphoria or gender affirming care?

A No.

Q Did any of the 590 total publications and presentations reflected in your CV relate in any way to pediatric or adolescent medicine?

A State that question one more time?

Q Sure.

Do any of the 590 total publications and presentations reflected in your CV relate in any way to pediatric or adolescent medicine?

A Yes, some of them might, because diabetes management in adults overlaps with diabetes management in adolescents and children.

So I did speak on that subject, and that would be part of that.

Q Are any of those 590 total publications and representations specifically about pediatric or adolescent

medicine, as opposed to on subjects that are incidentally relevant?

A There is overlap certainly with pediatric and adolescents, but none of them were solely on pediatric or adolescent.

Q Were any of those 590 publications predominantly about pediatric or adolescent medicine?

A Not that I recall.

Q Turning to page 7 of Exhibit 2, which is your CV, you list 64 major courses and meetings for continuing medical education you have attended or undertaken, right?

A If that's what it says, yes. 64, okay. I don't remember the number.

Q Have you undertaken any continuing medical education not listed there?

A Let's go back to the last -- let's go to the last one, because I might not have listed them, some since then.

Certainly I have done continuing medical education since the

submission of the CV.

Oh, there is substantial continuing medical education after that, yes.

Q Okay, so the CV that you submitted in this matter doesn't actually reflect all of your continuing medical education, right?

A Correct.

ATTORNEY KORBERG: Counsel, we would ask you submit an updated CV that accurately reflects the witness' experience.

ATTORNEY DROZ: We will take it under advisement.

Q Have you undertaken any continuing medical education related to gender dysphoria or gender affirming care?

A Yes.

Q What were those?

A I read the section on Up to Date, on gender dysphoria.

Q Can you explain what you mean by you read the section on, Up to Date, on

gender dysphoria?

A Yes, so Up to Date is an online reference that many physicians use to get guidance on diagnosis and treatment of a variety of medical disorders.

It's used throughout the world.

Q Okay. So other than reading entries on this online reference source, have you undertaken any continuing medical education on gender dysphoria or gender affirming care?

A Well, that online reference source is -- provides AMA category 1 credits for review.

So that is continuing medical education.

Q And have you, in fact, received category 1 credits for your review of gender dysphoria, entries relating to gender dysphoria or gender affirming care on Up to Date?

A Yes.

Q When did you receive those

category 1 credits for that education, reading that online read source on gender dysphoria or gender affirming care?

A I don't remember.

Q What specifically did you look up or reference on that online resource relating to gender dysphoria or gender affirming care?

A Management of patients with gender dysphoria.

Q Other than reading those entries on that online resource related to management of patients with gender dysphoria, have you undertaken any continuing medical education on gender dysphoria or gender affirming care?

A No.

Q Other than attending a symposium in 1989, have you received any continuing medical education related to pediatric or adolescent endocrinology?

A I probably have, although I don't -- I have not -- nothing specific with regard to that, because the Endocrine

Society meetings I might have attended, I did attend, and I listed those.

I would have gone to sessions that included pediatric and adolescent endocrine issues.

Q Okay. So other than attending meetings of the Endocrine Society, where pediatric or adolescent endocrine issues may have incidentally been discussed, have you received any continuing medical education relating to pediatric or adolescent endocrinology?

ATTORNEY DROZ: Objection.

A I wouldn't use the word incidentally, because the Endocrine Society has many sessions on adolescents, children and adults.

But when I list the credits, the CME credits, continuing medical education credits provided at those meetings, I don't list each particular session I went to. That's just not done.

And some of those discussions may have been focused on and perhaps even

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entirely devoted to adolescent or pediatric endocrine issues.

I just don't recall.

Q Okay. So you may have over the years attended sessions focused on pediatric or adolescent medicine, but you have no specific recollection of having affirmatively done so, right?

A Correct.

ATTORNEY KORBERG: I would like to introduce as Exhibit 4 what's tab 4.1, which is your deposition transcript in K.C. v. individual members of the Medical Licensing Board of Indiana.

Q Have you reviewed your transcript in that case?

A The deposition transcript?

Q Yes, in the Indiana case?

A I looked at it briefly.

(The above described document was marked Exhibit 4 for identification as of this date.)

Q Is there anything inaccurate

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in your testimony in the Indiana case or anything that you wish to amen?

A Well, having not looked at the whole transcript, I can't tell you.

ATTORNEY DROZ: Can I stop just a second here, and it's a sort of housekeeping thing, and forgive me.

On the Exhibit Share, should these be showing up in my folder as well on the Exhibit Share, or I'm just limited to what's on the screen?

THE CONCIERGE: That's affirmative. They should be showing up, and you and the witness and everybody else should be able to independently go through the documents.

ATTORNEY DROZ: So I'm showing only 1 and 2.

THE CONCIERGE: You have to refresh your web browser.

ATTORNEY DROZ: Got it.

DANIEL WEISS

Thank you. I apologize for the delay.

THE CONCIERGE: You're welcome.

ATTORNEY DROZ: Please continue, I apologize.

Q So you testified that you did review at some point your transcript in the Indiana case, right?

A Briefly; in part, not entirely.

Q And based on your review, do you recall whether there was anything in, that you read in that deposition transcript, that you believe to be inaccurate?

A No.

Q And based just on your recollection of what you said in the Indiana case, regardless of whether you read it in the transcript or not, is there anything that you said that you believe to be inaccurate or that you wish to amend?

A Not that I recall, no.

THE VIDEOGRAPHER: I would

like to introduce as Exhibit 5 tab 4.2, which is your written testimony submitted in Florida in October 24, 2022 to the Board of Medicine.

(The above described document was marked Exhibit 5 for identification as of this date.)

Q You have no reason to believe this is a true and complete copy of your testimony there, right?

A What's the question?

Q Do you have any reason to believe that this isn't a true and complete copy of your testimony to the court?

A It looks correct.

THE VIDEOGRAPHER: Same for what I would like to introduce as Exhibit 6, which is tab 4.3.

(The above described document was marked Exhibit 6 for identification as of this date.)

Q This is your written testimony submitted in North Dakota to the Senate Committee on Human Services regarding

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HB 1254.

Same question, any reason to believe this isn't a true and complete copy when it comes up of your testimony in North Dakota?

A Looks correct.

ATTORNEY KORBERG: Same with respect to what I will mark as Exhibit 7, which is tab 4.4, which is the written testimony submitted in Ohio in support of HB68.

(The above described document was marked Exhibit 7 for identification as of this date.)

Q Any reason to believe that this, when it comes up, is not a true and complete copy of your Ohio testimony?

A Looks like my testimony.

Q And just to be clear for the record, this is your testimony in support of HB 68 in Ohio.

ATTORNEY KORBERG: I would like to introduce as Exhibit 8, which is tab 4.5, your written

testimony submitted in support of another Ohio law, HB 454.

Q And when that comes up, is there any reason to believe that this isn't a true and complete copy of your testimony in Ohio in support of HB 454?

(The above described document was marked Exhibit 8 for identification as of this date.)

A Looks correct.

Q Great.

THE VIDEOGRAPHER: And I would like to introduce tab 4.6, and mark it as Exhibit 9, which is -- which I believe to be oral testimony that you gave in support of Ohio HB 454.

(The above described document was marked Exhibit 9 for identification as of this date.)

A Yeah.

ATTORNEY DROZ: Objection. What is this?

ATTORNEY KORBERG: Why don't

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we click on the link.

THE WITNESS: Which one?

THE CONCIERGE: It may not go smoothly. I'm just giving you a heads up. So just give me one second.

ATTORNEY DROZ: We don't need to do that if counsel is prepared to just represent that those links are links to --

Q Okay, I will represent that we have links to your testimony in Ohio in support of HB 454, which we have marked as Exhibit 9, your testimony in support of Utah Senate Bill 16, which we have marked as Exhibit 10, and your testimony in support of Montana SB 99, which we have marked as Exhibit 11.

And we would just like to confirm you have no reason to believe that these wouldn't be accurate representations of the testimony you gave there.

A No reason to believe.

(The above described documents were

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marked Exhibits 10 and 11 for identification as of this date.)

Q So I understand you're here today as an expert witness, and I want to understand which areas or subjects you believe yourself to be an expert in.

Do you consider yourself to be an expert in pediatric or adolescent medicine?

A Some aspects of that, yes.

Q What aspects of pediatric or adolescent medicine do you believe yourself to be an expert in?

A Those that focus on endocrine issues.

Q There is a Board certification for pediatric endocrinology, right?

A I believe so.

Q And you are not Board certified in pediatric endocrinology, right?

A No.

Q And a separate Board certifications for pediatric medicine,

right?

A I think so, yes.

Q And you are not Board certified in pediatric medicine?

A No.

Q In what aspects do you consider yourself to be an expert in pediatric endocrinology?

A In the aspects that we are dealing with here.

Q What do you mean by that?

A Hormonal interventions in minors who have a condition called gender dysphoria.

Q So you believe yourself to be an expert in minors who have a condition called gender dysphoria, is that right?

A Yes, well, the hormonal -- the effect of hormonal interventions in those children.

Q Okay.

And what's the basis of your expertise in the effect of hormonal interventions in children with gender

dysphoria?

A The basis of my expertise is my expertise as an endocrinologist, rationality, my experience, and my review of the scientific literature.

Q Is pediatric endocrinology distinct from adult endocrinology?

A In some areas.

Q In what areas is pediatric endocrinology distinct from adult endocrinology?

A Well, for example, a growth hormone treatment in children is different from growth hormone treatment in adults.

But the action of testosterone and estrogen is very similar in children and in adults.

It's not -- that's not different.

Q The action of testosterone and estrogen is --

ATTORNEY KORBERG: Withdrawn.

Q Is the action of testosterone and estrogen in prepubertal children the

same or similar to in adults?

A The action is similar. The children are different from adults, but the action of the hormone is similar.

Q The action of testosterone and estrogen in prepubertal children is similar to adults, right?

A Yes.

Q How are they different?

A You need to be more specific than that in your question.

Q Sure. You said that the action of testosterone and estrogen is, in prepubertal children, is similar to that in adults.

A Right, the action on receptors is similar.

So the hormone is the same chemical structure, it's just that the results might be different in a person who is an adult versus a person who is a child.

Q Do you believe that a pediatric endocrinologist who has never treated an adult is an expert on adult

endocrinology?

A In general, I think one can become very knowledgable and be an expert using the general principles of that specialty and extrapolating, based upon that experience, that knowledge, that expertise that you have gained, and then coupled with careful reading of the scientific literature, you can become an expert.

So yes.

And I should add, I have treated many children earlier in my career with endocrine disorders, including growth hormone problems and other -- even down to the age of 5 I was treating such children based upon my knowledge of the literature, my -- and my training as a pediatric -- in pediatric endocrinology in my fellowship.

So I have treated children with endocrine disorders, including growth hormone disorders, congenital adrenal hyperplasia.

So I have had that experience, because I have had over 36 years

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of endocrine practice.

In a big group I was in, I was the sole endocrinologist, and I was seeing children.

Q Have you ever treated a child or adolescent for gender dysphoria?

A I have treated down to the age of 18. I have seen children, I have seen people down to the age of 18 with gender dysphoria.

Q But you have never treated a legal minor under the age of 18 for gender dysphoria, right?

A So, I think it would be -- it would be unethical, improper and wrong to do so.

And as you are familiar with my declaration, I have treated 100 adults with gender dysphoria with opposite sex hormones or hormonal blockade.

But at the time I was treating, there were very few minors being treated, and I would consider it completely unethical to do so.

DANIEL WEISS

So I did not do so.

Q I appreciate that.

You know, we have a lot of ground to cover today, so it would be helpful if you could answer the questions as I pose them, and then if I would like you to expound on them, I can certainly ask you.

But, you know, my question was have you treated a minor under the age of 18 for gender dysphoria?

ATTORNEY DROZ: Just objection.

Q And the answer is no, right?

ATTORNEY DROZ: Objection. He gets to answer the way he feels he needs to answer the question.

A I have not treated anyone under 18 with opposite sex hormones.

Q Is the efficacy of hormonal treatment similar for adolescents and adults?

A You need to define efficacy.

Q Sure.

Is the effect of hormones

similar for adolescents and adults?

A Yes, but one needs to keep in mind that each person that's being treated is -- responds differently, and that is in part related to age.

Q Well, I understand that you believe yourself to be an expert in the treatment of children and adolescents for gender dysphoria based on your experience treating adults for gender dysphoria, right?

A I object to the use of the word treatment.

Opposite sex hormones, hormonal blockade and puberty blockers for children with gender dysphoria is not treatment. It's a hormonal intervention which is harmful.

I don't call it treatment, and I have thus far not objected to your use of the term gender affirming care, because it's misuse of language.

It doesn't affirm the child, it attempts to alter their body and to treat a mental health disorder.

So it's not treatment, it's an intervention. But it's not care and it's not treatment.

Q Okay, so just to sort of table set, can we agree that when, for the purposes of this deposition, when we use the phrase gender affirming care, what we -- or gender affirming treatment, it is not a judgment on the reasonableness of such treatment, but rather the administration of either puberty blockers or cross sex hormones or potentially surgery to treat gender dysphoria?

A I object to the use of gender affirming. I think that's not a neutral statement to call it gender affirming care. I don't like that term.

And you're basically supporting it when you are using the term gender affirming care.

I prefer that you use the term cross sex hormones, puberty blockers, and it's more specific.

Q Okay, same cross sex

hormones, puberty blockers, cetera, takes up some space, can we just agree that to the extent I will try to do so, we agree to the extent I'm using the phrase, and we have used the phrase gender affirming care or gender affirming treatment so far, while you object to what you perceive to be a value judgment about that, the administration of those, they are conventions, that we are referring to puberty blockers, cross sex hormones and potentially surgical care?

A You can use that term, I will be more specific.

Q Great.

So you testified earlier that you believe yourself to be an expert in the administration of puberty blockers, cross sex hormones and potentially surgery to minors based on the fact that you have clinical experience performing those interventions on adults, right?

A And I have treated children with same sex hormones for delayed puberty in the past.

DANIEL WEISS

Q So, am I correct, based on what you're saying about your expertise, that experience with, or studies on adults with cross sex hormones, for example, are relevant to adolescents?

A Yes.

Q And is it fair to say that studies, data, experience, related to the -- any potential side effects or risks of the administration of cross sex hormones with regard to adults are also relevant to the effect of cross sex hormones on children?

A Yes.

Q Can the symptoms of any given endocrine disorder be different in children and adolescents than adults?

A They might be.

Q Do you consider yourself an expert in psychology?

A Knowledgeable in many areas of psychology, yes.

Q Do you consider yourself to be an expert in psychology?

A How do you define an expert?

Q Well, you are appearing here today as an expert witness, right?

A Yes.

Q And you said that you are an expert in endocrinology, right?

A Yes.

Q And that you believe yourself to be an expert in the administration of what I call gender affirming care to minors, right?

A Yes.

Q So, however you meant expert with respect to those subjects, I'm asking you if you consider yourself to be an expert in psychology?

A No, not an expert in psychology.

Q And why not? What is lacking with regard to your expertise in psychology as distinct from your purported expertise in the effect of these interventions on children suffering from gender dysphoria?

A Well, there are certain psychiatric disorders, if I may, psychology

is not the same as psychiatry, but I'm not an expert in psychosis.

But I am knowledgeable in the comorbidities that are seen in many minors with gender dysphoria.

But I am not an expert, for example, in schizophrenia.

Q Sure, but I am asking actually sort of a simpler question.

You said that you're an expert in the provision of these medical interventions which I call gender affirming care to minors to treat gender dysphoria, right?

A Yes.

Q And you said you are not an expert in psychology, right?

A Yes.

Q What expertise are you lacking in psychology such that you cannot say the same thing with respect to psychology?

ATTORNEY DROZ: I object to form. You can answer.

A I just gave you an example. For example, treatment of psychosis.

Q Right.

A Or, for example, I am not an expert in providing cognitive behavioral therapy in people with psychological disorders.

I'm not an expert in treating post traumatic stress disorder. I am not an expert in treating sexual abuse.

Q So is the distinction just that psychology is a broader category, whereas you feel that treating children with -- for gender dysphoria is a narrower category?

A No, I have not had extensive years of experience being trained in psychological counseling and psychological disorders.

That's the distinction.

Q Can you catalogue for me all of the mental health training or education you have undertaken?

A Catalogue, no. I have done

continuing medical education courses, and I have done reading on my own.

Much of it is reading on my own and training in my residency, fellowship, attending courses.

Q Do you consider yourself to be an expert in the diagnosis and treatment of mental health disorders?

A No.

Q Do you consider yourself to be an expert in pediatric psychology?

A No.

Q Do you consider yourself to be an expert in the diagnosis and treatment of mental health disorders in children and adolescents?

A No.

Q Do you consider yourself to be an expert in the psychology of gender identity?

A I think you need to define what you mean by gender identity. You mean gender identity disorder, gender dysphoria?

Q Do you consider yourself to

be an expert in the psychology of gender dysphoria?

A Yes.

Q And what is the basis of your expertise in the psychology of gender dysphoria?

A Reading the literature.

Q What literature have you read related to the psychology of gender dysphoria?

A Much of the published literature in this regard.

Q Other than reading published literature relating to the psychology of gender dysphoria, do you have any other basis for your belief that you are an expert in the psychology of gender dysphoria?

A No.

Q And just to be clear, you have not read all of the literature related to the psychology of gender dysphoria, right?

A No one has.

Q Do you consider yourself to

be an expert in psychology of gender identity development in children and adolescents?

A What do you mean by that specifically?

Q Would you agree that all of us develop a sense of our own gender identity?

ATTORNEY DROZ: Objection, form.

A WPATH can't even define gender. Look at the glossary in W path, they can't define gender.

Gender identity is a -- is an internal sense of the sex that a person feels that they are.

That evolves over time and is modified by many factors.

Q Do you consider yourself to be an expert in the diagnosis of gender dysphoria in adults?

A I think it's -- I have defined -- I have described gender dysphoria as a social construct, and it's very

confusing, even for W path.

Am I an expert in it? Yes.

Q Are you an expert in diagnosing gender dysphoria in adults?

A Yes.

Q What's the basis of your expertise?

A Reading the scientific literature and my experience in treating adults.

Q Is it your belief that someone can be an expert in a subject solely by reading academic literature in that subject?

A Yes.

Q What qualifications or experience would make someone an expert on the diagnosis of gender dysphoria?

A I'm not sure I understand your question.

Q Have you ever --

ATTORNEY KORBERG: Withdrawn.

Q Have you ever diagnosed someone with gender dysphoria?

A Yes.

Q How many people have you diagnosed with gender dysphoria?

A About 100 people.

Q And to be clear, I'm not talking about treating someone with gender dysphoria.

You are saying you have diagnosed 100 people with gender dysphoria, is that right?

A Yes.

Q And how did you diagnose any given one of those people?

A At that point I was seeing people in what's called gender identity disorder, and those people also had significant comorbidities that I was not addressing, but they had -- they presented to me with a sense of incongruence about their sex, their gender, that was contrary to their natal sex.

Q Okay. So you're able to diagnose someone with gender dysphoria when they present to you with a sense of

incongruence between their natal sex and their gender, right?

A In those people.

All those people had significant comorbidities, and I think, my opinion is that if those comorbidities were addressed, they would not have gender dysphoria or gender identity disorder.

Q I understand. But I'm just asking you about how you diagnose someone with gender dysphoria.

A At that point I was using the criteria, the DSM criteria of gender identity disorder.

Q And for each of those 100 people, did you do a full assessment to determine whether they met the criteria for gender identity disorder outlined in the DSM?

A I don't recall.

Q Is there anyone who presented to you with a perception of the incongruence between their natal sex and gender identity who you determined should not be diagnosed

with gender dysphoria?

A Not that I recall.

Q Do you consider yourself to be an expert in the diagnosis of gender dysphoria in children or adolescents?

A I think gender dysphoria is a description of an internal mental state that is a result of other comorbidities.

Q So, is it possible to experience gender dysphoria without the presence of other comorbidities?

A I do not think so.

Q And what are all of the comorbidities that you think account for gender dysphoria?

ATTORNEY DROZ: Objection, form.

A There are many comorbidities, including sexual abuse, autism spectrum disorder plays a role, physical abuse, social contagion is important, although that's not a comorbidity, peer influence is important, bullying, social isolation.

All of these are factors

DANIEL WEISS

in -- I believe that in all cases those can be identified as a precipitant as the cause of the dysphoric state.

So I think the gender dysphoria is not the underlying area of focus, it's the comorbidity that's causing it.

Q Are there any other comorbidities, other than sexual abuse, autism spectrum disorder, physical abuse, social contagion or bullying that can cause gender dysphoria?

A Well, social contagion is not a comorbidity.

But those are the main ones, and those need to be identified and addressed for treatment of the psychic distress that we call gender dysphoria.

ATTORNEY KORBERG: We have been going about an hour and change, so it might be time for a break.

Does that seem fine with you, Dr. Weiss, and the court reporter?

THE WITNESS: I am fine.

DANIEL WEISS

THE VIDEOGRAPHER: Thank you, counsel. This is the videographer. The time is 11:22, this ends media file 1.

(At this point in the proceedings there was a recess, after which the deposition continued as follows:)

THE VIDEOGRAPHER: We are back on the record. The time is 11:31. This begins media file 2.

Q Great.

I just want to follow up on something that we were talking about just before the break.

Which is that you had diagnosed adults with gender dysphoria, but you have never diagnosed someone under the age of 18 with gender dysphoria, right?

A That's correct.

Q Do you have --

ATTORNEY KORBERG: Withdrawn.

Q Have you read Dr. Cantor's expert report in this case?

A No.

DANIEL WEISS

Q Do you consider Dr. Cantor to be an expert in diagnosing and treating gender dysphoria in minors?

A So, you know, the diagnosis of gender dysphoria is a description by DSM, and in all those children who have it, they have some psychiatric cause or some psycho-social basis for their dysphoria.

So, it's not -- it's not a disorder that we need to be focusing on, it's the underlying causes for that dysphoric state.

Q Is it possible for someone to be an expert in the diagnosis and treatment of gender dysphoria?

A It's possible for someone to be able to diagnose, yes, based upon some criteria that have been established that are evolving over time, gender identity disorder, gender dysphoria, gender incongruence.

Certainly many people can be experts on just coming up with a diagnosis based upon those stated criteria. It's

easy.

Q Okay.

Do you consider Dr. Cantor, who is being also offered as an expert witness in this case, to be an expert in diagnosing and treating gender dysphoria in minors?

A I can't speak to his expertise.

Q So you don't have an opinion one way or the other about whether he's an expert in the things that he professes to be an expert in?

A I think he's very knowledgeable in that area, and I read some of his publications.

Q Are you familiar --

ATTORNEY KORBERG: Withdrawn.

Q Have you read Dr. Malone's expert report in this case?

A No.

Q Do you consider Dr. Malone to be an expert in diagnosing and treating gender dysphoria in minors?

A Dr. Malone is an expert in this -- the field of hormonal and medical interventions in the -- in an attempt to modify a person's appearance who has dysphoria that they attribute to an incongruence between their male sex and the sex they believe they ought to be.

He is an expert in those aspects.

Q And what's the basis of Dr. Malone's expertise in those aspects?

A He's an endocrinologist and he knows the scientific literature very well.

Q Are you familiar with Dr. Kara Connelly?

A Only having read her declaration. I don't know her otherwise.

Q And would you consider Dr. Connelly to be an expert in the diagnosis and treatment of gender dysphoria in minors?

A Absolutely not, because she's promoting harmful medical interventions on

these children, and obviously does not know the scientific literature that indicates that it's harmful and not helpful.

So she's the opposite of an expert.

Q Okay, because you just testified that Dr. Malone is an expert because he's an endocrinologist and because he knows the scientific literature very well.

A Correct.

Q So you agree that Dr. Connelly is an endocrinologist, right?

A Yes.

Q And while you may disagree with the conclusions that you would each draw from the scientific literature, you would agree that she knows the scientific literature very well, right?

A Absolutely not. She does -- I think it's clear that she doesn't know the scientific literature.

Either that or she refuses to accept the scientific literature.

DANIEL WEISS

I suspect she doesn't know it, and like many pediatric endocrinologists or commonly adolescent med people who are not endocrinologists who intervene by giving opposite sex hormones or puberty blockers on these children with a mental health disorder, the fact that they do this appears to show that they do not know the scientific literature at all, which shows clearly that these interventions are harmful and not helpful.

So, she is not an expert.

Q Okay, so it would be impossible for someone, regardless of their clinical experience, regardless of the number of studies that they have reviewed, if someone disagrees with you and believes that it is reasonable, at least in some circumstances, to provide gender affirming care to minors, then they cannot be an expert in the provision of gender affirming care to minors.

Is that your opinion?

ATTORNEY DROZ: Objection to

form.

A Yes. So I would object to your phrasing. It not a matter of belief, it's a matter of careful and balanced and rational reading of the scientific literature that indicates -- it doesn't matter if she's treated 1,000 people, that means that's 1,000 children that she's harmed based upon the science.

And I have given examples in my declaration of people who are so convinced that they are doing the right thing and they have caused harm, because the studies have shown, subsequent studies or studies that have already been published, show that it's not beneficial, and that it's harmful.

Q So someone who reads all of the same studies as you have ever read and based on their training and experience comes to a different conclusion about the efficacy of this course of care, then they cannot possibly be an expert, is that your opinion?

ATTORNEY DROZ: Objection to

form.

A It's not care, it's an intervention, it's harmful, and if they come -- it's very difficult to believe that they have read the same studies.

I think they haven't read, and many people come out of their training and they stop learning. They stop. I see that all the time.

I've taught a lot of people over my 36 years of practice, and I see that people after their residency or fellowship, they just basically continue the same thing and they don't stay current, they don't read, and they are not critical thinkers.

And I think that's many of the people, however well intentioned they are, I'm sure Dr. Connelly is well intentioned, she thinks she's doing the right thing, but I suspect she hasn't read the literature.

And if she does, she has read it, which I doubt, she is so conflicted by the fact that that's her job, so she can't

see the science.

And the science clearly shows these interventions are not care, they are not treatment, they are harmful and they should be stopped.

Q So, other than the subject of hormonal interventions for minors suffering from gender dysphoria, are there any other subjects where it is your belief that if a fellow doctor reads the same studies as you but comes to a different conclusion, it means that they are not an expert in their clinical -- area of clinical focus?

ATTORNEY DROZ: Objection, form.

A I don't think such -- I have not seen examples of that, because when there is a difference in opinion, it usually means the person has not read those other studies. That's usually what it means.

Or they are not open to scientific discourse and discussion. They are closed minded, they don't want to see the other side.

DANIEL WEISS

Q Okay, let's think about some other subject in endocrinology, let's call it like you know, some element of diabetes management.

And let's say that you have a fellow endocrinologist who practices diabetes management who is Board certified, and some element of diabetes management, despite having reviewed the same literature as you, they disagree about the appropriate course of treatment, okay?

Would you assume from that fact, the fact that you disagree about the conclusions of the same literature, that they are not an expert in diabetes management?

ATTORNEY DROZ: Objection, form.

A I have not seen any circumstance like that.

I think there are judgments, and there are different styles and different approaches, but here we are talking about a complete apparent unawareness of the

scientific literature that shows that these interventions on minors with normal puberty that cause irreversible changes and don't help their psychic distress, they are not aware of them and it's just -- it's not the same as a minor, oh, I treat diabetes this way and I do this.

I mean, there is an example, for example, treating patients with a form of high blood pressure caused by overproduction of a hormone from the adrenals.

So there are guidelines on that, treating that, but there is controversy, some people do it this way, some people do it that way, and they are both knowledgeable.

I wouldn't use the term expert. My style is to not do surgery on those people.

They say oh, you should do these tests and you should do surgery.

They are both acceptable, these people, we are all knowledgeable on

it, we just interpret it a little differently.

But Dr. Connelly appears to not be knowledgable, because if she were knowledgeable on it, and read what's published, she would not be doing what she's doing to children. She just wouldn't.

You know, I can't imagine doing that to children if you read the science in a fair way.

Q Okay, I'm now talking to you about any subject other than gender affirming care. Okay?

A Yes.

Q Does the very fact that someone disagrees with you about the body of evidence in the literature disqualify them from being an expert in their field of practice?

ATTORNEY DROZ: I object to the form.

A In this case, in this situation I say it would disqualify her, because she seems to not be aware of any of

the science.

Q Dr. Weiss, again, I'm asking you about everything other than gender affirming care.

A I can't think of another example. But also --

Q You can think --

A But I might add that this is the only mental health disorder for which modifications of the physical body are employed to fix the mental health disorder. So it's unique.

Q We are talking about whether someone is an expert or not and whether they agree with you or not, okay?

A I can't think of anything else, any other condition in which --

Q So if there is any other area where there is a body of literature and your fellow doctors may disagree about the conclusions from that body of literature, the fact that they disagree with you doesn't disqualify them from being an expert, it's only if they disagree about gender affirming

care for minors, right?

ATTORNEY DROZ: Objection, argumentative and form, asked and answered.

A So there is a use of the word expert in a legal context, and there is a use of the word expert in -- as a medically knowledgeable person. So, I don't think we should confuse those two.

That person might be medically knowledgeable and interpret the science differently.

In this case, legally, I don't see how she could be an expert if she makes statements that support the interventions that she is doing on children when the science and the literature shows that it's harmful.

So, it seems -- I don't know, that's the best way I can answer that question.

Q Do you believe that Dr. Christine Brady is an expert in diagnosing and treating gender dysphoria in

minors?

A I don't remember who Dr. Christine Brady is.

Q She is one of Plaintiffs' expert witnesses. She has a Ph.D. in child clinical psychology, Board certified in psychology, and has treated over 1,000 youth experiencing gender dysphoria.

A What's the question?

Q Do you believe that she is an expert in diagnosing and treating gender dysphoria in minors?

A She may be knowledgeable and an expert in diagnoses, but beyond that I would say no, she's not an expert if she recommended medical interventions to address their psychic distress.

That means she's not an expert.

Q Could we pull up Exhibit 1, which is your declaration in this case, and go to paragraph 17.

So you write, "I have been designated and asked by Defendants to

provide expert opinion based upon my clinical experience treating adults with gender dysphoria and my review of the scientific literature concerning the diagnosis and treatment of gender dysphoria."

So, first, is there a word missing? Were you asked to provide an expert opinion or expert opinions? What exactly was your assignment in this case?

A I'm not sure what the question is.

Q You say, "I have been designated and asked by Defendants to provide expert opinion."

A Right.

Q And I'm asking were you asked to provide an expert opinion, multiple expert opinions?

A No, just the one expert opinion.

Q Okay.

So this sentence tells me what expertise you were asked to draw upon

to form your expert opinion.

But what question were you asked to provide an opinion on, using that expertise?

A The -- relating to the House Bill 71.

Q So you were asked to opine on the reasonableness of HB 71 or something else in relation to HB 71?

A Yes.

Q So it's your expert opinion that HB 71 is a reasonable law?

ATTORNEY DROZ: Objection; form.

A The science -- the science behind HB 71 and my experience related to my treatment of adults with gender dysphoria was used to form this opinion.

Q And do you know what science was behind HB 71, what science the Idaho State Legislature relied upon in passing HB 71?

ATTORNEY DROZ: Objection to form.

A I do not know, but I would imagine it would be at least some of what I have cited in my declaration.

Q Okay. So you don't know what science was behind HB 71, so you are not -- so your opinion is whether HB 71 is reasonable from a scientific perspective, right?

A Yes.

Q Turning to paragraph 21 of your declaration, which is just a little bit further down, so here is five bullet points listed here.

And if we scroll down on to the next page, right, am I correct that those five bullet points represent a summary of the opinions you are offering in this matter?

A Yes.

Q Are you offering any opinions not set forth in your declaration?

A No, but -- and there are other opinions beyond the summary.

Q Can we turn to paragraph 18.

DANIEL WEISS

You indicate that in preparing this declaration you relied on Idaho House Bill 71, the Complaint, the declarations of Plaintiffs' experts and the references that you cited in the declaration, right?

ATTORNEY DROZ: Objection, form.

A I did.

Q Did you review any other materials in forming the opinions in your declaration aside from those cited in your declaration?

A Not that I recall.

Q And then in paragraph 19 you write, "I formed my opinion from my clinical expertise and experience, my rationality or common sense, and my critical review of the scientific literature and the publications on the subject."

First, what clinical expertise and experience did you use to form your opinions?

A As an endocrinologist and as

a physician who has treated adults with gender dysphoria.

Q And generally speaking, more clinical experience is a better indication of expertise than less, right?

A Say that again?

Q Generally speaking, if you rely on clinical experience, it's better to have more clinical experience than less in forming expertise, right?

ATTORNEY DROZ: Objection, form.

A All else being the same, yes.

Q What does it mean to form an opinion based on your rationality and common sense?

A Well, there are some conclusions one might come to that are not based upon a study.

For example, one might say there are no studies that show that crossing the interstate as a pedestrian in the middle of the night is dangerous.

But it's rational to think

that's a really foolish thing to do.

Q Which opinions in your declaration did you form based on your rationality and common sense?

A I can't point to any particular one, but the -- it is completely irrational to think, for example, that an adolescent can make a decision that is life long and produces irreversible change and can have any contemplation about being a father or a mother when they are 14 years old.

So it's irrational.

It's not sensible to offer a judgment like that for an adolescent to make, nor is it rational to modify the body to fix a psychic disorder.

That's not rational, it really isn't.

But it wasn't just rationality that played a role in those decisions, there is science behind it, and I have cited references too.

Q So, is it your opinion that

even for an adult, it is not rational to access hormonal interventions or a surgery to address gender dysphoria?

A Adults are more able and more competent to make those decisions.

I do not think the evidence shows that those hormonal interventions will improve their psychic distress.

So if they have gender dysphoria, they will not tend to help them.

But it's a different decision in an adult than an adolescent.

And I've seen adults, mature adults, regret decisions months after they have had.

I mean, I'm talking about with regard to gender affirming care.

For example, a man who had orchiectomy, I had two patients who had their testes removed, and within months they regretted it.

And they were evaluated by psychologists and were thought to be appropriate candidates for the orchiectomy

as so-called gender affirming care.

That was harmful intervention and the patients regretted it, and they were mature adults.

So.

Q But as a matter -- but an adult is, you think an adult is capable of assessing the risks for themselves as to whether the benefits outweigh the risks of gender affirming care, right?

A Adults are more likely to be competent, more able -- they can give informed consent.

Children cannot give informed consent. They can ascent, but adults are more likely to realize or understand the consequences of their decision.

But, as in my example, adults make these mistakes, too.

Q So, going to the opinions just there in paragraph 21, the first bullet, can you explain what in your endocrinology training informs your opinion that gender dysphoria is a social construct?

DANIEL WEISS

ATTORNEY DROZ: Objection to form.

A So, that training is not -- usual training -- discussion of gender dysphoria, the diagnosis is not in most persons' endocrine training.

On the other hand, in my endocrine fellowship at the University of Iowa, I saw patients with gender identity disorder and was treating with opposite sex hormones in those people.

Q So the basis for your expertise and ability to -- as an expert offer the opinion that gender dysphoria is a social construct, is the fact that during your fellowship training you treated patients suffering from what you then characterized as gender identity disorder, is that right?

A No, so I think I didn't probably answer your specific question at first.

So, it's a social construct based upon reading of the literature.

That's my conclusion.

Q What literature tells you that gender dysphoria is a social construct?

A Much of the literature.

Let's pull up WPATH's definition of gender dysphoria.

Q So WPATH's definition of gender dysphoria informs you that gender dysphoria is a social construct?

A Yes, that and other reading.

Q Have you received any formal training on the social construction of gender?

A No formal training on it, no.

Q In the second bullet -- can we scroll down, please.

Can you explain what in your endocrinology training informs your opinion that hormonal and surgical interventions usually leave psychologic issues unexplored and unresolved?

A Well, certainly I can explain that.

So endocrinologists are

not -- are not trained, any endocrinologists are not trained in that regard.

You have to read the studies to understand that these hormonal and surgical interventions do not help psychologic issues in minors with gender dysphoria. They don't help.

Q So again, you're appearing as an expert witness in this case to opine that hormonal and surgical interventions usually leave psychologic issues unexplored and unresolved, and the basis for your expert testimony is you have read some of the literature?

ATTORNEY DROZ: Objection, form.

A So, the scientific literature, the publications, the research that's been done, show that these interventions do not help psychic distress in minors with gender dysphoria.

And if Dr. Connelly read this literature and did so in an open minded way, she would not have caused harm to all these

children.

Q What in your medical training qualifies you to opine --

ATTORNEY KORBERG: Sorry, withdrawn.

Q Could you just scroll down, please, to the fifth bullet. Great.

And you -- one of your opinions is that a perverse set of financial incentives is likely to play an important role in the massive expansion of these harmful interventions in the U.S., right?

A Yes.

Q What in your medical training qualifies you to opine on the role of financial incentives in certain types of medical care?

ATTORNEY DROZ: Objection, form.

A State that one more time?

Q Yes. What in your medical training qualifies you to opine on the role of financial incentives in certain types of medical care?

A This is an example of just rationality, and so this doesn't derive from endocrinology training or medical training, but we know, and there is a multitude of studies show that the more there is a financial incentive, the more people -- the more people will do the procedure.

For example, those who have an ultrasound machine in their office, do lots of thyroid ultrasounds, that's what endocrinologists do.

If they have a machine in their office, they will biopsy repeatedly, do ultrasounds every year, unnecessarily, on people, because they get money for it.

And what I have cited, some of my references, indicate that this is likely.

The financial incentives are likely an explanation for the failure to realize the evidence, recognize the evidence that the Europeans have recognized on the harm of these interventions.

And the Europeans don't have

financial incentives like we do in the U.S. for surgeries.

And the medical treatment of minors with gender dysphoria, and that's why there has been in massive expansion with so many gender clinics now, because there is a financial incentive.

There is money made to being involved. At least that would be one explanation why they have failed to see the clear-cut evidence of harm, whereas here they do see it.

Q So it's rational to conclude that someone with a financial incentive to provide a particular type of treatment is going to be more likely to employ that treatment to patients, even if providing that treatment is not in the patient's best interests, right? That's your opinion?

A Correct. And there is other examples of that when these procedures are performed.

Q That's fine, understood.

Do you believe that the

citations and references that you reference in your report are from reputable sources?

ATTORNEY DROZ: Objection, form.

A I'm not sure what you mean by that.

Q Well, do you think it's important when forming an opinion to reference reputable or reliable sources?

A Yes.

Q Okay. What makes a source reputable or reliable?

A There are many factors to consider.

Q What factors did you consider in selecting which references and citations to rely upon in your report in forming the opinions there in?

ATTORNEY DROZ: Objection, form.

A When I looked at the methodology of the research, if it was a research paper, and I looked at the, basically the methods was the main thing in

evaluating references -- references.

There are citations that are websites that I might have listed, and that's the website.

But for published literature, it was the methodology, the sample size, the conflict of interest that might be involved, the guidelines, the quality of the research, the gray criteria.

So it depends on the citation.

Q What's the difference between causation and correlation?

A Well, correlation is just an association that does not prove that B is caused by A. It's just an association.

So, association is interesting, but causation is more meaningful and speaks to something being caused by the event that preceded it.

Harder to show causation.

Q And it's your belief that gender dysphoria is caused by trauma, history of abuse, autism spectrum disorder,

depression, anxiety or bullying, right?

A Yes.

Q Would you agree that transgender people face higher rates of discrimination and violence than cys gender people?

A No.

Q You don't think that as a statistical matter a transgender person is more likely to experience discrimination and violence than a cys gender person?

A No.

Q What's the basis of that belief?

ATTORNEY DROZ: Objection, form.

A I have not seen any statistics that support that conclusion. I think it's a common narrative. I think it's false.

So you have to show me solid evidence that that's the case.

I have not seen it. What evidence I have seen is the contrary.

DANIEL WEISS

Q To the contrary. So it's your belief that transgender people experience less discrimination and violence than cys gender people?

A At least no more.

Q So, you testified earlier that you saw first, you encountered a small number of patients seeking gender affirming care during your endocrinology fellowship with -- in the 1980s, right?

ATTORNEY DROZ: Objection, form.

A Yes.

Q Do you recall how many patients you saw during your fellowship?

A I think that was about 12.

Q And do you know how any of those 12 patients are doing now?

A Oh, no. That was in the 1980s that was in Iowa, I do not know. They were adults, too.

Q Um-hum.

What do you think is the appropriate role of government in the

doctor/patient relationship?

A Licensing and ensuring that there is appropriate conduct in the office, so that doctors do not violate the doctor/patient relationship with regard to things like sexual abuse.

And to protect persons from harmful interventions such as, in this case, doctors who might be doing inappropriate interventions on minors with -- that are not helpful.

Q Are there any other examples where you think it's appropriate for government to legislate what treatment is available to patients and doctors?

A Well, we have restrictions on the use of marijuana, for example, medical marijuana.

There are requirements to have informed consent for procedures. There are rules on -- there are very clear rules on clinical research.

And in this case I think, and I think what you're getting at is are they

interfering with the doctor/patient relationship.

And I think because it's clear cut that there is harm being done to these children, and there is no end -- there is no -- it's continuing, and the role of the state is to protect children from harm.

They are vulnerable, and doctors have been not been able to stop that.

It's easy to access these interventions, opposite sex therapy, and even surgery?

And for whatever reason, maybe it's financial incentives, it's continuing, and the role of the state is to protect them, because doctors aren't doing it.

Medical societies could say this should not be done, it's considered improper, but they are not.

Q Okay. Is there any other type of treatment that you think it's appropriate for the government to outlaw?

A Well, this is not a treatment, it's an intervention, that I think when they did pre-frontal lobotomies for a long time, those were then outlawed.

And there are procedures that are not being reimbursed by insurance because they are judged to be ineffective.

And the insurances, for example, require prior authorization for some procedures that -- that the physician has to prove that this is necessary, because everything else has failed.

So there are payment obstacles through insurance or Medicaid in some states to ensure that a person has less, perhaps less invasive treatment before the next step, next iteration in terms of the intervention is performed.

So, yes. For example, kyphoplasty for vertebral crush fractures, there is a controversy on the benefits of that.

So the insurance might not cover it unless other --

DANIEL WEISS

Q Sure. That's an insurance question, though, right?

How about this. Although you don't support gender affirming care, you would agree that the provision of gender affirming care, which is to say hormonal interventions, to people suffering from gender dysphoria, is the current standard of care medical treatment in the United States, right?

ATTORNEY DROZ: Objection.

A Absolutely not, absolutely not. I object to the use of standard of care. It's not the standard of care, it's not a care, it's not a standard, it's WPATH guidelines.

It's what many people who -- people who are on the gender clinics, that's what they do, but many -- most endocrinologists don't treat, don't see patients with gender dysphoria, because they think it's not right to do these hormonal interventions.

It's not standard of care.

It's typically done by gender clinics, but it's harmful, and it can't be the standard of care, because it doesn't work and it's harmful.

Q So it's your opinion that most endocrinologists believe that it is not appropriate to provide cross sex hormones to people suffering from gender dysphoria, right?

A Correct.

Q What's the basis for your opinion that the majority of endocrinologists think that such care is inappropriate?

A The basis of that is my 37 years of teaching and interacting with endocrinologists, going to meetings, and most of them do not see these people with gender dysphoria and don't agree with that approach.

And one needs to keep in mind that these societies that have come out with statements or guidelines that have been written, have people who are on gender

clinics on them, and they have not polled their members in terms of the members' opinions in this regard.

Q Do you think that you interact with a representative sample of all endocrinologists in America with respect to their opinions on gender affirming care?

A Yes, I do. Over the 36 years of experience, yup. And in fact, in our -- just my employer currently, most endocrinologists are, people in the endocrine department are not seeing these people. They decline seeing them.

Q Now, the basis for your belief that the majority of endocrinologists do not support cross sex hormones for people suffering from gender dysphoria is that you personally, with regard to the doctors you happen to have encountered, have experience that the majority of those doctors that you happen to have encountered do not support cross sex hormone intervention for gender dysphoria, right?

A That's correct.

DANIEL WEISS

Q Do you have any other basis for your opinion that the majority of endocrinologists are opposed to the provision of cross sex hormones for gender dysphoria?

A That basis, and in addition, the fact that very few endocrinologists will treat people with gender dysphoria; very few.

Q What's the basis for your belief that very few endocrinologists will treat people for gender dysphoria?

A It's easily found on, when you go to endocrinologists and sites and you can call offices.

Most of them do not treat, and I have trained people -- I have trained and people I have interacted with over the years, they don't see those people.

I was -- in Ohio, I was the only endocrinology in northern Ohio seeing people for years.

Q What is your confidence interval in your blanket statement that the

majority of endocrinologists do not support cross sex hormones for people suffering from gender dysphoria based on?

ATTORNEY DROZ: Objection.

A Well, of course, you know that's -- there is no confidence interval. But there is no data to indicate that the majority of endocrinologists do support it.

So, on the contrary, on the other hand, there is no evidence that the majority do support it.

My experience over 36, 37 years is that they don't.

Q You agree that the American Medical Association, for example, supports the provision of gender affirming care to treat gender dysphoria, right?

A I agree that the American Medical Association made that statement, and they represent less than 25 percent of doctors in the United States. Less than 25 percent.

Q If you were to add up all of the major medical associations that have

expressed their belief that it is appropriate and in patient's best interests in some cases to provide cross sex hormones to people experiencing gender dysphoria, what percentage of the doctor population do you think all of those organizations would cover?

ATTORNEY DROZ: Objection.

A That's a meaningless question, because it's not a popularity contest, and many of these statements, most of them, I think statements from the organizations are written by a very small group of members who -- and they have not taken account of the majority of their constituents.

For example, as I have written in my declaration, we can go to that section about societies, this is not a popularity contest.

It's -- the -- the decision should be based on the science.

Those statements are not, where they might come out and supported, are

not based upon science.

The most recent statement from the pediatric group, the large pediatric group which has 66,000 members, they say well, we are still supporting it, but we are going to do a systematic review.

Okay, so wait a minute, you're supporting, you're promoting this concept without having done a systematic review?

So they are backtracking a little bit.

And the Endocrine Society is, they are going to revise their guidelines. How they are going to revise them I don't know, but they are looking at it again.

Q Okay, I understand your opinion on that.

You would agree with me at the very least that hundreds, if not thousands of doctors, currently provide cross sex hormones to people experiencing gender dysphoria in the United States, right?

A No, I don't know that number. I don't think you do either.

Q You wouldn't be willing to say that hundreds of doctors provide such care across all the gender clinics and all of the major universities at InterMountain, your employer, even in your state?

A It might be a few hundred, yup.

Q Okay. Let say a few hundred?

A Okay.

Q Do you believe that criminal penalties are appropriate for care that hundreds of doctors are providing?

A It's not care, and I think when there is harm to vulnerable minors, and the doctors' organizations are not stopping that harm, I think criminal penalties would be appropriate.

Q And should there be any exceptions?

Like, is imprisonment appropriate for a doctor that honestly believes that the care is in a patient's

best interest?

ATTORNEY DROZ: Objection, form.

A I think these interventions ought to be banned, and whatever it takes to ban them in minors, we are just talking about minors, whatever it takes to ban them would be appropriate, because the medical groups themselves have thus far not been able to stop them.

Q Okay, so you think imprisonment is appropriate for a doctor providing interventions that he believes is in a patient's best interests, if those interventions are the provision of puberty blockers to minors suffering from gender dysphoria?

ATTORNEY DROZ: Objection, form. You can answer.

A I think with full awareness and an understanding of what he or she is doing to that minor, and if he proceeds to cause harm, despite knowing the law, I think yes, then he should suffer the consequences.

DANIEL WEISS

Q And if the doctor has observed that puberty blockers benefit other patients, other minor patients suffering from gender dysphoria?

What if that doctor, based on their clinical experience, disagrees with you that it's harmful?

It's your belief that it's still appropriate for that doctor to be imprisoned?

A Yes.

There is an example of that. You know, with use of -- doctors who are thinking they are doing the right thing by giving narcotics or benzodiazepines, sedatives, and they think I'm really helping that person, and this is even less harmful, because you can stop those drugs.

But that doctor will be imprisoned because of regulations on scheduled drugs if they are inappropriately prescribing those drugs.

Here we are talking about an intervention which is irreversible on a

minor, not on an adult, on a minor.

And with full knowledge of the law, that prescriber or that physician does this to a minor, yeah, that's even -- that's more justified to imprison that doctor than it is to explain imprisonment of a physician who is prescribing a scheduled drug on an adult.

Q What are your opinions on the COVID vaccine mandate?

ATTORNEY DROZ: Objection, relevance. I object to form.

A I think that's outside the scope of this discussion.

Q Well, one of the subjects of this discussion is the proper role for government and law making when it comes to treatment decisions for doctors and patients.

Right? That's what this law does.

A Yes, and it's dealing only with minors.

Q Sure.

DANIEL WEISS

But you said that you, when I asked you about whether you thought it was appropriate for the government to make treatment decisions for doctors and patients, you said there are other areas where you think it could be appropriate or perhaps not appropriate.

So I'm asking you what is your opinion with regard to the COVID vaccine mandate?

Do you think that was an appropriate government regulation?

ATTORNEY DROZ: Objection to form.

A Yes, I do.

Q Are there any other courses of medical intervention that are supported by the American Medical Association that you think should result in imprisonment of a doctor who provides that intervention?

A I cannot think of any, but I don't stay current on those other AMA endorsements.

I used to be a member of the

DANIEL WEISS

AMA, and then I discontinued my membership.

ATTORNEY KORBERG: I think this might be a good point for another break. We have been going for about an hour.

THE VIDEOGRAPHER: Thank you, counsel. This is the videographer. The time is 12:31, this ends media file 2.

(At this point in the proceedings there was a recess, after which the deposition continued as follows:)

THE VIDEOGRAPHER: The time is 12:37. We are back on the record. This begins media file 3.

Q So, as a clinician, you only recommend treatment for your patients that you believe is safe and effective, right?

A Yes, there is balancing of risks and benefits.

Q And you only recommend treatment that you believe is sufficiently supported by evidence, right?

A The best evidence that's

available, in discussion with the patient and balancing risks and benefits.

Q So, at least at the point in time in which you were treating patients with cross sex hormones for gender dysphoria, you believed that such treatment was safe and effective, right?

A Yes, at that point. The evidence was much more sparse.

Q But at that point you thought that the evidence as it existed when you were providing cross sex hormones to people suffering from gender dysphoria, you believed that your care was sufficiently supported by the evidence that you could ethically provide it to your patients, right?

A Yes, and that were adults.

Q I understand that you treated patients, you encountered patients suffering from gender dysphoria during your fellowship in the 1980s, right?

A Yes.

Q And then beginning in 2003

you began also treating patients, adult patients for gender dysphoria, right?

A Yes.

Q Did you treat or diagnose any patients for gender dysphoria between the 1980s and 2003?

A Not that I recall.

Q You write in your declaration that at your independent clinic you became the "key physician responsible for treating patients requiring cross sex hormones," right?

A Yes, in that area of Ohio.

Q And what does it mean to be the key physician?

A I was the principal physician in the area in northern Ohio seeing people requesting hormonal intervention for their gender dysphoria, and I was listed on an LGBTQ website.

Q What steps did you take to establish yourself as a key physician responsible for treating gender dysphoria?

A I was just willing to offer

treatment, and word got around, and then I was listed on the website.

Q Did you play any role in your listing on the website?

A No; no, and other endocrinologists declined treatment consistent with what I have said before about endocrinologists not treating.

People would call the office and say -- and would convey to me that there was no other endocrinologist who was willing to treat, other than there was a doctor who in inner city Cleveland who was willing to treat.

But was less accessible, less accessible.

Q Is it your belief that other endocrinologists at the time, in 2003, were unwilling to treat physicians because of the state of the evidence regarding the safety and efficacy of cross sex hormones for gender dysphoria?

A I think you misspoke there. Was unwilling to treat patients?

DANIEL WEISS

Q Yes. Why don't I try that again.

Is it your belief that other endocrinologists in 2003 were willing to treat -- unwilling to treat patients with cross sex hormones for gender dysphoria because of the state of the evidence regarding the safety and the efficacy of such treatments?

A No, I don't think that was the reason.

I think there was -- there were not that many people who felt they were -- had gender dysphoria, and there was an explosion of a number of people after around 2015 or so, and then eventually gender clinics arose.

But I don't think it was that there wasn't the evidence.

Maybe, let see, in -- there was an Endocrine Society guideline statement already, and WPATH was around.

So it wasn't lack of evidence, it was just doctors who were not

willing to treat.

Q And why do you think doctors were unwilling to treat in 2003 when you were willing to treat, if not for the evidence?

A I think some of it was not having experience with it, and I had some experience in my fellowship and I wanted to help people.

I felt it was probably the right thing to do. They were adults, I could discuss the possible side effects that I knew of, and my goal as a physician is to help people and reduce suffering, reduce pain and suffering, and I felt this was an appropriate step to do so.

And only later did I learn, not just from the fact it wasn't helping them, despite the physical changes, but that the science indicated, especially in minors, that it does not help them.

Q What was the principal LGBTQ website that you are referring to?

A It no longer exists. I

looked for it. It's not there anymore. It was called -- it was called Be All, like Be All You Can Be.

Q And how did you determine that was the principal LGBTQ website? Are you familiar with LGBTQ websites?

A Well, there is so much, it's changed. It was, I stopped, that was 2010, 2003, 2010, 2013, so at that point it was.

I would see my listing on there, and -- but that website is not there anymore.

And there are a lot of other websites.

Q You testified earlier that the patients that you were seeing in 2003 and the subsequent years to whom you were providing cross sex hormones for their gender dysphoria, you testified that you were the one to diagnose them with their gender dysphoria, is that right?

A No, they would come to me after having seen a therapist.

Q Okay.

DANIEL WEISS

Is there any patient who you diagnosed with gender dysphoria rather than a therapist?

A No. They had seen a therapist. Most of them had seen a therapist already and then came to me.

Q Okay, of the -- am I right that you believe you saw roughly 100 patients during that span?

A Yes, correct.

Q Of those 100 patients, how many of them were coming to you not having received a diagnosis of gender dysphoria from a therapist?

A I think all of them had. They may not -- some of them didn't have letters in support of hormonal interventions, but I think all of them felt they had gender dysphoria or gender identity disorder at the time, and they had at least one visit with a therapist.

Q Would you have treated someone suffering from --

ATTORNEY KORBERG: Withdrawn.

DANIEL WEISS

Q Would you have treated someone with cross sex hormones who had not received a diagnosis of gender dysphoria from a mental health professional?

A No.

Q Did you take steps to independently diagnose those patients with gender dysphoria?

A No -- well, I should clarify.

I would ask them at their first visit, tell me about your feelings, and to explore the question of gender incongruence to just confirm the diagnosis that the therapist would have made.

Q Did you perform a psychological evaluation of those patients?

A Well, to the extent that the questioning was, but no formal questionnaires or SF 36 or things like that, Beck Depression Scale.

I didn't do those types of things, because I left that to the therapist.

Q You testified earlier you

took steps to determine whether those patients fit the criteria for either gender identity disorder or gender -- or gender dysphoria under the DSM.

Is that still your testimony?

A Yeah. Well, just in terms of confirming the diagnosis that the therapist would make. But I didn't do it proactively, before they saw a therapist.

Q Would you specifically go through the DSM factors and do an analysis under the DSM guidelines, or were you doing something else?

A It was a broad overview of the DSM guidelines, yes.

Q Of those -- were there ever any patients that you assessed for gender dysphoria who you determined did not, in fact, meet the DSM criteria for gender dysphoria?

A There was one of my patients who wanted opposite sex hormones, and I really was -- felt that they needed more psychological evaluation.

And this female was -- wanted hormones right away, and was going off to college, and that person I was really unsure of, and I declined giving her hormones.

And I said, you know, I think that we needed to wait a little bit. So that was one person.

Q And when you say female, what was this person's gender identity as expressed to you?

A She felt she wanted to have hormones to make her appear like a boy; male.

Q And you are referring to this person using she/her pronouns now.

Did you do so at the time?

A Yes, because she was, she looked like a female and was living like a female at that point, and she was fine with that.

Q Do you know whether that person ever did access testosterone?

A No, because she didn't follow up with me.

Q Did all 100 of the patients that you saw access cross sex hormone therapy?

A Yes, all except that one.

Q And have you ever prescribed anyone puberty blockers for the treatment of gender dysphoria specifically?

A So, I did not use puberty blockers for males or females because I didn't -- I was not seeing minors.

Everyone had gone through puberty.

Q Did you offer referrals for surgery for any of these 100 patients?

A Yes.

Q Approximately how many of the 100?

A This was quite a while ago, but I would estimate -- well, referrals, yes, so referrals is one thing, and those who actually had surgery is another.

So, probably about 40 people I referred for surgery and probably about -- well maybe 50, hard to remember.

Those who had surgery, most of the time that surgery was bilateral mastectomy in biologic females, and perhaps 10 to 15 had orchiectomy or production of a neo-vagina, faux vagina.

Q Sorry, how many of the 100 had bilateral mastectomy?

A I would say probably 40.

Q So, of the 100, 40 of your patients had bilateral mastectomy, 10 or 15 had orchiectomy, and did any of your patients have any other type of surgery?

A I think -- I had probably about 5 who had -- well probably about 5 who had vaginal -- vaginoplasty, and then a couple who had neo-phalluses made, phalloplasty.

Q So somewhere around 65 of the 100, perhaps, accessed surgery for their gender dysphoria, is that right?

A That seems high. I don't think it was that high, it was probably -- it hard to remember.

Probably -- so those who had

mastectomies. Some of those had lower surgery, too, others didn't. The majority did not.

So, I will leave it at that.

Q I mean, you are appearing as an expert in this case and offering all sorts of expert opinions on the provision of cross sex hormones.

Based, as I understand it, on your personal clinical experience providing these treatments, right?

ATTORNEY DROZ: Objection, form.

A And the review of the scientific evidence on these interventions in minors.

Q Right. But you would agree your clinical experience with these 100 patients is a major part of the basis of your expertise in offering the opinions that you do in your declaration and are today, right?

A It's part of that, actually.

Q These 100 people are your

data set, right?

A Right.

Q Okay. So I want to understand from you how many of the data set accessed gender affirming surgery.

A I think that -- I think the number of mastectomies is probably high.

But, you know, I don't have -- that's a long time ago, and I know that some of them had mammoplasty, probably maybe more like 30 or 40 had top surgery, and then about 15 had bottom surgery.

Q Okay.

So, maybe something like 45 to 55 of your patients had some sort of surgery to address their gender dysphoria?

A Yes.

Q How often did you see these patients?

A Usually every three months or so.

Q What steps did you take during those visits to assure yourself that the care they were receiving was safe and

effective?

A I would ask them how they felt and what changes they noticed.

I would measure blood tests, and I would ask them about their therapy visits, if they had them.

Q Are there any other steps you felt important to take to assure yourself that the care that they were receiving was safe and effective?

A Yes. So again, it was a questioning related to symptoms and physical changes, and I would examine them, and the blood tests.

Q And were you following the Endocrine Society treatment guidelines at this point?

A What were the guidelines that were available, yes, and my best judgment.

Q Did you conceive of your role, part of your role as evaluating your patient's mental health status?

A Yes.

Q And how did you do that?

A I would ask them how they felt, their mood, their interest in things, their sleep, their mental focusing, were they sad or down a lot?

Were they anxious, what were their stressors in their life, how was job, how was school, and so on.

Q What if someone said that they were anxious or depressed, what would you do then?

A Well, I would try to explore why in the time available for the visit, and then often encourage them to follow up with their therapist.

Q At any point did you counsel a patient that they should consider stopping hormone therapy?

A There were some females, biologic females who were on testosterone where I modified the dose because of a high red cell count.

But stopping, no, those, some who had certainly with, after orchiectomy there is no need for -- there is -- it's

appropriate to modify dosing at that point, and so that would be a reason to modify or reduce a dose of estrogen.

And those would be -- so yes, there were circumstances, there was a modification for discontinuation, usually temporary, of the medication.

Q Of those 100 patients, was there ever a patient that you counseled to consider stopping hormone therapy because it was not either safe or effective for them?

A So, the principal assessment of efficacy I was looking for, even though one would hope there would be an improvement in psychotic distress.

I saw no improvement in psychic distress, but I was primarily looking at physical changes.

In those people, no, I didn't stop, because there was inadequate physical changes.

So, that's the safe and effective thing. Efficacy was originally designed in the trials for minors with the

hope of reducing psychic distress, which it did not do.

And in this case, it didn't reduce psychic distress in my adult patients either. At least that was my perception.

Q So you perceived that cross hormone therapy and in some cases surgery, did not reduce psychic distress in any of these 100 patients?

A No, I think actually it tends to increase it.

Q Okay, so let's just -- so zero of the 100 patients experienced an improvement in their psychic distress as the result of hormones or potentially surgery, right?

A Right.

Q How many of your patients experienced a worsening of their psychic distress as a result of hormones or potentially surgery in this period?

A Oh, I can think of one who attempted suicide twice after surgery.

No one else that I can think

of where it appeared to be worse.

Q How did you monitor and evaluate psychic distress in your patients?

A So, it's really just talk therapy, talking to them, asking about dysphoria and hedonia, and energy, sleep, those kinds of things aspects of depression.

Q Did you have standards of evaluative questions that assess the mental health or psychic distress of your patients?

A Not that I recall.

Q So, you might ask each of those patients different questions or no questions at all, right?

A No, no, I would always ask questions, and it was often open-ended.

So I didn't do yes/no type stuff, but more open-ended, to allow for discussion and exploring.

Q Have you ever received training in psychologic or psychiatric evaluation of the type that you were doing?

ATTORNEY DROZ: Objection, form.

A Of continuing medical education and -- would provide some guidance in that regard and reading.

Q So you specifically read up on how to perform psychologic evaluation to determine any changes or lack thereof in-patients' psychologic distress?

A Well, beyond that, continuing medical education, I've had in that regard and -- so reading and continuing medical education.

But I'm not Board certified in psychology. But one can gain expertise and know how with open-ended questions can explore symptoms that relate to anxiety and depression.

Q So you felt qualified to assess the absolute and relative level of psychic distress of a patient via a conversation, is that correct?

A Yes.

Q According to your declaration, you stopped accepting new patients with gender dysphoria in 2013, when

you realized the lack of benefit and the harm these interventions caused, is that right?

A Yes.

Q Was that realization that you had in 2013 sudden or an evolution of some sort?

A Oh, it was an evolution.

Q Can you describe to me that evolution, how it unfolded, when it unfolded?

A It was gradual, and then I also saw people coming to me who did not have, I felt, adequate psychological evaluation.

And they had lots of other psycho-social factors that were complex, that needed to be evaluated, and would not be fixed by giving them opposite sex hormones.

Q Is that a sudden development that at some point between 2013 and -- sorry, 2003 and 2013 you started seeing patients that seemed to have other

psycho-social factors separate and apart from their gender dysphoria?

A I think it was gradual, I think it was a realization that was a gradual realization.

Q Can you roughly pinpoint when in the decade that sort of realization coalesced into a concern?

A No.

Q And as that realization was developing for you, did you take any additional steps to evaluate the safety or efficacy of the care that you were providing to those patients that you hadn't been taking prior?

ATTORNEY DROZ: Objection, form.

A Nothing new, really just to still doing the open-ended questioning to explore their psycho-social factors.

Q Did that open-ended questioning change at all as you began to develop concerns about the safety and efficacy of the treatment that you were

providing?

A I don't recall.

Q Did you take any steps to quantify or track the psychic distress or well-being of your patients over that time?

A No, I didn't quantify it.

Q Did you take any steps to qualify it?

A It was just my tracking. I didn't write things down.

Q If we looked at your patient notes from this time, were you keeping notes of whether a patient's psychic distress was better, worse or the same as compared to the prior time you saw them?

A Yes, I would have done that.

Q And how would you have notated that?

A Just in a dictated -- I would dictate a note.

Q Would you have notated whether the patient's psychic distress was better, worse or the same as compared to when they first presented to you for care?

DANIEL WEISS

A As compared to baseline.

Well, it was all qualitative.

Q And how did you keep track of it qualitatively?

A Just through a description.

Q What would be an example of a description?

A Patient is feeling sad and down a lot. The doctor went up on the dose of antidepressant.

He is feeling bullied at work. He quit his job. Things like that.

Q Do you have a very good memory?

ATTORNEY DROZ: Objection.

A Not as good as it used to be.

Q Were you able to determine the relative psychic well-being of your patients based on your recollection of how they appeared to you in your informal conversation three months prior, or were you going by some other -- did you have some other system for keeping track of that?

A Oh, I had -- well, I had

excellent -- I would transcribe a detailed note. It was text, it was not an electronic medical record at that point.

And I knew these patients, there weren't that many of them, so I recalled exactly what was going on with them, but my medical record would reinforce my previous visit.

Q Did you have any like quantitative system, like a scale of 1 to 10, for mental health or anything like that, which would allow you to compare the evolution or lack thereof of a patient's psychic distress?

A No, no quantitative, no numerical scale, no.

Q How did you choose the day that you would no longer accept new patients?

A Again, it was a gradual realization that both the science didn't support it, the patients didn't seem to be improving from a psychological standpoint, which was the principal reason that those

hormonal interventions were initiated.

And lastly, that they did not have adequate psychologic assessment before they were coming to see me.

Q So you came to realize that the psychological assessment and diagnosis of gender dysphoria that they had received prior to coming to see you was inadequate in some way?

A Well, because the gender dysphoria arose from other issues that had not been addressed.

The fact that their parents fought all the time, that their father abused them, that this guy sexually abused them, that they were depressed and anxious for other reasons, and so on.

That those were the principal psychologic issues that needed to be addressed, and I wasn't addressing those with hormones.

Q Lots of people have parents that fight all the time, have been sexually abused, et cetera.

DANIEL WEISS

And are cys gender, right?

A Say that again, I'm sorry, I missed that.

Q Lots of people have had parents that fight all the time or were abused sexually or otherwise and are cys gender, right?

A If they don't -- that don't express gender dysphoria, correct.

Q Why are you convinced that your patients' gender dysphoria was caused by these other traumatic circumstances that do not cause gender dysphoria in the majority of people who experience them?

A I think the --

ATTORNEY DROZ: Objection to form.

A I think right now it's very clear that there is an increasing number of minors who come out with saying they have gender dysphoria, and that is in part related to peer influence and social contagion and social media, in conjunction with having these stressors.

DANIEL WEISS

The treatment for someone who is sexually abused, it's a convenient -- if you're a girl and you are sexually abused by a male, it's an unconscious -- it's just so straightforward that that girl might not want to look like a girl and attract -- and encourage any more sexual abuse, so they want to change their appearance.

So that's just -- it's so obvious that that would be an explanation for that desire.

And just because someone a so-called cys gender person, someone who doesn't express gender dysphoria dealt with a sexual abuse and doesn't -- isn't dealing with it with an attempt to change their body, doesn't mean that there is a whole -- there is a whole group of people who pursue that route.

Those who say they are gender dysphoric, but really that's not the problem, the problem is they were sexually abused.

So I think there is on the

other hand absolutely no evidence to claim, as many people do, who treat those with gender dysphoria, or I should say intervene with hormones, that it's the fact that they are discriminated against or bullied, the so-called minority stress idea, that's why they have the problems with anxiety, depression.

For causation, there is no evidence for that.

And it makes psychologic sense that they have -- these other psychological problems could be and likely are the cause for their simple, quick fix desire of hormones to change them.

That's a long answer, but --

Q Why would a young person assigned male at birth who was sexually abused respond to that by accessing cross sex hormones and identifying as and living their life as a woman, when statistically women experience much higher rates of sexual violence and assault?

ATTORNEY DROZ: Objection to

form.

A Yes, so psychological issues are very complicated.

So you're presenting a hypothetical case, and there is probably many factors in that unfortunate child's history that need to be explored and addressed, and bonafiding their body experience is not the answer to those psychological problems.

And they may actually unconsciously think that modifying their body appearance might fix it.

They are a child, they don't know about the statistics about woman being assaulted.

So, you are giving me a hypothetical example that likely has many -- would in reality have many complex factors that all need to be explored.

And those aren't being done. They are just -- they are being approached by hormonal interventions.

Q When I asked you why you

became convinced that your patients' gender dysphoria was caused by all these other traumatic circumstances that don't cause gender dysphoria in the majority of people who experience them, you talked about social contagion, right?

A Yes.

Q Do you believe that the patients who were coming to you in 2003, 2004, were experiencing social contagion?

A There was peer influence and there was likely social factors, seeing it on media, on social media; very likely some of those people.

Especially later on in that period.

Q In your expert opinion you say that you stopped providing care because of what you determined to be a lack of benefit of interventions for gender dysphoria, right?

A Yes.

Q What do you mean when you refer to lack of benefit?

A I mean the psychic distress that they were feeling, that they attributed to this discordance between their natal sex and their internal sense of what they were, was not fixed.

Their anxiety, depression, other factors, were not mitigated by the hormonal intervention.

And there was concern about harm from those hormonal interventions.

Q Let's talk about that.

First, did any of those 100 patients express to you pleasure or satisfaction or happiness about the physical changes they were experiencing as a result of cross sex hormones?

A Yes.

Q How many, would you say?

A Maybe 15, 20, something like that.

Q So, 15 or 20 of the 100 expressed subjective happiness at the results of the treatment that you were providing, right?

A The physical changes, yes.

Q Did you ever ask why the 80 to 85 who didn't express affirmative happiness at the results of the treatment were continuing treatment?

A There is a substantial number who didn't -- during those ten years, they chose not to follow up.

Q Well --

A So I don't know what happened to those people.

Q Um-hum, sure.

A So they either stopped, maybe they went to another doctor, or maybe they just desisted, or the child, say, thought oh, this is not really helping me that much, I got the physical changes, but I'm still anxious, depressed, whatever.

Q Or maybe they moved?

A Yup.

Q Did any of your 100 patients ever tell you that they were discontinuing hormone treatment because they were dissatisfied with the results?

A No.

But you know, the literature that we have available shows that those who stop, 70 percent or so never inform their doctor.

Q Okay. But you would still expect some number of -- you would expect someone, even if it was just 70 percent, to inform you why, right?

But nobody ever did, right?

ATTORNEY DROZ: Objection to form.

You can answer if you understand.

A Yes, correct.

Q Did you determine there was a lack of benefit of all of the interventions you were providing to patients for their gender dysphoria?

A There was -- the benefit in terms of the physical changes was seen.

So if they were seeking physical changes, they did get changes with those hormonal interventions.

On the other hand, if the condition we are treating, which is this psychic distress related to this gender incongruence, I don't think they -- most of them had benefit from them.

Q But some did, you believe?

A Perhaps, yes.

Before -- I don't know whether it was that or maybe the counseling they were getting was helping.

So, we don't know, we don't know because it was a before and after thing.

Association, not causation.

Q Did you have a requirement that anyone in your care continue to receive mental health treatment while they were in your care?

A I did not have a requirement that they had to continue to, no. I think it's a good idea, but no.

Q Did you ever speak to your patients' mental health provider and get their assessment of whether the treatment

you were providing was beneficial in relieving the psychological distress of gender dysphoria?

A Not after I embarked upon treatment. But early on, whether the person was appropriate for prescribing it, I did converse I think on a couple of occasions with their therapist.

Q So a couple of times out of the 100 you spoke to one of your patients' therapists?

A Yes, early on.

Q As over the course of that decade, 2003 to 2013, you came to believe that the treatment that you were providing was not actually relieving your patients' psychic distress.

Did you at that point undertake any effort to consult with anyone else as to whether that hunch might, in fact, be true?

ATTORNEY DROZ: Objection to form.

A I was reading some literature

there, and it wasn't really clear that it was helpful from a scientific literature. But as I stated, I continued to provide those interventions. I didn't discontinue them.

And those patients who continued under my care, I continued to prescribe them and encouraged those people to follow up with therapy more frequently.

Q But you didn't take any steps to ensure that your patients did, in fact, follow up with therapy more frequently, right?

A Say that again?

Q You didn't take any steps to ensure that your patients did, in fact, follow up with their more frequently, right?

A I could just encourage them, I couldn't enforce that; no.

But I was going to not abandon them. I continued to provide this hormonal treatment, which they -- those who stayed with me, wished to continue.

And so I was going to

continue to offer that to them.

Q So you refer to both what you came to believe was a lack of benefit of the interventions you were giving your patients, and also the harm of the interventions you were giving your patients for gender dysphoria, right?

A Yes.

Q What do you mean when you refer to the harm?

A Well, the harm can occur, I have detailed possible harms in my declaration at great length, and most of those data are in adults, because we have very little data that's been gathered in minors, and it's harm, that's long term harm.

But I saw, for example, patients who had very high hemoglobin content, that's their red -- their blood becomes very thick on testosterone, worsening in sleep apnea, because, perhaps related to testosterone.

So those are two examples of

harm from those -- that intervention.

Q And when you had patients with very high hemoglobin content, you testified earlier that you adjusted their dose of testosterone to bring their hemoglobin down, right?

A I adjusted the dose. Some of them I encouraged to have -- to donate blood.

Q Were there any harms that your 100 patients experienced that you were not able to address with medication management?

A Not that I recall.

Q Did you ever raise with any of your patients your belief that the treatment you were providing them was not benefiting them?

A No, I didn't. I did raise the risk of harms like blood clots with estrogen therapy, mineral imbalances with spirolactone and so on.

But if they -- but I did not raise the concern that it was not helping

them.

Q And why not? Why didn't you raise the concern that with your patients that the treatment that you were providing them was not helping them?

A Well, I think they were convinced that it was the right thing to do, and it was, again, as I said, a gradual evolution.

When I came to conclude that it was really not the appropriate and best and most effective intervention for them, it was really more therapy counseling that they needed to focus on.

Q But by 2013, you had reached the conclusion that the treatment you were providing was not effective, right?

A Yes.

Q But that's not something that you told the patients that you continued to provide treatment to, right?

A Right.

Q Is it your belief that all interventions for gender dysphoria cause

harm?

A Well, gender dysphoria arises, as I said, I think from other factors, and those need to be addressed.

And we are not addressing them when we focus on modifying physical appearance to fix this sense of incongruence, and there is a potential to cause harm with all those interventions.

And so they are not addressing the underlying harm, and there is a risk of harm.

Now, in an individual case, a person may or may not be harmed.

But why should we be intervening with a treatment that's not directed to the underlying cause? Especially when it has a risk of harm.

We shouldn't.

Q Did you take any steps during your clinical practice to test your theory that gender dysphoria is solely the product of some other mental health condition or trauma?

DANIEL WEISS

A That's not something -- I wouldn't do an experiment in my clinical practice.

So, that sounds like a clinical research trial, and that would be unethical, to conduct that on patients.

Q So, I understand your theory of why sexual assault would cause someone to experience gender dysphoria and desire to undergo cross sex hormone treatment.

What about eating disorders, which is another one of the causal factors that you have said for gender dysphoria?

What's your theory for why eating disorders cause some people to experience gender dysphoria?

A Where do I say eating disorders --

ATTORNEY DROZ: Objection to form.

Q Sure, it's in your declaration, we can pull that up.

We can return to that, actually. Let's put a pin in that one.

A But eating disorders is -- I know, and I have cited that in the declaration, is a -- we are seeing less of it now than we did years ago.

But eating disorders often occur in a setting of peer influence and social contagion.

So, that has some analogy to gender dysphoria.

You know, adolescent development is very complicated, and children want to fit in, they want to be liked, and they might feel bullied, they might feel isolated.

And it's not just my theory that these underlying psychiatric and psycho-social factors could contribute to the development of gender dysphoria in a child.

There is, you know, others who, in published literature, who describe this as a concern, and that those underlying factors must be addressed before you embark upon hormonal interventions if you are

thinking that that's an appropriate thing to do.

Q What's your theory for, let's see, I believe let's go to paragraph 27, let's pull up Exhibit 1, which is your declaration, paragraph 27.

You say, "Discomfort or distress with regard to one's body is especially common in those with anxiety, autism, eating disorders or history of trauma," right?

A Right.

Q And earlier I believe you testified, we can go through the exercise of it, but the rough transcript here should say that as a causal matter you believe that gender dysphoria is caused by these totally separate conditions and circumstances, right?

ATTORNEY DROZ: Objection, form. That's not what he said.

A I think it's simplistic to claim that one's psychiatric condition is totally separate from another, that's really

silly, and that each individual needs to be carefully evaluated through a supportive exploratory approach to understand the dynamics involved in the development of eating disorders, their anxiety, their distress and their depressive symptoms, and why that child might respond with a hope that changing their body is going to fix these issues.

And that is manifested, they call it gender dysphoria, and it overshadows then all of these other psychiatric and psycho-social factors that must be addressed.

And it just -- it makes no sense to intervene with modifying the body to fix or help children who have all these other factors that are -- that need to be addressed, and safely.

If you look at just the risk/benefit thing, you are doing physical changes on the body with the hope of a -- making the child a little more happy right at the moment, because that's what they

think is the answer.

So complicated problems that need to be addressed without changing their body.

Q Okay, we will come back to that.

How did you communicate your decision to stop accepting new patients suffering from gender dysphoria to your front desk?

A Oh, I just said I'm not going to be seeing new people.

The patients who are established in my practice, I will continue to see.

But if patients call for a visit, no, and for about, gee, maybe even a year or longer after I stopped, I still would be getting calls for patients to be seen, patients requesting that I see them; new patients, that is.

Q Um-hum.

And was it the standard practice then for a new patient calling in

to have some sort of screening interview in which the front desk asked what they were seeking treatment for?

A Remember, something very short, you know, what are we seeing you for.

And patients could refer themselves. They didn't have to have a referral from -- I was very welcoming in that regard.

Patients did not have to have a doctor's note to be seen by me.

They could just say I'm being seen for -- I'm transgender. Okay. Dr. Weiss is not seeing new people, I'm sorry, at this time, and we can give you the name of this other clinic.

Q And how did you -- you didn't tell them that you were no longer providing gender affirming care, right?

A I was no longer seeing new people with gender dysphoria, we told them that.

Q You did tell them that?

A Yes.

Q And did you say why?

A No.

Q Did anyone ever ask why you were no longer accepting patients?

A Not that I know of.

Q Did you communicate to your existing patients who you were going to continue to provide treatment to that you were no longer accepting new patients seeking the care that you were providing them?

A I think probably just in a few situations where they said they were going to refer their friend, I would just convey to them oh, I'm sorry, I'm not seeing new people.

Q Did you specify you weren't seeing new people for gender affirming care, or did you leave it more broadly, as if you weren't accepting new patients, period?

A I think I was pretty clear that I was just not seeing new people who had gender issues.

Q And what reason did you give

your existing patients who were in fact receiving that care from you, as to why you were not accepting new patients to provide that care to them?

A That's a very good question.

I don't recall giving them a reason, and I don't think they asked.

But my practice was very busy in general. It took maybe four months for most patients to get in to be seen.

And those patients with -- I had been seeing with gender identity disorder, I would make special effort to get them in sooner, because there was no other doctors providing readily available care.

So during those ten years I would -- they would get priority, frankly.

Q Why did you think it was important that they not wait very long amounts of time, to not have to wait long amounts of time to begin receiving cross sex hormones?

What was the urgency?

A Well, I wouldn't call it

urgency, but I was feeling that -- again, as a physician I went into medicine because I want to relieve people's suffering.

And I felt that they were seeking help, no one else was there for them.

Their primary care doctor certainly wouldn't do it, and I wanted to help them, so I just wanted to relieve their distress.

Q Did your decision to stop accepting new patients for gender affirming care coincide with any changes in your personal beliefs?

A No.

Q Did your decision to stop accepting new patients to provide --

ATTORNEY KORBERG: Withdrawn.

Q Did your decision to stop accepting new patients seeking gender affirming care coincide with any changes in your personal religious beliefs?

A No.

Q Did any of those 100 patients

begin treatment for their gender dysphoria while they were minors not with you, I understand you didn't ever provide care to minors, but prior to seeing you?

A Maybe one person was getting some hormones on the internet, and that's the only one I can think of.

Q And they began receiving those hormones prior to turning 18?

A No, I don't think so, no. He or she was an adult.

Q And am I correct that after you stopped accepting new patients you continued to treat your existing patients with cross sex hormones for a number of years, until 2022?

A Correct.

Q And when in 2022 did you stop providing gender affirming care treatment to your existing patients?

A Well, when I moved from out of Ohio and relocated to Utah, I was not going to be doing it from Utah, and so that would have been the last day of practice in

Ohio, which was I think December 2nd, 2022.

Q Why do you choose to continue to treat your existing patients with care that you thought was not efficacious and was potentially causing them harm after 2013?

ATTORNEY DROZ: Objection, form.

You can answer.

A So those patients who continue to follow with me, some of whom had surgery, a fair number who were living as the opposite sex, required some hormonal intervention, because they maybe had orchiectomy or oophorectomy, and they chose to, the patients, wanted to stay on those hormones, or they needed to for other reasons.

So it was only appropriate to still continue that.

Q Did you only continue providing care to patients who had undergone surgeries that would affect their hormone production?

A No, some who chose to stay on

opposite sex hormones or blockers who still had their gonads, and they just preferred to do that.

And they were not going to be changing their conception of whether they felt it was helpful or not.

And most of those people I think were getting psychological counseling, were on antidepressants, and had been on treatment for some time, and they just chose to stay on it.

These are all adults, of course.

Q How many people did you continue to treat for gender dysphoria after 2013, when you stopped accepting new patients?

A How many did I continue to treat? I think it was about 30 people I was still seeing at that point.

Q How many of those 30 people underwent a surgery that affected their hormone production?

A Maybe about five to eight or

so.

Q For the rest you continued to provide cross sex hormones to, regardless of, right?

A Yes.

Q And you didn't tell any of those patients that you believed that the care that you were providing to them had a lack of benefit and, in fact, was potentially harming them, right?

A Well, I always talk about potential harm and the benefit from the psychiatric standpoint, psychological standpoint.

That's where I continued to recommend if, depending upon how they were doing, psychiatric or psychologic follow-up.

And some of them were doing fine, they were adapted, they were okay, and it was just a regular routine visit looking at general medical care.

Q How many of those 30 patients were doing fine on cross sex hormone treatment?

A From a psychological standpoint, I don't recall at this point.

Q Do you have a rough sense of the proportion? Was it the majority?

A I would say maybe 10, so the majority were not.

Most of them had ongoing depression and anxiety. One had a suicidal attempt, and that was a person who had had surgery in Thailand, I think.

It was a male to female.

Q And that was the one person out of the 100 that you said, that you believed was really harmed by the treatment in a way that wasn't addressable with medication management, right?

A So, you know, as it -- to be able to honestly evaluate it, I can't prove causation. It's just -- again, it's an association thing.

That person had surgery, had reassignment, had a faux vagina created and was on antidepressants and had a suicidal attempt, and was on estrogen.

DANIEL WEISS

And what was the cause of that severe depression and suicidal attempt? I don't know.

But hormones at least and surgical reassignment didn't fix that person, because there was significant depression for years after.

Q Did your political beliefs change in any way in 2022?

ATTORNEY DROZ: Objection.

A No.

Q Do you feel that doctors have an ethical obligation to provide patients continuity of care if they have to discontinue treating a patient?

A I think it depends on what the science shows in terms of interventions.

And my knowledge of the science is much more than it was back in 2013 now.

And so I have learned a lot, even from then, and I looked at the new guidelines and the systematic reviews, and a lot of publications have come out in the

last ten years.

But in general, if there is no other option for treatment, and the intervention is the best intervention we can offer the person, then the physician should continue following that person.

Even if it was withdrawing, let's say, a medication that might be pulled from the market because it showed some risk, like Vioxx, it was harmful, it was pulled from the market, but patients might have loved it because it provided pain relief.

Well, if the studies showed that it caused harm, we are going to stop it. We will try to use something else.

Q If you hadn't moved to Utah in 2022, would you still be treating those -- your existing patients today?

A Yes.

Q Do you know how many of the 100 patients over that period experienced some sort of physical harm, like the blood thickening, that you ultimately addressed with medication management?

A I think it was just a few, just -- those are the things that come to mind.

But the harms that are described in the literature, with literature as poor as it is, suggest increased risk of stroke, clots in the legs, heart attacks, and in many of those harms are shown only with longer term follow-up.

And of course the literature does not describe long term harms in minors treated who would be, then have longer exposure to these interventions than adults.

Q Sure, but out of your 100 person data set, some of whom you followed for a decade, none of the -- none of your patients experienced any of those types of harms, right?

ATTORNEY DROZ: Objection.

A Other than what I had just came to mind, the worsening of sleep apnea and the erythrocytosis, thickening of the blood.

ATTORNEY KORBERG: We have

DANIEL WEISS

been going for a while now. Is it a good time to take a break?

ATTORNEY DROZ: I'm okay with it.

THE VIDEOGRAPHER: Thank you. This is the videographer. I'm going to go off the record, if that's okay. The time is 1:55. This ends media file 3.

(At this point in the proceedings there was a recess, after which the deposition continued as follows:)

THE VIDEOGRAPHER: The time is 2:06. We are back on the record. This begins media file 3.

Q So, returning to the patients that you were treating who you no longer treated when you left the state in 2022, did you make any attempts to find alternative care for them?

A Yes.

Q How did you do that?

A I talked to the endocrinologist I had hired who was

remaining in the practice, and he was willing to see those people who were stable from a hormonal standpoint, and was willing to continue providing their hormones.

Q And did you talk to that doctor about your concerns that providing cross sex hormones to people suffering from gender dysphoria was not safe and effective?

ATTORNEY DROZ: Objection, form.

A Well, at that point, those patients that he was willing to see, I think they had all had gonads removed.

So, I don't think there was any safety issue in those people from that standpoint.

They were primarily on hormonal replacement, opposite sex hormone replacement.

Q You talked earlier of the 30 who you were still seeing at the time of which you moved to Utah, only 5 to 8 had had some sort of surgery that would require some form of hormone replacement, right?

A Right.

Q So, what happened? Did you continue to see the, you know, 25 or so patients who you were providing care who had not received surgery that would require some form of hormone replacement?

A I don't recall seeing any of those particular people in that last year I was there.

So I couldn't convey that to them.

Q So, just naturally, like 25 of your patients stopped coming to you for care, and the only ones that were remaining were the ones that happened to need some form of hormone replacement therapy as a result of therapy?

A That's my recollection, yes.

Q Did that happen all at once?

A That was gradual, and it was attrition over the course of years.

So, there was, again, a fair number of people who for whatever reason stopped returning.

Q So it's your understanding that the only patients receiving care for gender dysphoria that your colleague continued to treat, were those who needed some form of hormone replacement therapy?

A Right. They had their -- they had orchiectomy or off oophorectomy, yes.

Q Earlier I believe you testified that at the time you left your practice in Ohio and you moved to Utah, you were still seeing 30 patients --

A Well.

Q -- for gender affirming care?

A I may have misspoke, but that last year I don't recall any patients that I would have turned over to my partner there that were on -- that still had their gonads.

So probably the other remaining patients I might have seen the year before, 2021.

Some of them would come in less frequently, every 6 to 12 months, and then there were a lot of patients who just

did not come back.

Q Does that mean by the time you ended your practice you were only seeing patients who had been assigned male at birth?

A No, I saw both, biologic females and biologic males.

One of the patients I had seen for many years was a biologic female who had had a penis created, had an oophorectomy, had a mastectomy.

I had seen that person for many years, and saw that person even that last year I was there.

Q And were you seeing any patients who were assigned female at birth who did not have an oophorectomy?

A In that last year it was actually, now that I think of it, there was I think one person who lived relatively far away, and that person still had ovaries, was on testosterone.

I had followed that person for quite some time, and I think that person

was following up with another doctor.

Q Not the doctor in your practice who you transferred the rest of the patients to?

A Correct.

Q And did you discuss with that doctor your belief that providing gender affirming care was potentially not safe and effective?

A No, and that person I was treating had mastectomy and was -- wanted to continue on the same course.

Q Do you think it was in that patient's best interest to continue receiving cross sex hormones despite not needing them from a surgical perspective?

A I don't know.

That needed to be judged on an ongoing basis, pros and cons versus risks and benefits, with their treating physician.

Q And at least as of the last moment that you were their treating physician, you believed that the benefits of receiving cross sex hormone treatment

outweighed the risks, right?

A Yeah, that person was about 38 years old.

Q For those patients that you continued to treat between 2013 and 2022, do you believe that your patients would have benefited by losing access to cross sex hormone treatment?

A I don't know. I think probably they would benefit more from more supportive psychotherapy, which they weren't getting, and they would have benefited more than the cross sex hormones.

Q Sure, but imagine a world where you hold the amount of therapy they were getting constant.

Would they have been better off, worse or the same if they were unable to get cross sex hormone treatment during that time?

A I think those people that I was caring for would be better off if they would just have taper-off.

Even with therapy unchanged,

they would be better off without it.

Q But you continued to provide them hormone therapy and cross sex hormones, right?

A I did.

Q So you provided them care that you thought they would have been better off had you not provided it to them, right?

A That's my thinking now, yes.

I think having studied the scientific literature, and in retrospect, seeing the psychological challenge that these people were dealing with, the social factors, and the science all would point to them being better off without it.

But that's adults, too.

Q Presumably every time you wrote a prescription or refilled a prescription for your patients, you were making an individualized assessment of the risks of that treatment versus the likely benefit of that treatment, right?

A Correct.

Q And you determined to

continue writing those prescriptions, refilling those prescriptions and providing them that treatment, right?

A In these adults, that's correct.

Q And you did so believing that the harms of those treatments actually outweighed the benefits for each of those patients, right?

ATTORNEY DROZ: Objection, form.

A I was worried about the harms, especially when the lack of evidence to support the benefits.

But I did continue them, because it was an individualized decision in discussing it with kind of so-called shared decision-making with the patient.

Q So even if a doctor believes that it is -- that the harms of treatment outweigh the benefits of the treatment, if a patient capable of sound decision-making determines that they would like to continue treatment, you believe the doctor should, in

fact, continue to provide that treatment, even if the doctor believes it is more harmful than beneficial?

ATTORNEY DROZ: Objection.

A No, I would not make an absolute statement like that, no.

I think sometimes the doctors don't know the evidence. Sometimes the doctors are conflicted, and often the patient isn't adequately informed or may not be competent to make that judgment.

So, it's complicated, and I think certainly, in the setting of minors, that's -- especially when doctors treat and minors are not competent to make long term decisions, I think that's where the role of the state comes in, I think.

Q Sure. But in 2021, in your own practice, you continued to provide cross sex hormones to people despite the fact that you are now telling me you believe they would have been better off had you not done so, right?

A Yes, based upon my

understanding of the science.

ATTORNEY DROZ: Objection to form.

A Which I didn't know as much back then, and there has been systematic reviews that have been published since then.

So I think that more is known about the lack of benefit and the potential harm than was known two years ago.

Q So in 2021, did you think the benefits of providing the treatment outweighed the harms of providing those patients cross sex hormone treatment?

A Yes, at that point I did.

Q And what were the benefits you believed you were providing your patients?

A Well, the physical changes that they felt were positive in their mood, outlook, approach to life, social interactions.

Q Do you think that all doctors should stop providing gender affirming care to adults?

A I think it's -- I think they should, based upon the science. But it's a different matter with adults, who are more likely, although often not, able to be competent and have informed consent.

But adults are a different matter than minors.

But I think the data on adults doesn't support it either, these hormone interventions.

So I don't think they should -- I don't think they should be doing it, but it's available, and it's okay with an adequately informed adult when they seek that intervention.

So I don't think it should be banned for adults.

Q And why did you think gender affirming care should not be banned for adults?

A I think adults are more likely to be able to make a sound decision on risks and benefits.

Some people want that --

those physical changes, and if they are consented and they -- adequately, which is very difficult, they can be offered that intervention.

But I think that -- I think it's bad, I think there is substantial risk with it.

And that consenting process, as one would do in an experiment, that consenting process has to be fair, balanced with a complete exchange of alternative interventions and the potential harms that might result.

And I think patients who are fully informed, if they are mentally competent adults, are more likely to decline the intervention.

Q In your personal knowledge, your personal clinical experience with gender affirming care --

ATTORNEY KORBERG: Withdrawn.

Q Outside of reviewing literature, your personal knowledge about gender affirming care is limited to your own

clinical experience, right?

A Yes, so opposite sex hormones and blockers relate to my scientific literature, careful review of the scientific literature and my clinical experience, yes.

Q You haven't personally visited any other clinics other than your own, right?

A That treat persons with gender dysphoria with hormones?

Q Um-hum.

A No.

Q And you say in your declaration that you observed that your patient has minimal psychologic evaluation and treatment for their significant psychic distress, right?

A Right.

Q Do you know if people seeking gender affirming care in Idaho have minimal psychologic evaluation and treatment for their psychicpsychic distress?

A I know that Planned Parenthood provides prescriptions with

usually the first visit and virtually no psychologic evaluation.

And that's routine.

Q Okay. Do you know if the majority of people who get gender affirming care in Idaho do so with minimal psychologic evaluation and treatment?

A No, but I suspect that's the case. I do not know that as a fact.

Q So, does the fact that your adult patients at your clinic, some of whom you were treating more than a decade ago, had what you viewed to be minimal psychologic evaluation and treatment, necessarily mean that minor patients at other clinics have minimal psychologic evaluation and treatment?

ATTORNEY DROZ: Objection.

A So the descriptions of parents and patients with whom I have -- patients I have communicated with, parents of children with gender dysphoria, what's online, desistors, detransitions, all indicates it's virtually universal.

The experience with the Gibbs Clinic in the U.K., it's all lip service that the whistle blowers, Tammy Reed, it doesn't happen.

They get hormones, basically.

They say the word gender, and they are already on the path to hormonal interventions. So there psychologic evaluation is virtually nonexistent.

They dismiss the psychiatric comorbidities, and that's not -- that's consistent with the 100 patients that I had, that those adults, they didn't have much evaluation before I started them on treatment.

But what's described extensively in these other settings that I just delineated, there is no significant evaluation, you know.

And WPATH says they should evaluate them, but they don't really specifically say there should be any treatment.

They just need to be,

basically make sure it doesn't interfere with the medical interventions.

Q Okay. So the basis for your belief that minors accessing gender affirming care in Idaho are getting minimal to no psychologic evaluation or treatment is Reddit, a whistleblower in the U.K.

Anything else?

A The whistleblower was Washington University, Hannah Barnes' lengthy description of the U.K. site, parents with inconvenient truths for transgender site, my interviews online with parents and minors who have had hormonal interventions.

Did I leave anything out?

That's it.

Q What steps have you taken to become knowledgeable about how gender affirming care is given to minors in Idaho? Which is the subject of this lawsuit.

Have you visited any clinics in Idaho?

A No.

DANIEL WEISS

Q Have you spoken to any gender affirming care providers in Idaho?

A No.

Q Have you taken any other steps to become knowledgeable about the provision of gender affirming care for minors in Idaho?

A Specifically in Idaho, no. But there is no reason to think Idaho would be an exception to what's happening around the world.

Q And it's your understanding that in Idaho, gender affirming care surgeries are performed on minors, right?

A I don't recall. Did I state that in my declaration?

Q You do.

A Okay, then that's my understanding.

Q And the sole source of support for that suggestion is something called the Gender Mapping Project?

A Is that a question?

Q Yes. What is the Gender

Mapping Project?

A It is a resource online of clinics that provide hormonal interventions for children, and I believe adults, too, with gender dysphoria, and also surgery sites that will do that.

Q Do you consider the Gender Mapping Project a trustworthy source?

A I'm not sure. I have no way of evaluating it's -- it's quality.

It's a resource where people will report what they see in their locale and they report it without -- because there is concern about being exposed when reported to the site, and they apparently assess it, its accuracy.

But I don't know, I can't speak to its authenticity.

Q But it's the sole support that you rely on for your opinion that gender affirming surgeries are provided on minors in Idaho, right?

A Correct. I did not call that clinic and make up some story that my

daughter wants to have her breasts removed and she's 14.

And people have done that kind of thing to provide that information to the Gender Mapping Project, I believe.

Q Do you consider the Gender Mapping Project an unbiased source?

A I think they are -- their belief is that these interventions on minors are not right.

If you call that bias, then yes. But that's a belief based upon what they believe is best.

Q Do you have any qualms about having the sole support for assertions that you make in your declaration be sources that you didn't independently verify, and in fact, think are biased?

ATTORNEY DROZ: Objection, form.

A I didn't say they were biased, and you would have to define biased, too.

So I think that that's, the

Gender Mapping Project raises that concern that surgery is being performed on minors.

I think that needs to be further evaluated.

I'm concerned that that is, in fact, taking place. And we know that hormonal interventions occur, and mastectomies are the most common surgical intervention on minors with gender dysphoria, and they are being done very -- with increasing frequency throughout the U.S.

Q Do you ever facilitate patients seeking to lose weight with gastric bypass surgery?

A Yes.

Q Talking now about the population of your patients receiving hormonal interventions which were not suffering from gender dysphoria, okay?

A Okay.

Q What are the risks when estrogen is provided to cys women?

A Women who are

post-menopausal, their estrogen has dropped down, and if they have hot flashes from low estrogen, then the risk with estrogen depends upon their presence of a uterus or not.

If they have a uterus, they need to also have progesterone, because estrogen alone increases the risk of cancer of the lining of the uterus.

If they don't have a uterus, they can just take estrogen.

There were doctors for quite some time believing that you should give post-menopausal women estrogen, and it would reduce the risk of heart attacks.

And only a big study showed that that was -- that was foolish, and that estrogen increased blood clots, risk of strokes, and progesterone increased risk of breast cancer.

So, it took a large study to show that and doctors were doing what was not best for people until that study came out.

Q Do the risks that cys gender women without uteruses taking estrogen face differ from those that transgender women taking estrogen face?

A So, transgender women are biologic males. So there is no -- there is no long term studies on giving males, biologic males estrogen.

So we have some data that estrogen increases risk of heart attacks from some old data when they were using it for prostate cancer.

So, there is published data now in adults followed with opposite sex hormones, and I have cited that in the declaration.

I would have to go back to give you details on that, but there is, yes, there is adverse events in giving estrogen to biologic males.

Q Do those adverse events differ from the possible adverse events of giving estrogen to cys gender women who do not have uteruses?

A Probably, probably, but the data are -- it's not that clear. There are two different people, two different -- two different sexes.

Q So if the data is not clear, why do you say probably?

A Because the data is weak, so you can't be sure.

Q Right, so you can't be sure. Why do you assume that there is?

A Let's look at the declaration of what it says, because I don't remember those numbers.

Q I'm just asking you as a general matter.

A I can't answer it as a general matter. There is increased risk of giving biologic males estrogen, yes, there is increased risk.

And what is that risk?

There is blood clots, it's strokes, those are clear. And maybe some other things, too.

Q But do those differ from the

risks of giving estrogen to cys gender women who do not have uteruses?

A We don't know, we don't know.

Q So you don't know, it's not probably?

A It experimental.

Q You are changing your answer. You don't know whether those risks are different or not?

ATTORNEY DROZ: Objection. You are being argumentative.

A I think it is not known.

Q So, am I correct that after 32 years as a member of the Endocrine Society you cancelled your membership in 2022?

A Yes.

Q And you cancelled your membership over the Endocrine Society's guidelines relating to the provision of gender affirming care for minors, right?

A It wasn't so much the guidelines, it was the fact that they were arguing in the Tavistock case that minors

should be allowed to or should be treated in that fashion.

Q So even after you stopped accepting new patients seeking gender affirming care in 2013, you remained a member of the Endocrine Society for another nine years, right?

A Correct.

Q When you were a member of the Endocrine Society, did you generally follow their guidelines for the treatment of patients?

A Some of them. It depends. I critically evaluate each one. There is -- each one is different.

Q So other than gender affirming care, are there any Endocrine Society guidelines you choose not to follow or that you disagree with?

A I would have to look at each individual one.

Q So sitting here today you can't think of any other Endocrine Society guidelines that you choose not to follow or

disagree with, right?

A Yes, I can think of the approach to aldosterone excess.

Q And what do you disagree with?

A My approach is they recommend extensive evaluation with the hope of doing surgery on some of those people.

And my reading of the scientific literature is that surgical interventions are often not helpful in those patients with aldosterone excess, and medication often is sufficient in addressing their problem.

Q In paragraph 177 of your declaration, you say that in the United States there are over 400 clinics and medical offices offering medical interventions for minors with gender dysphoria.

For how many of those 400 clinics do you know how care is provided to minors with gender dysphoria, and whether adequate psychological evaluations are done

prior to initiating hormone treatment?

A I would reiterate just what I said before, that the -- my discussions with parents and with minors who have had these interventions, my -- what's seen on Reddit and Pitt and what was seen in the U.K. and the whistle blowers, all of those reports are congruent, and indicate that there is minimal psychologic evaluation in minors with gender dysphoria.

Q Sure. But of the 400, how many of those clinics do you have knowledge about?

A I don't have specific knowledge about any of them.

Q Your report refers to jeopardy in quotes. Why is that?

A Because I think it's really a description of a person's feeling.

Q Do you put all feelings in quotes?

A This particular one I do.

Q Why do you put this particular one in quotes?

A Because I think it's -- it's usage is problematic.

Q Why?

A Why are we here today? This is a very difficult area.

The diagnosis -- the term gender even can't be defined by WPATH.

Gender clinics describe that they follow WPATH guidelines, and the diagnosis of this gender identity disorder, gender dysphoria, gender incongruence, it's constantly evolving and changing, and basically it's a self-report of the person's description of their feeling.

So I put it in quotes.

Q You do agree that some people really do experience gender related distress, right?

A I would say that many people feel that their distress derives from this discordance or incongruence between what they are in reality, their biologic sex in reality and what they feel they are.

That's affected by so many

factors, what's culturally acceptable, stereotypes.

And so I think their attribution of this being gender related is -- is a misattribution.

And that's part of the reason I put it in quotes.

Q Okay. But you do agree that some people experience gender related distress, right?

Regardless, we can dispute the origins of that distress, but you agree that some people experience gender related distress, right?

A What do you mean by that?

Q Okay, well, let's go to Exhibit 1, which is your declaration, paragraph 40.

A Okay.

Q You say the goal of treatment of patients with gender dysphoria should be to relieve gender related distress.

A Okay.

Q So what did you mean by

gender related distress, if you will not agree that some people experience gender related distress?

A So, what I mean is this, is in reference to those studies, from the Dutch protocol, that claim that the children they were treating, who were all thoroughly evaluated from a psychologic standpoint and were excluded if they had significant psychological problems, at least in that study, that they felt that their distress was related to this gender.

Q Okay. So you would agree with me that some people experience gender related distress, right?

A Distress that they relate to their gender, yes.

ATTORNEY KORBERG: You can take down the declaration.

Q How would you diagnose gender dysphoria if not via the DSM checklist?

A I would -- I don't think -- I think gender dysphoria, again, the reason I put it in quotes, is people who have these

symptoms that they feel is related to their gender, they have something else that's explaining it.

And so calling it gender dysphoria, I'm not diagnosing it, I would have a therapist see them.

If they say it's gender dysphoria, that's fine. But I don't think the intervention that is promoted addresses the underlying problem.

This is like an epi phenomenon. They are saying it's gender, it's not from their -- this is a feeling that they have, but they have other things going on.

And the DSM criteria, you can use that, it's going to be different next year, there is ICD 11 criteria, it changing all the time in response to a variety of factors.

But basically, it's distress related to what the child feels is this incongruence between their biologic sex and what they feel that child feels their sex

ought to be or their gender ought to be.

Q Do you disagree with the DSM's diagnosis of gender dysphoria?

A No. It's a description, nothing wrong with it.

But, you know, the WPATH doesn't require, in adolescents, doesn't require any distress.

WPATH just requires incongruence, and there is WPATH now has no lower age limit.

And in fact, a child can say I identify nonbinary, or I identify as a eunuch, and I think I would want to have my testes removed. That's in WPATH.

No lower age limit.

Q Sure. We are talking about the DSM here, though?

A Sure, but that relates to the diagnosis of gender dysphoria.

Q Do you believe that gender dysphoria should be recognized as a psychiatric diagnosis?

A Yes.

Q Is it possible to suffer from gender dysphoria and not suffer from other mental health disorders?

A I don't think so.

Q So, for example, I, personally, told you that I have experienced gender dysphoria since I was a child, consistent with the DSM diagnostic criteria. You would tell me that I have to be suffering from some other mental health condition, is that right?

A Correct.

Q There is no way possible that I do not suffer from any other mental health condition?

A Is that a question?

Q Yes.

A Oh, I would say no, you just haven't identified it, and you're focusing on gender dysphoria as the sole condition, and that we ought to do whatever medical interventions to help you is misguided at best.

Q Okay. But do you think there

is any possibility that I could suffer from gender dysphoria and not have another mental health disorder?

A And you have significant psychic distress related to an incongruence between the fact that you are this biologic sex and you feel you should be another biologic sex or nonbinary, that's what you're telling me?

Q Sure, yes.

A Not possible.

Q There is no way?

A Not possible you have something else going on.

You have psychiatric issues -- psychological issues, psycho-social issues that are not addressed.

They are complicated, and you might not get to them, but you have them.

Q And how are you so certain? What is that based on?

A I think it's just rational, and the literature would be supportive of that, too.

DANIEL WEISS

Q The certainty that I am suffering from some other health disorder is rationality, it would be impossible, it would be irrational to think that I do not suffer from some other mental health disorder?

A Right.

ATTORNEY DROZ: Objection, form.

A It doesn't have to be serious, and the scientific literature also would be consistent with that.

And especially these last, you know, 15 years or so, most of these children, 70 percent, they have identified a problem, they have identified psychological disorders.

And that's, you know, you have to carefully study each person, but you would identify significant ones I think in everyone.

Q So what about the 30 percent for whom there has been no identified other psychological disorder other than gender

dysphoria?

A I think you would identify it in 100 percent if you carefully evaluated each one, 100 percent.

Q How do you know that the gender -- the gender dysphoria isn't causing the various other mental health conditions identified in that purported study?

A Right. So you're saying that it could be that this psychic distress related to the person's feeling about their being wrong, in the wrong body, that would be another way of saying it, is the real cause for these other things?

It's completely absurd.

Q Why is that absurd?

Why is it not possible that the feeling of and the distress of having been born in the wrong body and perceived by the world as someone other than who you are, would cause anxiety or depression?

A There is no evidence to support that, that so-called minority stress kind of concept.

DANIEL WEISS

People are not born in the wrong body, they are born in the right body, and it's just they may have distress related to growing up, adolescence, social factors, again, a variety of other things in their environment.

It's just -- there is nothing to support causation from gender dysphoria.

Q What is there to support causation from depression or sexual assault or an eating disorder or autism to gender dysphoria?

ATTORNEY DROZ: Objection, form.

A Because interventions, in some cases just supportive exploratory therapy resolves the dysphoria.

And there are many people over time who no longer have gender dysphoria without treatment.

And there is -- and there is desistors and detransitioners who regret having had these interventions.

And they say I really had

this problem and that problem, and it wasn't gender that was the issue, it was the fact that I was physically abused, sexually abused, there was depression, I felt bullied, I felt I had no friends, I wanted to fit in.

There is emerging and more and more evidence that it's not causal, it's a description that people latch onto to try to feel better, and doctors are offering this as a simple quick fix.

And then, in addition to that, the statement about gender dysphoria that maybe this is the cause, how do you explain there is a statement that people say well, it's fixed, the gender identity is fixed, you don't change, but then on the other hand, there is all this evidence about fluidity?

So if you're dysphoric and then you've got fluidity, a third of them have fluidity, it doesn't -- it's not consistent to say that gender dysphoria can be the fundamental cause for all these other

things in the presence of that evidence.

Q As a scientist, how can you tell me that the fact that there exists on Reddit someone who says that they didn't actually experience gender dysphoria, they were really just experiencing anxiety, mean that it is impossible for someone else to legitimately experience gender dysphoria and not have anxiety be the cause of that dysphoria?

ATTORNEY DROZ: Objection, form.

A I'm just citing Reddit, which has whatever, 49,000 members, I'm citing desistors, detransitioners, the resolution of dysphoria untreated, and I have cited those studies, and the presence of gender fluidity.

So, I think the gender dysphoria, you remember, is -- it's a new creation.

It used to be gender identity. We have had depression and anxiety as DSM diagnoses for decades.

But gender identity disorder and then gender dysphoria are -- they are novel.

And I think to say that they were the cause of these other things makes lessens, and is not based upon any good -- you have to have -- in order to show that its gender dysphoria is the cause for that, you would have to have a treatment that affects just -- it a gender dysphoria pill and then everything else gets better after that.

And we don't have that. We have now modification of the body for a feeling.

Q So in order to prove causality, what we would need is a pill that treats what we think is the underlying cause, and then if the secondary cause still persists, then we have proven that there was no causality, right?

So we can treat depression, right, with pills.

There are people who --

DANIEL WEISS

ATTORNEY DROZ: Objection to form.

Q Who take pills for depression who continue to experience gender dysphoria. Their depression is resolved.

They are not depressed by any metric. How then is that not using the very criteria you say to prove causality here?

A Because, again, you're giving me kind of a general picture here, but the individual person needs to be carefully evaluated, and there is a lot of factors going on.

And I would like to see that study where you're treating the depression and the person still has gender dysphoria.

What else is going on in those people or are is that person sexually abused, and they are maybe no longer dysphoric and hedonic, so they don't meet the criteria for depression, but they still want to exchange their body because they were sexually abused.

So that doesn't answer

anything.

Q Design a study, prove to me that gender dysphoria is caused by depression, anxiety, autism or abuse?

A I think --

ATTORNEY DROZ: Objection.

A The evidence for the improved -- the resolution with watchful waiting, the evidence that treating post traumatic stress disorder, people figure out that this was really not what I needed to do.

The reports on detransitioners and desistors, those are all evidence that the intervention, because you are only talking about one intervention, which is modification of the body to change a psychologic -- a feeling, a feeling in a person's body that they don't like the way their body is, they feel they are born in the wrong body.

It makes -- it's as much -- it's as sensible as, you know, modifying -- I give the example of a girl who has

anorexia. She feels she's fat, but she's really underweight.

And she wants to have weight affirming care. We don't help her lose weight, we get her to psychological problems.

Q So your proof that gender dysphoria is necessarily absolutely in all cases caused by some other mental health disorder, is that you have desistors self-reporting a comorbidity, depression or abuse, and then assigning causality themselves to that comorbidity.

That's your data, right?

A No.

ATTORNEY DROZ: Objection.

A No, it's much more than that, because the diagnosis of depression is not just self-reporting, it's diagnosis of depression and post traumatic stress and sexual abuse and physical abuse. That's more than just self-reporting.

And those, and treating those disorders is certainly less harmful than

modifications to the body.

Q Sure, that may be true for some subset. How does the fact that -- are you saying that there is a study that shows that treating depression cures someone's gender dysphoria?

ATTORNEY DROZ: Objection; form.

A There are publications where they have done just therapy, and people's gender dysphoria resolves because they are addressing past traumas -- yes, so there are studies.

They are small, though.

Q Does the fact that that works for some subset of the population, if it does, mean that there is not someone else in the population for whom their gender dysphoria is not caused by other mental health concerns and would not be addressed by other mental health treatment?

A So, there is -- there is -- those other mental health or psycho-social factors would need to be addressed, and

everyone is different, they are complicated, they are complex.

But that doesn't mean that modification of the body in those people who say they are or meet the criteria for gender dysphoria is the treatment for those people.

It is not a treatment, it's an intervention that has shown in minors to not be beneficial.

The data shows it's not beneficial.

So the original study was the Dutch protocol, where they didn't even have these kids with psychiatric comorbidities, or at least they said they didn't.

They ended up having 55 of them there, and at the end of the study, there is no convincing evidence from that where they manipulated the questionnaire or earlier on, where they had more people, that their psychic distress improved.

So the data we have shows that the intervention, which is the intervention you are promoting, is not

helpful and there is clearly evidence of potential harm.

So that's just pretty clear-cut.

Q How does the fact that gender affirming care doesn't resolve gender dysphoria for all people in all circumstances prove that there is not some subset of the population for whom gender dysphoria is unrelated to other mental health conditions?

ATTORNEY DROZ: Objection to form.

Q As a scientist, how does that work?

A So, I think we are talking about two different things.

Opposite sex therapy treatment, opposite sex hormones, puberty blockers and surgical -- surgery, the data shows in minors it does not resolve their psychic distress.

There is no data that shows that it does. And there is potential harms.

In the event study, which was in U.S. gender clinics, I cited that. It had opposite sex hormones, this was in the gender clinics, opposite sex hormones followed over two years; males, no improvement in their psychic distress, none.

And two suicides while on treatment.

You I shouldn't call it treatment, on these opposite sex hormones, it didn't help them. So that's one thing.

The interventions and medical interventions modifying the body do not help the dysphoria, period.

The other thing is well, what's the case for the dysphoria?

There is at least 70 percent have these comorbidities.

It's a certainly safe intervention and a reasonable intervention to sort out what is going on in that child's life and just to help their distress, whatever it is, because often it's claimed to be related to be just gender, easily

fixed by trying to change their body.

But if you look at harm versus benefit, the least invasive intervention would be addressing these comorbidities.

To answer your question, you said how do I know there is not some who might just have persistent gender dysphoria, and they might not have anything else.

I don't know of any data that shows that.

And there is no -- and there is, I don't know how that would be studied, but it certainly is clear that from the Dutch study where they didn't have any apparent comorbidities, and they were minors, they did not benefit from modification of the body.

And the more recent studies, where lots of these kids have comorbidities, they don't benefit from those modifications to the bodies.

So I don't know, what's your next question?

DANIEL WEISS

Q Is there any circumstance in which it would be appropriate to provide gender affirming care where, for example, you have a 17 year old who is in regular exploratory therapy, has no history of trauma or other co-occurring disorders, and has persistent gender dysphoria since childhood?

A Such a child does not exist.

Q You're certain that such a child does not exist? It's impossible that a 17 year old could be in regular gender exploratory therapy, could have no history of trauma or other occurring disorders and had gender dysphoria consistently since childhood?

A So, there are two -- there are three papers that I cited in the declaration that have described changes in gender identity, gender fluidity and resolution of dysphoria in adolescents with no treatment. No treatment.

So, I would say --

Q How does the existence of

someone improving with treatment prove that there isn't someone who is in gender exploratory therapy, has no history of trauma or co-occurring disorders, and has persistent gender dysphoria, they are totally unrelated, how does what you just suggested prove that?

ATTORNEY DROZ: Objection to form.

A The conclusion is that person should continue on gender exploratory therapy, because they often change their feelings, or their dysphoria resolves with time.

Q So the way this works is if I presented you someone who is in gender exploratory therapy for five years without history of trauma or co-occurring disorders, and their gender dysphoria didn't resolve, you would just tell me they need five more years of therapy, and then five more years?

It is impossible to prove to you that you are perhaps not correct?

ATTORNEY DROZ: Objection,

argumentative; form.

A It's possible to prove to me if you give me a sensible example. That's not sensible and that person does not exist.

Because the usual approach now for an adolescent who might say they are gender dysphoric is the conveyor belt of social transition and then hormonal interventions and then often surgery. That's the usual approach.

It's -- I can't imagine a child with gender dysphoria that appears to only have gender dysphoria having five years of exploratory psychotherapy, most kids don't have exploratory psychotherapy at all.

Q So the fact that most kids do in fact get to receive gender affirming care means that it is impossible that there is a child, who instead of receiving gender affirming care, is put by his parents, perhaps, who don't believe gender dysphoria is real, into gender exploratory therapy?

A They probably lose custody of the child and domestic services will get

them, for not affirming them.

Q It's your belief that someone who does not give their child cross sex hormones is going to have Child Protective Services take aware their child?

A Often.

Q Not in Idaho, right? In Idaho it is literally going to be illegal for that child to get gender affirming care, right?

A Do you have a question?

Q Does having access to hormones or surgery preclude patients from also accessing gender exploratory treatment that you think is more appropriate for gender related distress?

A It depends on the state laws. So, some laws have required therapists only to so-called affirm.

Q I don't understand that. Is it impossible for someone to be receiving hormones or hormonal gender affirming care and also be in gender exploratory therapy?

A No, that's possible.

DANIEL WEISS

Q So let's assume that you are right, that a regime of puberty blockers, opposite sex hormones and ultimately surgery doesn't work for everyone.

Is it still possible that a regime of publicity blockers, opposite sex homicide and ultimate surgery would benefit some people, person suffering from gender dysphoria?

ATTORNEY DROZ: Objection, form.

A Well, the question, I think we need to be clear about what you mean by benefit and work.

If you are talking about psychic distress related to this just gender incongruence, it might help them with that, but it might be a much less -- much simpler and less harmful intervention where they can understand where their rejection of their natal sex derives from, and feel less anxious, less depressed and so on.

Q Is the only way in your mind to treat gender dysphoria to have, at the

end of the day, the person say that they identify with the sex they were assigned with at birth?

A Absolutely not, no.

No, we are talking about minors, of course, but the goal of any intervention, as per the Dutch Protocol, the developer of the Dutch Protocol and others say is to relieve psychic distress, period, just psychic distress.

Whatever they have, and if they attribute it to gender dysphoria, gender incongruence, fine, you still want the relief of psychic distress.

Whatever gender they or non-binary they feel comfortable with, they identify with, you want their psychic distress to be relieved.

So, that's the goal of treatment, to have them not depressed, not anxious, be good in terms of psycho-social functioning, job, family, so on, work.

Q Okay, so it's possible that for some people, cross sex hormones helps

relieve gender related distress, even if you believe it would have been more efficacious to have just had gender exploratory therapy?

ATTORNEY DROZ: Objection, form.

A So, in your question you are implying causation.

I don't think the opposite sex hormones, gender affirming surgery and all that would be the reason for the improvement.

Maybe the person would have improved over time. Maybe they got psychological counseling also.

So it's complicated, but -- so just because they improved after that intervention, doesn't mean that was the reason that they improved.

And that's the problem with a lot of these very poor, low quality evidence that's published.

There are psychological interventions in the example I gave, the study by Chen, et al, published by the New

England Journal of Medicine this year, he had two years of treatment.

These were minors who were seen in QS gender clinics.

They had opposite sex hormones and they -- the males did not improve at all in terms of their psychic distress.

And again, there was two suicides, a very high suicide rate in this group.

Now, maybe the females got better. Was it from the opposite sex hormones they got?

I don't know. Maybe it was, two years they would have gotten better, maybe it was the support of being in a study, maybe it was the psychological counseling.

So I don't think we -- we shouldn't be sure about causation just post-hoc here or propter hoc.

Q Right, we cannot be -- I certainly agree we cannot be certain of

causation.

You would agree, likewise, that if you had a study where people suffering from -- there are some number of people suffering from gender dysphoria attempted suicide, we cannot know how many people would have -- how many more people would have attempted suicide had they not gotten access to gender affirming care, right?

ATTORNEY DROZ: Objection, form.

A Right. Or how many less people would have been attempted suicide if they didn't get these interventions.

Because I think the bulk of the evidence shows it actually increases suicide risk.

You can argue with the quality of the evidence, but the best evidence suggests it increases suicide risk, not decreases.

I would argue with any suggestion otherwise.

DANIEL WEISS

Q What's the causal proof of that?

Is there a control study where you have people from the same population who were denied access to gender affirming care?

A So, those who promote these interventions refuse to do any comparative studies, any controlled studies.

But the studies we have, which are described in my declaration, all point to an apparent increased suicide rate as compared to a control population who -- control population.

For example, in the Chen study, this is just over a two year period, we are talking about minors, most of the data is with adults, but in the Chen study they had minors, and they had two suicides in this small study, two suicides in a small study over two years on opposite sex hormones.

Now, that's pretty embarrassing to have that happen in these

top notch gender clinics during treatment with these hormones that are supposed to help their mood, depression, anxiety, dysphoria, that suicide rate is 45 times higher than the general population in that age range, 45.

That's much higher than even children who would have depression. That's really high.

Q Okay, but again, we are just talking about correlation. There is nothing in that study to suggest causation, right?

A That's correct, but -- that's right, we don't have good data, but the data that is available doesn't look like it's helpful.

Q Okay, let's look, let's turn to page 28 of Exhibit 1 of your deposition, which is where we discuss this.

ATTORNEY KORBERG: Can we pull up that Exhibit 1, please.

ATTORNEY DROZ: Are we getting close to a point for a break, lunch a little bit?

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ATTORNEY KORBERG: Sure, we can do that now.

ATTORNEY DROZ: Whenever you are ready, I am just throwing it out there.

ATTORNEY KORBERG: Yeah, since we are here now, why don't we do this, then we will take a break. Somehow that --

ATTORNEY DROZ: Sounds great.

Q Can you go to the top of page 28.

So your conclusion is that hormonal and surgical treatments for gender dysphoria do not reduce suicide risk, right?

A Yes.

Q And I have to admit that this section really confused me, and the reason it confused me is because every single study that you cite merely concludes that transgender people committed suicide at higher rates than non-transgender people.

Do you agree with that?

A In general, yes. The studies

I'm citing also are in people on -- already treated.

Q Sure. The only conclusion we can draw from your studies, though, is that transgender people committed suicide at higher rates than non-transgender people, and that cross sex hormones did not entirely eliminate suicidality, right?

A I think it's a little more nuanced there.

So the -- in that first, in the section 89, the rate of suicide in youth with distress attributed gender appears similar to the rate in youth with other mental health disorders.

That's one, right?

So, yes, it's higher than the youth who are not seen for psychiatric disorders. It's higher in those with gender dysphoria.

But on the whole, the suicide rate in transgender youth is low. I mean, that 13 out of 100,000 versus 15 -- sorry, 11.8 out of 100,000.

So it's not a high suicide rate. It is actually very low, although it's higher than people have with mental health disorders.

Q Can you point me to any study that compared suicide rates for transgender people who had received hormonal and/or surgical treatment against the suicide rates for transgender people who were denied access to hormonal and/or surgical treatment?

ATTORNEY DROZ: Objection to form.

A I'm looking at my declaration here. No, the comparisons are to -- you have a general population. These are -- these are people with gender dysphoria who had interventions, they had access to the interventions, and -- one moment.

No, so if you are looking for a prospective group, prospective study, this is what you need, a prospective study, to show that those who had the -- these interventions compared to a similar matched

group who were not given the interventions, had whatever, lower, higher, similar suicide rates.

That study has not been done.

Q Okay, great.

So you would agree with me that it is impossible to conclude that hormonal and surgical treatments for gender dysphoria do not reduce suicide risk without comparing suicide rates of trans people who received hormonal or surgical treatments versus similar trans people who were denied hormonal and surgical treatments, right?

ATTORNEY DROZ: Objection to form.

A I don't think I would agree with that. Because I think if you're claiming that these interventions really reduce the risk of suicide, the suicide risk in people who have had hormonal or surgical interventions are extremely high, they remain extremely high as compared to the control population.

And if they were -- these

interventions were really effective, they would not be that high.

Q Well, that's a different question, isn't it?

That's a question of how effective are they.

I'm talking about -- you have your opinion the hormonal and surgical treatments for gender dysphoria do not reduce suicide risk, right?

It may be that they reduce suicide risk some small amount, but you have no proof that hormonal and surgical treatments for gender dysphoria do not reduce suicide risk, right?

A I would say --

ATTORNEY DROZ: Objection to form.

A I would say that the hormonal and surgical interventions, that despite hormonal and surgical interventions, suicide risk in these people is extremely high, and it's not clear whether they -- these interventions increase or decrease or do not

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change the suicide risk at all.

They are extremely high as compared to the control population.

But they obviously don't decrease it much, because they are so much higher than the control population, despite the interventions.

Q Okay. But you cannot say that hormonal and surgical treatments do not reduce suicide risk, right?

A I would say I can't say it versus an untreated population.

ATTORNEY KORBERG: This is a good time for a break.

THE VIDEOGRAPHER: This is the videographer. The time is 3:24. This ends media file 4.

(At this point in the proceedings there was a luncheon recess, after which the deposition continued as follows:)

THE VIDEOGRAPHER: The time is 3:47. We are back on the record. This begins media file 5.

DANIEL WEISS

CONTINUED EXAMINATION BY
ATTORNEY KORBERG:

Q So Dr. Weiss, you are here as an expert witness in support of HB 71, right?

A Yes.

Q Can you please explain to me what you know about HB 71, what exactly it prohibits, what the penalties are for violations, et cetera?

A It bans hormonal and surgical interventions on minors with gender dysphoria.

Q And what are the penalties for violations?

A I don't recall the penalties.

Q Did you ever know what the penalties were for HB 71?

A Yes, I read the bill, but I just don't remember them right now.

Q Are there any penalties that you think would be too extreme for doctors providing gender affirming care to minors?

A That would in general be too extreme?

Q Yes.

A Execution would be too extreme.

Q What about life imprisonment?

A I think that would be extreme.

Q What about 30 years' imprisonment?

A I think that's extreme, too.

Q What about 20 years' imprisonment?

A That's extreme.

Q What about 10 years' imprisonment?

A Not sure.

Q What about 15 years' imprisonment?

ATTORNEY DROZ: Objection.

A I'm not sure. I think the intent I think of the bill is to make it -- to ban it, is to stop it, and you have to have firm penalties to discontinue this

harmful, these harmful interventions.

Q So up to 15 years' imprisonment for doctors providing gender affirming care might be reasonable in your mind?

A I'm not sure.

Q Do you have any concerns about HB 71 going into effect?

ATTORNEY DROZ: Objection to form, vague.

A Not that I can think of at this time, no.

Q So if I let you know that HB 71 carries the same penalties as, criminal penalties as manslaughter, including up to 10 years' imprisonment, does that change your opinion on the reasonableness of HB 71?

A No.

Q Do you think there should be any exceptions to HB 71?

ATTORNEY DROZ: Objection, form, vague.

A Not that I can think of, no.

Q So HB 71 would ban clinical

research into gender affirming care for minors in Idaho. Would you agree?

A Yes.

Q Do you support that, a ban on clinical research on gender affirming care for minors?

A I believe some research is being done, and I would support a ban in Idaho into such research.

Q You would support a ban on such research in Idaho because such research is being legally done otherwise, is that right?

A I don't think there is need for clinical research on hormonal interventions in children who have normal puberty.

But, for those people who feel it's important to do such research, there are venues for such research in the world.

Q So it's your opinion that there is not sufficient data to prove the safety and efficacy of gender affirming care

for minors, right?

ATTORNEY DROZ: Objection, form, vague.

A There is evidence that the -- these interventions on minors are harmful and do not improve psychic distress related to gender dysphoria or other psychic distress.

Q Do you think there is sufficient evidence to prove that hormonal interventions on minors are harmful?

Is that correct?

ATTORNEY DROZ: Objection, form.

A There is sufficient evidence that hormonal interventions in minors with gender dysphoria is not helpful, and there is reason to believe based upon the evidence that we have that it's harmful.

Q So, you cannot yet conclude from the evidence that it is harmful for minors to receive hormonal interventions, but you think the evidence suggests that there is reason to believe that's the case,

is that right?

A No, it is harmful in that it interferes with normal puberty, brain development and many other things.

So, there is evidence of harm, and there is no evidence of benefit.

Q So the evidence of harm is that hormonal interventions interfere with puberty and brain development, is that correct?

A We can go through our declaration, my declaration, listing concerns about harms.

Much of those are derived from data in adults, but there is evidence of harm, and one obvious harm is you're interfering with normal pubertal development in children.

Q Is there any evidence of harm for children who delay puberty through puberty blockers and then experience a puberty consistent with the cross sex hormones that they subsequently take?

A There is evidence of harm to

the children who had puberty blockers and then opposite sex hormones when those are used for treatment of gender dysphoria, yes.

Q And is there always harm, regardless of the period of time where puberty was delayed before the administration of cross sex hormones?

A The data would indicate that yes, there is always harm.

Q And what data is that?

A Well, let's go -- I would go -- let's go to my declaration and we can look at opposite sex hormones section.

Q Do you think that all gender affirming care for minors should be outlawed?

A All hormonal --

ATTORNEY DROZ: Objection, just vague as to --

A All hormonal interventions in minors who are being treated for gender dysphoria, yes.

I think those hormonal interventions which are intended to relieve

psychic distress attributed to gender dysphoria should be outlawed.

Q Would you support HB 71 becoming the law of the land in the United States?

A Yes.

Q You would agree if HB 71 became the law of the land in the United States, there would be no more clinical research into cross sex hormones or puberty blockers on minors in the United States, right?

A Correct.

Q And you don't have any concerns about the -- there being no more advancement in terms of U.S. research into gender affirming care for minors?

A There would be -- there could be advancements, absolutely could be advancements.

How?

Don't use opposite sex hormones.

Don't use medical

interventions to modify the body to help people who have psychic distress related to gender dysphoria.

You could still research it, you can do other interventions where they are helping people's psyche and relieve their distress through other means that do not produce irreversible changes in their body, potential infertility and other harms.

Q Okay. So as a scientist, you don't think that there needs to be any more clinical research into the effects of providing puberty blockers or cross sex hormones to children, minors who are experiencing gender dysphoria, is that right?

A That's correct.

Q Can you conceive of a version of this law you would support as protecting patients, but was less extreme in some way?

ATTORNEY DROZ: Objection, form.

A Well, these medical interventions and often subsequent surgery

on children with a mental health disorder, I think they are extreme.

Q What would your opinion be of a law that required parents to pass a test on the risks of gender affirming care for their minor children?

ATTORNEY DROZ: Objection, form; vague.

A Say that one more time?

Q Sure.

So, let's take a step back.

Adolescents, do you believe that adolescents can't give informed consent under any circumstances, right?

A Correct. They can't, they can give ascent, but not informed consent, correct.

Q And the way that adolescents receive medical treatment, including experimental medical treatment, is that their parents give informed consent on their behalf, right?

A Right, and the child can give ascent, correct.

Q Do you think that parents should be prohibited from giving informed consent on behalf of their minor children as a general matter?

A No.

Q Do you think that parents should be prohibited from giving informed consent on behalf of their minor children to access gender affirming care and puberty blockers and cross hormone treatment?

A Yes, I think they should -- they should not be giving informed consent or approving a procedure that is not beneficial, clearly, and it's harmful.

So that would be, the same reason that a parent cannot deny, for example, or in many states, they can't deny chemotherapy for a treatable cancer.

Q So this is an area where I think no matter how informed parents are, they just should not be able to give informed consent?

A Not for this, not for this, correct, because it's not -- it's not --

there is -- it's very difficult to get adequate informed consent because of those people who are convinced that it's the only way to go and because this -- the scientific evidence that is available indicates harm and not benefit.

Q So let's say hypothetically that there is a 17 year old who has been suffering from gender dysphoria their whole life, and their parents come to you and say we would love to -- we have all the time in the world, we are incredibly educated, we would love you to explain to us all of the risks and walk us through the science on why you think it is harmful for our child to access puberty blockers or cross sex hormones, okay?

A Right.

Q And let's say at the end of multiple days of sitting with you these parents just disagree about the literature.

A Okay.

Q Do you think that they and their child's doctor, if a doctor thinks it

is likewise in that 17 year old's best interest to access gender affirming care, do you think that they should be prevented from getting that medical care for their child?

A Yes.

I would also say I probably didn't explain it to them well if they still are convinced that it's the way to go.

Q What would your opinion be of a law that says that minor children can only receive hormonal treatment if they first have been treated with psychotherapy and that psychotherapy proved unsuccessful at relieving their suffering?

A I would still be opposed to such a law, because it would imply that the hormonal interventions, opposite sex hormones, puberty blockers, surgery, are helpful interventions, whereas the evidence we have is that they are not helpful and that they are harmful.

Q In your declaration you assert that countries with longer experience than the U.S. have curtailed hormonal and

surgical interventions, right?

A Yes.

Q And you refer to a number of countries, including the U.K., Sweden and Denmark, among others, right?

A Yes.

Q Do you agree with the current approach that each of those countries takes with regard to gender affirming care for minors?

A I think they should be -- some of them should be even more firm.

The U.K. bans basically bans these interventions on children under the age of 16. So I think that's a clear approach.

And the others are pretty close to bans.

Q Just to be clear, are there any of these countries where you think we should adopt their approach?

A No, I think the -- the ban that Idaho has is a very reasonable approach, given the environment in the

United States, where some more -- somewhat more cautious approaches are stated in some of these European countries.

Now, all of them place psychological counseling as the primary intervention, and great reserve or caution in the use of any kind of or bans in the use of any client of irreversible medical intervention.

But in the United States, I think that kind of more -- somewhat more liberal approach that's not quite as strict would not work, for whatever reason, I don't think it would work.

Q Why would such an approach not work in the United States?

A I think because these are -- each of these countries, their healthcare system is different than the U.S.

So there can be kind of healthcare guidelines that govern the whole country.

And here we have various states with their different regulations, and

we have, in the United States, financial incentives that play a role in healthcare, and you don't have that in Denmark, U.K., France and so on.

Q So, just to be clear, are there any countries that you think have an appropriate legal policy with regard to gender affirming care for minors?

A I think the U.K. looks -- it's good from what I have seen of their most recent statement, which is basically no medical interventions in children under 16.

And the primary intervention in those 18 -- under 18 is psycho-social intervention and psychological support.

So they have a window of 17, 18, where they will give you at least a little bit, perhaps, unclear there.

There still is psychological intervention, but they may allow for medical interventions there. And that's the U.K.

Q And you would agree that the U.K. policy is that teens who have already been receiving gender affirming care can

continue to receive that treatment, right?

A No. No, they have to not have started before the age of 16, otherwise it's discontinued.

Q Well, let's break this down.

Is it your opinion that the U.K. bans treatment, or that the U.K. just won't have public funding, like through the NHS for gender affirming treatment for minors under the age of 16?

A I'm not sure on that. My understanding is it was a ban for under 16.

Q So if I told you that even in the U.K., as long as you privately fund treatment, you can access gender affirming care and hormone treatment for your minor children under the age of 16?

A That's unfortunate if that's true.

Q Okay. So you also -- does that mean that you also don't agree with the legal regime in the U.K.?

A If it allows for under 16 year olds, yes, to access it outside of a

governmental system, yes.

Q Is there any country that you think takes an appropriate legal approach to gender affirming care for minors?

A Well, multiple countries are very close to bans, but they are not strict bans like we are looking at here with this bill.

But again, their healthcare is quite different, and most people do not seek care outside of the government system.

Q So, just to be clear, no country in the world, to your mind, goes far enough with regard to banning gender affirming care without exception, right, for minors, without exception, right?

A Yes. If indeed, as you said, you can access it in the U.K. outside of the government system, I would agree, yes, they do not go far enough.

But they are moving, you know, it's taken them a long time, decades of experience, and they have finally learned from their studies that these interventions

appear to be experimental, not helpful, and so psychological support is the primary intervention that's used.

And if we did -- if they had something like that in Idaho where oh, we would encourage psychological support, we are not going to ban it, it's going -- it won't change the situation, I think, there would still be perfunctory psychological intervention, and unless there is penalties, there will be no improvement, no reduction in the harm that minors are suffering.

Q Are there any studies showing that puberty blockers alone, absent cross sex hormones, impact fertility?

A No, but most of those -- not that I know of, but 95 percent or so of children who start puberty blockers for gender dysphoria go onto opposite sex hormones.

So that kind of -- it's a little immaterial, because if it's only 5 percent that don't, you're basically making infertile all those children who are -- who

move on, 95 percent, who move on from puberty blockers to opposite sex hormones, you are impacting their fertility.

Q So it's your opinion that everyone on opposite sex hormones is rendered infertile by those hormones?

A It depends on when they are -- when that intervention occurs.

If it's after gametes are formed in late puberty, there may be some chance to have -- they might be able to have fertile gametes, but it's expected that they will be infertile.

And that's why there is guidance now for all those children on opposite sex hormones, that they be counseled on fertility preservation or gamete preservation, sperm, ovacite preservation, because it is expected that they will be infertile.

Q And it's actually not clear to me from your declaration, but what are all the risks that you believe are associated with puberty blockers?

A Well, let's go to that section.

Q Sure, why don't you direct us.

A That would be page 32.

Let's start with 110, hot flashes, weight gain, fatigue, mood disorders, seizures, hip disorders, reductions in bone density, increases in pressure in the brain, called pseudo tumor cerebrae, reduction in the development of the external genitalia, such that it may be very difficult to create a vagina-like structure if you are treating biologic males early on in puberty.

Orgasmic dysfunction has been described, and there is -- there are concerns about brain, you're stopping brain development that occurs, normal brain development that would occur in puberty with a puberty blocker, and so cognitive changes may be seen.

There is one study where it showed a reduction in IQ in children treated

for precocious puberty with puberty blockers.

We talked about infertility.

Q Are any of these purported risks of puberty blockers different from the risks that a cys gender minor receiving puberty blockers for some reason other than gender dysphoria might experience?

A It's not known, because there is no comparative studies.

And there is very little data. I think most of this is, that I have quoted, most of it I have cited is in people with treated with precocious puberty.

Because the data on treating minors with gender dysphoria is just so poor, it's not captured.

Q And were any efforts undertaken to separate out what risk factors and health concerns might actually just be correlated with precocious puberty itself as opposed to the administration of puberty blockers?

A That's of course an excellent

question, and it's hard to know.

For example, like seizures, well, did they have seizures because they have something going else on in their brain or is it from the puberty blockers?

But causation association, its difficult to know.

It's not like there were -- in most of these there is not controlled studies, it just is these are descriptions that -- of adverse events that occur in people on puberty blockers, and it's uncertain to what extent.

In some of these cases, the puberty blockers is the cause.

Now, with brain development and bone density, that's pretty clear. With the orgasmic dysfunction, with the small genitalia being inadequate to create a pseudo vagina, those -- that's pretty clear.

Some of the other things, hot flashes are clear, weight gain is probably real and related to the puberty blockers, and maybe some mood alterations.

DANIEL WEISS

But some of them may not be, may be from the associated disorder that the child has as precocious puberty.

Q Returning to our discussion about the regime in the U.K., I understand I have now clarified to you the actual state of the law in the U.K.

But would you be okay with a ban on gender affirming care for minors under the age of --

ATTORNEY KORBERG: Withdrawn.

Q Would you support an approach where 16 year olds and 17 year olds were allowed to access gender affirming care for gender dysphoria, but not adolescents who are younger than 16?

A No.

ATTORNEY DROZ: Objection, vague.

Q So you think that the only legal regime you would support is one where only those 18 and older were able to access gender affirming care, is that right?

A Yes; and in fact, you know,

people even in their 20s, the decision-making is not optimal. So, but 18 would be the minimum.

Q So you think the reason for that doesn't have to do with some difference in the risks of gender affirming care when you're 17 versus 18, but rather with the fact that we believe that 18 year olds are mentally competent to make informed decisions about risks and benefits?

A It relates to mental competence at age -- that's right.

Q And you would agree that the adult parents of children accessing gender affirming care are mentally competent to, just as mentally competent as an 18 year old to assess the risks and benefits of care, right?

ATTORNEY DROZ: Objection, vague, form.

A So, parents are mentally competent, yes, but again, if they are asked to assess or approve of a harmful intervention on their child, that should not

be an intervention that should be performed.

So, regardless of parental ascent, a minor should not be on or be given medical interventions that modify their body for gender dysphoria.

Q Is it fair to say that you are opposed to gender affirming care because you believe the evidence of efficacy is of low quality?

A I think it's an irrational intervention for a mental health disorder.

There is evidence of harm, add the -- and the evidence that is available shows harm and no benefit.

So, part of it is there is no quality evidence that shows benefit, and the evidence that's available shows harm.

Q Is there any high quality evidence that supports that psychotherapy alone can treat gender dysphoria?

A No, it's not high quality.

It's low quality evidence, but it's an intervention that's not harmful. It doesn't induce -- it doesn't cause

irreversible changes that the child might regret years later.

And exploratory psychotherapy doesn't cause infertility.

Q Do you think that politics should play a role in the practice of medicine?

A No. It should be science.

Q Do you think that religion should play a role in the practice of medicine?

A No.

Q Your CV states that you are a senior fellow at Do No Harm Medicine, is that right?

A Yes.

Q Can you tell me about Do No Harm?

A Do No Harm is an organization that supports the elimination of politics from medical care.

They want what's best for training doctors to provide the best care for patients and to leave politics out of

medicine.

Q How did you become involved with Do No Harm?

A It's a long story, but I will make it short.

I joined when I heard about the organization and their mission. I happened to send an e-mail, or -- e-mail I think it was, in support of Florida's ban.

I didn't know about Florida's ban until I was notified by Do No Harm that if I was interested I could support their efforts to protect children with gender dysphoria.

And then subsequently Do No Harm contacted me by e-mail and said if you wrote a letter in support of Florida, would you send it to us?

After that they contacted me and asked me to join.

Q So, you wrote an e-mail in support of Florida's ban on gender affirming care and Do No Harm found out about that e-mail and then got in touch with you, is

that right?

A Correct.

Q And you hadn't known about Do No Harm prior to Do No Harm reaching out to you, is that right?

A No, no, no, so, you missed the first part.

So, I heard about Do No Harm some way online, and I saw their mission statement and what their goal was, to keep politics out of medicine, and I said I'm going to join, I'll be a member.

They said a noble effort, noble cause, let's not bring these kinds of ideologies into medicine, let's just do the best for patient care, and that's what their goal is.

And I joined, and then subsequently they contacted me.

Q And they asked you -- did they ask you to write an e-mail to Florida or --

A They sent an e-mail out, they said if you're interested and you have --

you provide -- if you are willing to provide input on Florida's ban, on Florida's legislation, please write to them.

Q Okay. And when was this?

A I don't remember. It was probably within the last couple of years or so, I don't remember.

It's probably mentioned in -- let me see, did my CV mention I'm on Do No Harm?

Q Yes, your CV says you are a senior fellow at Do No Harm.

A It was within the last oh, probably 18 months.

Q How much time elapsed between when you sent this letter to Florida with Do No Harm's encouragement and when you became a senior fellow at Do No Harm?

A I don't recall exactly, but to estimate probably four or five months.

Q And did you have any contact with Do No Harm in those four or five months before you became a senior fellow?

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

DANIEL WEISS

Q And how did it come to be that you became a senior fellow?

A They -- we had a discussion, we had like a Zoom call, and they said -- because they know I was experienced in treating adults with gender dysphoria, and so they knew my view on this matter, particularly with regard to treating minors or giving these interventions on minors.

And they asked whether I would be interested in working with them.

Q How many senior fellows are there at Do No Harm?

A I don't remember. Maybe -- I'll guess and say seven, something like that.

But you could find it on line, it pulls right up.

Q And what do you do as a senior fellow at Do No Harm?

A No, I have -- I am basically, my efforts primarily have been in support of legislation; that's basically it.

Q In the gender dysphoria

context, what are the goals of Do No Harm?

A The goals are to protect minors, and I think very clearly to not interfere with the adult gender dysphoria, but to stop medical, opposite sex hormones, puberty blockers and surgery on minors with gender dysphoria.

Q Is it a goal of Do No Harm to in any way limit adults' access to treatment for gender dysphoria, including cross sex hormones?

A No, not that I'm aware of at all, no.

Q Is a goal of Do No Harm to end clinical research on gender affirming care for minors?

A I'm not sure what their stance is on that.

Q Is it your goal to end clinical research on gender affirming care for minors?

A I think it's -- I think hormonal interventions, I can't justify any clinical research of hormonal interventions,

even in the research setting, on minors with gender dysphoria.

I think it's unethical.

Q And you provided testimony in several states in support of bills banning gender affirming care for minors, is that right?

A Yes.

Q Those states are Indiana, Ohio, Montana, Utah, Wyoming and North Dakota, right?

A Sounds right. Your list is probably better than my memory.

Q Were all of those testimonies in connection with your role as a senior fellow at Do No Harm?

A I think most of them -- one or two might not have been, but I believe most of them were as a senior fellow with Do No Harm.

And I would have listed that on, it would probably be the testimony might even have been submitted on Do No Harm letterhead.

DANIEL WEISS

Q So, if your testimony wasn't submitted on Do No Harm letterhead, can I infer from that that you were testifying in your individual capacity and not as a senior fellow of Do No Harm?

A Correct.

Q Is there any difference in your testimony if done in your individual capacity or as a senior fellow at Do No Harm?

A My thoughts and my understanding of the science might have evolved over time, so the testimony might have changed a little bit because of that.

For example, I testified in Ohio before I think even Do No Harm existed, what they called the SAFE Act, and you maybe cited that earlier on, and that was my own testimony.

There was no involvement with Do No Harm.

ATTORNEY KORBERG: By the way, can we take down the declaration?

Q Other than the extent to which your understanding may have evolved over the period in which you were testifying before legislators, is there any difference in the testimony you give on your behalf versus the testimony you give in your capacity as a senior fellow at Do No Harm?

A Not that comes to mind, no.

Q Have you provided testimony to any state legislators considering laws outside the context of gender affirming care?

A One testimony comes to mind, and that was in, I think it was Indiana, related to surgery on prisoners.

Do you have that one?

Q I don't.

A You missed that in your search?

Let me see, that was one.

I also had testimony in Texas, a statement, this is a statement submitted related to medical care for detransitioners. I bet you don't have that

either.

Q No. Why don't you go ahead and explain to me. Let's start with Texas.

What was -- what sentiment were you expressing to the state for their medical care for detransitioners?

A Sure. So if someone had hormonal or surgical interventions for gender dysphoria the insurances should cover any complications that might arise from that, or in those persons who chose to detransition.

Q You wanted to make sure that someone that received hormonal or surgical interventions for gender dysphoria had insurance coverage for any complications that arose from that treatment, right?

A Right. We can't abandon these people, however number there might be, 2 percent, 1 percent, 5 percent, doesn't matter.

They need medical care, and I wanted to support both the state and private insurers to cover those problems that might

arise.

Q Let's say that someone accessed surgery that made it such that they needed hormone replacement.

Were you advocating that insurers cover cross sex hormone coverage for those people?

A I'm very sorry, I missed that first part. Can you restate it?

Q Sure. So let's say that someone has surgery, and it is a type of surgery that thereafter requires some form of hormone replacement therapy.

Were you advocating for insurance to cover the provision of cross sex hormones as a form of hormone replacement therapy for those people?

A No, this was a statement in support of those people who had a complication related to their procedures or had -- needed medical care, now that they decided to return to their natal sex.

Q I see. So this was only advocating for people who decided to cease

accessing gender affirming care?

A They desisted or stopped the medical interventions, or they decided, we use the term detransition, to go back to their natal sex.

Or they had a complication, let's say they had genital reconstruction, and they had a complication, lots of infection, suffering, pain, chronic pain, whatever, related to that, that that medical care was covered.

Not just for those people who were no longer -- those people who still identified with say the opposite sex, if they had a complication related to that intervention.

Q And your Indiana testimony, what was your testimony with respect to prisoners and surgery?

A I don't remember the details on that.

It had something to do with should the state require -- should the state pay for surgery in a person with gender

dysphoria who insisted upon surgery because they had gender dysphoria and they wanted those surgical modifications.

Q And what position did you take, should the state pay for that or not pay that?

A Not pay for it.

Q Am I right that you also testified against vaccine mandates in Ohio?

A I think it was specifically COVID vaccine, COVID vaccine mandate.

Q I believe earlier you testified that you were supportive of the COVID vaccine mandates, is that right?

A No, that's incorrect.

Q Okay.

A I'm opposed to it. I'm opposed to the COVID -- I opposed the COVID vaccine mandate, and this is a completely separate scientific area where we can go at great length.

I don't want to use up your time, but it's very complicated, and I oppose the COVID vaccine mandate in Ohio.

Q And do you believe that the COVID vaccine is not safe and effective?

A That's correct. It's unsafe and ineffective, and any careful reading of the literature, which is very biased, reveals that it's bad.

It's bad, it's a messenger RNA, it's experimental, and many people suffered because of it.

The reporting of the studies were fraudulent, they covered up adverse events. I can go on and on. It's not safe and it's not effective.

Even Dr. Fauci says it does not prevent transmission or infection. They claimed it only reduced severity of infection.

Q Are you compensated by Do No Harm for your work as a senior fellow?

A Yes.

Q How much are you compensated by Do No Harm for that work?

A $325 an hour.

Q And since you became a senior

fellow with Do No Harm in the last year or so, how much money has Do No Harm paid you in total for your activities either as a senior fellow or otherwise?

A I don't remember that, I will have to go look it up.

Q Roughly?

A $15,000; $12,000 to $15,000.

Q And that's the total amount you would have received from Do No Harm for all of your various activities, whether as a senior fellow or otherwise?

A Correct, that's my best estimate.

Q Has Do No Harm compensated you for your work as an expert in Indiana, Montana or in this case?

A No, absolutely not. They know nothing about that work.

Q Do you know what groups provide funding to Do No Harm?

A No, I don't.

Do you? I think -- it not apparent, but they are funded, not as well

DANIEL WEISS

as ACLU.

Q Do you -- did you have any concerns or curiosity about where the money that was funding your work was ultimately coming from?

A Oh, no concerns at all. I'm curious, but no concerns.

Unfortunately, you know, the funding is substantial on -- for your viewpoint, it's very extensive, as you know.

Q Have you ever asked anyone at Do No Harm where the funding that is ultimately flowing to you is coming from?

A Not specifically -- I think -- no, I haven't asked directly that question.

But I think it's kind of, it's kept discrete, because if that person, persons announced that they were funding it, they would be cancelled, assaulted, attacked.

There would be protests and whatever.

Q Do you have a guess or a

hunch as to who is funding Do No Harm?

A Not at all, no idea.

Q Do No Harm also opposes, "The radical ideology of anti-racism," is that right?

A I believe that's correct, yes.

Q What does that mean?

A Well, I'm not a fellow in that regard, but I think what they are referring to is the promotion of ideas that states that white people are oppressors, and people of color are victims.

And that within medicine there is systemic racism that we as physicians, especially if we are white, are racist, and then it impacts on our care of patients.

And we need to say that we have white privilege, and all this nonsense. I believe it's nonsense, that's not true.

Q Do you believe that minority populations have unequal access to healthcare in the United States?

A No.

ATTORNEY DROZ: Objection, irrelevance.

A No.

Q Do you agree that healthcare outcomes are ever different for minority populations than for white people in the United States?

ATTORNEY DROZ: Objection, relevance.

A So, this is the kind of, you talk about association and causation.

So, I would say a thoughtful person, I think you should know that this is the standard kind of conclusion, that if the outcomes are different, it must be that something wrong is being done where we are failing in terms of treating these people.

So sure, the outcomes are different, but there are so many factors. And to claim that the outcome of a person who has a darker skin is worse because I am providing bad care to them is wrong, or that, or that the access isn't good.

Well, there are many factors. There is drug use, there is broken homes, there is poverty, there is crime, there is -- all these are factors.

And to say oh, there is a difference in outcomes, it must be racism, that's an inappropriate and unwarranted conclusion.

Q Is Do No Harm a politically motivated organization?

A No, I think on the contrary, they are motivated to eliminate politics from medicine and from healthcare, to eliminate it, to focus on the best outcomes and the science.

Q What's your definition of a politically motivated organization?

A An organization which makes decisions based upon ideology and not science and medicine.

Q Is the American Medical Association a politically or religiously motivated organization?

A The leadership I believe is,

I think their politics and ideology, that is, that has captured their leadership.

And remember, only about 25 percent at most of doctors are members of the AMA.

Q What about the American Pediatric Association, do you think that's a politically or religiously motivated organization?

A It's not -- I don't think there is religion in the leadership there.

There is politics, there is ideology in the leadership.

They have 66,000 members. They do not poll the members to get their input on how to help children who have psychic distress that is attributed to gender, they just made this statement without a review of the literature.

So, they are politically motivated.

Q Are the leadership of Do No Harm politically motivated?

A I don't think so.

DANIEL WEISS

Q Is there any major medical group that supports the provision of gender affirming care for minors suffering from gender dysphoria that you believe is not principally motivated?

ATTORNEY DROZ: Objection, vague and ambiguous.

A No, I think all of those -- any medical organization that evaluates the scientific evidence on hormonal and surgical interventions on children with gender dysphoria will conclude that or will decide not to support it.

And they will look at the comp reviews, they will look at the systematic reviews, they will look at the European experience, and they will say no, we do not support it.

So, I think those that are supporting are either not knowledgeable, they just kind of go along, and I think there are organizations that just will go along with maybe the AMA or the Endocrine Society.

DANIEL WEISS

They may not be politically motivated, but they are kind of lazy and they can't really do their own research.

And they might be afraid to come out and oppose it, because it's very difficult for people to be outspoken and challenge this narrative, very difficult.

It's scary. People are attacked and there is -- we have seen violence, threats and so on.

Q Is it your belief that any physicians that support gender affirming care for minors are either lazy, afraid or politically motivated?

ATTORNEY DROZ: Objection.

A You know, the lazy in terms of -- maybe I shouldn't use that word, lazy, they didn't put the effort into looking at the science. That's what I mean by that.

They either didn't put the effort in to study it, or they are afraid, because they don't want to speak out and challenge it.

So that's why often they

won't treat children who are, or even adults with gender dysphoria, or they are politically motivated.

I think the politically motivated people is relatively small, but they happen to be often on these leadership committees that come out with these statements.

Q And the leadership of these organizations are all physicians, right?

A It depends what you mean by all.

So, pediatricians, yes. Endocrine Society, some of them might be Ph.D.s, theory searchers, and not M.D.s.

Q Okay, how about this way. You agree that there is a number of doctors that support gender affirming care for minors, right?

ATTORNEY DROZ: Objection, vague. And I don't want to do a speaking objection, but we keep talking about gender affirming care, and I don't know what that includes.

DANIEL WEISS

And so maybe just so we can all get on the same page as to what that is.

ATTORNEY KORBERG: We did that like hours and hours and hours ago.

We agreed on a definition of gender affirming care, which actually the doctor provided to me.

Would you like to change his definition?

ATTORNEY DROZ: No.

ATTORNEY KORBERG: Okay.

A It's okay, I will restate.

I think what we are talking about with the gender affirming care term, phrase, is opposite sex hormones, puberty blockers and surgical treatment to modify body appearance to the child's, person's choice of appearance, gender.

It might be just, it might be removal of gonads, their testes, because they identify as a eunuch.

So that is what's being

DANIEL WEISS

called gender affirming care.

So there are doctors who support that, and there is, for WPATH guidelines, there is no lower age limit for that.

If they say they endorse WPATH, they are endorsing a 6 year old.

I should also add WPATH says there may be some children who don't want hormones first.

That is, they don't want opposite sex hormones, they just want their gonads removed or they want the surgery, and they are fine with that.

So one needs to keep that in mind, that those doctors, like Dr. Connelly, who endorsed WPATH, are endorsing this approach.

So there are doctors who support it, yes.

Q Yes. And doctors all take an oath to do no harm, right?

A I don't know what the current -- you know, they have changed the

Hippocratic oath, so they have kind of eliminated it, and it's really become substantially modified.

But that is a fundamental principle of not harming, Do No Harm in evaluating any intervention looking at the benefit and potential risk.

Q And is it your opinion that financial incentives in part explain the provision of gender affirming care in the United States?

A Yes.

Q Is it your opinion that anyone who provides gender affirming care is too biased to have an opinion on the provision of such care?

A No, I think there are some people who are just -- may not be informed, they didn't put the effort into really studying it, and, you know, it's a complicated matter, there is a lot of material, and they just may go along.

But there are others who are running gender clinics, and they don't have

an incentive to look at the science, because that's their job.

They don't want to lose their job, so they are convinced that what they are doing is right, and they don't want to -- they have a confirmation base, they don't want to see anything that challenges that.

Q Your employer, InterMountain Health, has a gender clinic in Utah that provides gender affirming care to minors, right?

A They do provide -- they were providing opposite sex hormones, puberty blockers, I believe, and in some cases surgery for persons with gender dysphoria in the northern part of the state.

Q And is it your belief that your colleagues at InterMountain providing such care are doing so despite the fact that it is against the fundamental medical principle to do no harm because they stand to gain financially from that?

A I don't know the reason.

I'm concerned about finances playing a role, and I think some of them just may have that's their principal job, and some of them may be biased or other reasons.

But I think, I like to think that everyone wants what's best for these children, but I just -- I am puzzled as to why they are encouraging these interventions which are not best for these children.

They are harmful, they don't help.

Q What is your affiliation with the Society for Evidence Based Gender Medicine?

A So, I'm not a member, but I do communicate with them periodically.

Q Is it fair to say that you generally agree with the positions taken by SEGM?

A Most of them, but not all.

Q Do you believe that SEGM is a biased organization?

A No, not at all.

DANIEL WEISS

Q Do you believe that the Yale School of Medicine is a biased organization?

A Which one, Yale?

Q The Yale School of Medicine?

A I can't speak to a whole school of medicine.

I can speak to a comment or a statement or a publication written by someone written on staff there.

Q Are you a member of the American Association of Physicians & Surgeons?

A I am.

Q I understand that that membership was included on your CV when you testified in Indiana, but has since been removed.

Is that deliberate?

A No, really, it got removed? That's a surprise. No, it should be on there.

It's not on there?

Q I don't believe so, but --

A I don't have my CV, but

that's an oversight, maybe, when I was updating it. No, I'm still a member.

Q And what's the extent of your involvment in AAPS?

A I've been a member since the '90s, and I just endorse many of their viewpoints and stances.

And their basic position mission is the sanctity of the patient/physician relationship, and keeping meddling and interference out of that.

Q Do you pay dues?

A Yes.

Q How much are those dues?

A I don't remember, something on the order of $250.

Q Do you receive the AAPS newsletters?

A Yes.

Q And do you read those newsletters?

A Usually.

Q Last month's AAPS newsletter explained that, "The switch to third person,

plural gender neutral language is a weapon of mass psychological destruction, far more lethal than bullets or bombs, which begins in our late childhood.

"This is part of the globalist agenda to destroy the U.S. and merge it into its own boundaryless planetary unistate."

Do you agree with that position taken by AAPS in its newsletter?

ATTORNEY DROZ: Objection.

A Was that written by Dr. Orient?

Q It was in the AAPS newsletter.

A Yeah, I think it's interesting, and it's some -- I agree with some of that.

I think controlling people's language is a powerful tool.

I don't know, I'm not sure about the globalist agenda.

Q So you don't think there is a globalist agenda to destroy the U.S. and

merge it into a boundaryless planetary unistate?

A No.

Q But you do agree that the use of they/them pronouns is a weapon of mass destruction, far more lethal than bullets or bombs?

A I wouldn't say that.

I think controlling someone's language is a powerful tool.

I wouldn't use the same verbiage that was used there.

Q So I use they/them pronouns, is personal use of they/them pronouns a weapon of mass psychological destruction that's more lethal than bullets or bombs?

A No.

Q The AAPS issued a press release protecting physicians who prescribe hydroxychloroquine and Ivermectin to treat COVID-19.

Did you know that?

A I think I did, yes. It's hydroxychloroquine is how you pronounce it.

DANIEL WEISS

Q Do you think there is evidence that hydroxychloroquine or Ivermectin treats COVID-19?

A Absolutely. They are very safe, too.

Q What's your support for the notion that hydroxychloroquine and Ivermectin treat COVID-19?

ATTORNEY DROZ: Objection, relevance.

A Yeah, I really think this is -- I mean, if you have another two hours I could teach you about this, but it's really complicated, and it relates to COVID infection, clinical experience, what's published, what's allowed to be published, where it's published, retractions, the government effort to crush any medical therapy for COVID infection, the promotion of the shots.

It's really complicated, and there is a lot of clinical experience that those drugs are effective for treatment of COVID infection when given early.

DANIEL WEISS

Q And do you believe with that the AAPS that abortion causes breast cancer?

A No, I think there is -- the data on that is very unclear. There is one or two studies that suggest that, but it's not clear; no.

Q Do you agree with AAPS that HIV does not cause AIDS?

A No; I disagree with that.

Q I understand -- what is your involvement with the Center for Christian Value?

A So, they contacted me when I was in Ohio, so they alerted me to the SAFE Act and that was -- that was kind of the impetus to give testimony back, what, maybe a year before last, 2021, I think.

You can check that.

Q Okay.

Do you generally agree with the views of the Center for Christian Value?

ATTORNEY DROZ: Objection, relevance.

A Yeah, I don't follow them,

they just -- they contacted me, I know their stance on gender dysphoria and hormonal interventions in children, and I agree with that position.

But otherwise I am not familiar with their other views.

I suspect that they are opposed to abortion, because they are religious.

Q "Among CCV's mission is ensuring government policy promotes strong families and strong marriages between one man and one woman."

Is that a mission that you also endorse?

ATTORNEY DROZ: Objection, relevance.

A Yeah, I am fine with any marriage between any sexes, but I think a family is very important. It's good to have two parents.

Q What's your involvement with the American College of Pediatricians?

A I don't have any involvement

with them.

Q Is there a difference between desistance and regret?

A So, regret is -- so, there are different definitions. There are articles on this. I reference some of them.

So regret, I would describe as expressing regret that a person has undertaken a particular step in life or accepted a certain intervention or procedure.

So a person might regret and still stay on their opposite sex hormones, for example.

And a person might desist, stopping the hormones and not detransition.

So it's complicated, and we need to define terms whenever we use them. But --

Q And it's possible that a person might stop receiving hormones, but not regret having received them, right?

A That's possible, yes.

Q And of the 100 patients that

you treated for gender dysphoria between 2003 and 2013, how many of those do you believe desisted?

A I think the majority.

Probably 50, 60, maybe even 70 of them. But I don't know, that's because they didn't come back and say I'm stopping hormones. They just didn't come back.

And as you said, maybe some moved, I doubt that. Maybe some went to another doctor, I doubt that, too, because there were not options and they didn't prefer -- the one other option was a person who was in another area of town and people didn't particularly like that clinic.

So I think most likely those who did not return just decided they weren't going to take them anymore.

Did they just stop the hormones and not regret it or did they just stop the hormones and regret it?

I don't know. I don't have that data.

Q And again, you don't actually know that they stopped taking hormones at all, right?

A I don't know who would have given them to them. As I said, there weren't options, there was no multitude of options available at that point.

I was the principal prescriber of hormones in northern Ohio at the time.

Q Well, the Cleveland Metro Clinic continued to provide cross sex hormone care, correct?

A Yes. And there would have been no reason to have gone there if they were seeing me, and I was closer.

Let's say -- maybe they got disenchanted with my care, but there was nothing to suggest that with the previous visits.

Patients, really -- I got very good reviews, they loved me.

Q Of the 100 patients that you cared for, did any ever express regret to

you regarding their gender affirming care?

A No. Well, I should say one person -- two people, sorry, so two people, went recently, recently, last year, I had a biologic male who had an orchiectomy in Philadelphia after being presumably evaluated by a therapist, had an orchiectomy. Within months he regretted it.

So he was on testosterone, same sex hormone, and then he wanted some estrogen, he went back and forth, and then he saw me, and so he was one person.

He was not originally seen by me, so that was one.

There was another man in his -- man, I can call him a he, he lived as a male, he had auto-gynephilia.

He really -- and I realized that later on, he was married to a female, having sex with her, had a ponytail, but lived as a male, basically, and wanted female hormones.

And I obliged him, and he seemed happy with that. He went by he, and

then came back after a hiatus of several months and said I'm having a little harder time getting erections since my surgery.

I said to him, what surgery?

Well, he had undergone orchiectomy, he had his testicles removed, having seen a psychologist first, I won't name the institution, and then had the orchiectomy.

And then he said this is not good, I'm having a hard time getting erections, having sex with my wife.

And so I called the urologist up I said how come you hadn't contacted me? I was following this guy for years, and he seemed to be fine on a little bit of estrogen, he just wanted some breast tissue and a little feminization.

That's all he wanted. And now he's having problems with erection.

So this urologist was surprised that this was the case. And I don't know why they didn't contact me, and the patient regretted having had the

surgery, and I had to put him back on -- I had to put him on testosterone.

So that's a person who's an adult in their, what did I say, 30s, he was in his 40s.

Q So other than those two of your 100 patients, each of whom had orchiectomy, did any of your patients express to you regret over any surgery or cross sex hormone that they had to address their gender dysphoria?

A I had one person who had a vaginoplasty, the full vagina created.

I wouldn't say that person had clearly regret, but was really distressed, had problems after the surgery that were happening related to infection and drainage and -- but strictly speaking, the word regret was not used.

Q So none of the patients expressed regret over the cross sex hormones that you had been providing to them, right?

A Well, no, the two with the orchiectomy, they had regret over the

surgery.

Q Yes, but none of your patients expressed regret over the administration of cross sex hormones, right?

A Correct.

Q Among the patients that you have cared for outside of the gender affirming care context, let's get a number, how many patients have you --

ATTORNEY KORBERG: Withdrawn.

Q Roughly how many patients have you cared for in the course of your career outside of the gender affirming care context?

A Oh, thousands, and thousands. Yes.

Q And have any of them ever expressed regret about some aspect of their treatment?

A Sure.

Q So how many of them would you say have expressed regret over some form of hormone therapy that is not cross sex treatment?

A I can't think of anyone who's expressed regret about hormonal treatment.

It would be other medications they might have expressed regret, because they had a complication from the medication that was not hormonal.

Q Okay. So how many of your patients have, roughly, have expressed regret, felt some aspect of their treatment or surgery outside of the gender affirming care context?

A That's a difficult to estimate. There are thousands. Maybe I don't know, 100, 150.

THE VIDEOGRAPHER: Just to note for the videographer, counsel, we have about ten minutes to a media change break.

ATTORNEY KORBERG: Thanks.

Q Roughly, like what percentage of that, would you say?

A I don't know. You can do the math.

Q When you say thousands, like

how many thousands do you think, like 2,000 patients you have seen, 1,000 patients?

A Oh, more than that, probably 10,000.

Q Okay.

And what percent of minors diagnosed with gender dysphoria who received gender affirming care do you believe come to regret that care?

A So the answer to that is not clear, but there is emerging evidence of increasing number of minors, and I have documented some of that in my declaration.

So we can turn to that section about desistance and regret and detransition.

Q So you don't have a particular percentage in mind?

A I think it's not well studied.

There is not prospective data, and the people, the adolescent medicine people and the pediatric endocrinologist people, they don't see these

people, they stop seeing them usually at the age of 18.

So, we don't know.

Q So, generally speaking, what would you say is an acceptable regret rate for surgery?

A For this type of surgery?

Q No, for any type of surgery. What's an acceptable regret rate where you should say okay, people should still provide that surgery?

A Well, you have to look at the other options, so the alternative treatments, harm/benefit, so it depends; depends.

Q What about for cosmetic surgery, what's an acceptable regret rate for cosmetic surgery?

ATTORNEY DROZ: Objection.

A I don't know the answer to that, and I would ask -- I would have to look at the plastic and cosmetic and aesthetic literature for surgery.

I would say it should be very

low.

Q So if, for example, there was a 20 percent regret rate for a surgery, do you think that surgery should be criminalized?

ATTORNEY DROZ: Objection, speculative.

A So, I don't think it's appropriate to compare treating a mental health disorder with surgery or hormonal interventions with -- in minors to aesthetic or cosmetic surgery in adults who want to change their body because they want bigger breasts or something like that.

And they are more competent in making that decision.

Q Do you have a sense of how often people come to regret having gastric bypass surgery?

A Yes, I think it's very low, very low. It's probably less than 5 percent, maybe 2 or 3 percent.

Because I see a lot of those people, I follow people post gastric bypass.

DANIEL WEISS

Q Do you recommend gastric bypass for any of your patients?

A Yes.

Q And if you came to learn that the regret rate for gastric bypass was 30 percent, would that make you disinclined to recommend gastric bypass surgery to your patients?

A Yes. Yes, I would look and see why is that? What surgical center is that happening in? What procedure do they have?

So, there are some older procedures where there was more, a lot more complications, and now, with the newer procedures, there are less complications.

And you're treating a physical problem in people who are severely obese, who have often a multiple comorbidities that resolve or substantially improve promptly as they lose weight.

And they failed all these other interventions that are less aggressive.

DANIEL WEISS

But now we have medicines that are seeming to work even better -- they are working well, and that some people respond well to those medicines, so well that they don't need the surgery.

Q You were making a distinction between being treated for a mental health versus surgery, so let's talk about mental health.

Do you think that people suffering from depression should take antidepressants?

A I think they should get counseling, and consider the use of an anti-depressant to help them if they choose to do so, yes.

Q Have you ever recommended to a patient that they go on an anti-depressant medication?

A Oh, yes, and I have prescribed it, sure. I treat depression. It's -- depression is common in people with diabetes. I see a lot of diabetes.

Q Are you aware that studies

have found that at least 16 percent of people prescribed anti-depressants had a negative experience, and only 54 percent report a positive experience?

A I believe that --

ATTORNEY DROZ: Objection.

Q You still believe that it is appropriate to prescribe anti-depressants, despite the fact that only 54 percent report having a positive experience with that medication, is that right?

A Oh, so it depends -- so I'm not familiar with that study you are citing. One can never predict which anti-depressant is going to work best for that individual.

And people who are suffering with depression are then in a shared decision-making process, are offered that medication, which does not produce irreversible changes on the body, and helps them be more positive, have interest in things, more motivation, sleep better and so on.

And if they don't respond,

they can try an alternative one.

Some people choose, however, they don't want medications, they just want counseling and therapy.

Q So you would still prescribe a treatment that has a meaningfully high regret rate for a mental health disorder, right?

ATTORNEY DROZ: Objection, mischaracterizing it.

A Yeah, so again, I don't know that particular study that you are referring to.

When you are using medication, you are not producing irreversible changes on the body for the mental health disorder, so they could stop the pill.

And with surgical interventions, removing breasts and cutting off penises, and it's not quite comparable to a pill that might give them an adverse reaction.

It's just not -- it's kind of

ludicrous to compare the two of them, even though they might both regret.

Q A number of times today you have referred to the number of people who are members of a Reddit website as evidence of a large number of people who detransition.

Do you agree?

A Yes, that's one piece of evidence.

Q And does following a Reddit site on the subject of detransitioning mean that that person has personally accessed gender affirming care and detransitioned and desisted from that care?

A In many cases yes, but I don't have data on that, I don't have precise data on that.

Q Have you taken any steps to verify anything about the people who follow the Reddit site on detransitioning and whether they did, in fact, receive gender affirming care, or have stopped that care?

A No.

DANIEL WEISS

Q But it's your belief that the majority of people who follow that Reddit site in fact access gender affirming care and then stopped accessing gender affirming care, is that right?

ATTORNEY DROZ: Objection, mischaracterizes.

A Had gender dysphoria and desisted or detransitioned or regretted.

So I think it's probably a diverse group of people who had gender dysphoria who then accessed the site who no longer are pursuing those medical interventions.

Q You don't think the people follow that site because, like you, they are interested in the question of whether, in fact, people desist from care?

A No. I don't follow it, either. I just have access to it. I'm not a follower of it.

ATTORNEY KORBERG: I'm turning to a new topic now. Should we change the tape?

DANIEL WEISS

THE VIDEOGRAPHER: Thank you, I appreciate that.

The time is 5:30, we are going off the record. This ends media file 5.

(At this point in the proceedings there was a recess, after which the deposition continued as follows:)

THE VIDEOGRAPHER: The time is 5:33. We are back on the record. This begins media file 6.

Q Are you religious?

A A little bit.

ATTORNEY DROZ: Objection, relevance. You can answer.

A A little bit.

Q Do you have any religious beliefs regarding transgender people?

A No.

Q Do you have any religious beliefs about gay and lesbian people?

A No.

Q I understand that you believe that sex is unchangeable and binary, is that

right?

A Yes.

Q Is sex the same thing as gender?

A I think it is.

And I should add again that WPATH can't define gender, look in their glossary, they can't define it. They use all this circular language.

And I would also add my religious views have not changed since 2003 through 2013 to now. So I was treating adults with gender dysphoria, and my religious views are the same.

Q And have your political beliefs changed at all since --

A No.

Q -- from 2003 until today?

A No. I think you asked that before, but they have not.

Q Do you think that men and women have different capabilities because of their biology?

A Of course.

DANIEL WEISS

Q Do you believe that men and women are better suited to particular jobs because of their biology?

A Of course.

Q And can you name some jobs that men are better suited to because of their biology?

A Construction work men are better at, and climbing telephone poles men might be better at.

Work that requires lots of heavy lifting.

Q Are there some jobs that women are better suited to because of their biology?

ATTORNEY DROZ: Objection, this relevance.

A I would say no.

Q Are there any non-physical jobs that you any think men are better suited to because of their biology?

A No.

Q In your report you refer to being nonbinary in quotes. Why do you do

that?

A Where is that?

Q Paragraph 84 of your report, you use the word nonbinary, and you put it in quotes.

A Okay, I would like to see how I refer to that.

Oh, yes, so I think because it's not clear what that means.

I think they are referring to a male who feels that they are neither, even though they are male, they feel that they are either, neither -- sorry, neither male nor female.

That is, they are nonbinary, that's the term that they use. They are not either of those binary options, even though in reality they are male.

So, WPATH used that term. I happen to put that nonbinary in quotes, and this is what I was stating before, they might feel they identify as a eunuch, so we are obliged to respect that and remove their testes, if we follow WPATH guidelines, as

Dr. Connelly does.

Q So do you think that there is any way in which someone who is nonbinary should be respected for being nonbinary?

A No, I think the term to say someone is nonbinary is nonsense.

They have some psychological problem accepting their -- the reality of their physical being, and they say they are nonbinary, that's the term they might use.

But I think it's nonsense.

Q Okay. So someone who is nonbinary, do you think they are suffering from a delusion?

A No, I think they have a psychological problem that they need help with.

And we should not -- we should not support that feeling or conviction by physical intervention, by surgical intervention, any more than we should a young lady who has anorexia nervosa who feels she's too fat, and then help her lose weight when she's underweight.

That would be as similarly absurd to intervene surgically in that person.

I am just shocked that people would consider supporting an intervention on a child, because there is no lower age limit, who doesn't like their testes who says I'm nonbinary.

Q Okay. What about an adult who's nonbinary?

A I think that person -- so that person is not likely to regret it, and I certainly wouldn't refer that person to a surgeon, and I think they need therapy.

If they say I'm nonbinary and I want my testes removed, I identify as a eunuch, I had a person who wanted, a female who had breasts and a vagina, normal external genitalia, I believe, I didn't examine her, she wanted a penis and she wanted to keep her breasts.

Now, she was psychotic, and she needed help for her psychosis. And there is this analogy between that and

someone who has -- who says they identify as a eunuch, and they are nonbinary.

Q It's your opinion that someone who is nonbinary and wants to physically appear in ways both like a male and a female, that that person is psychotic, is that correct?

A No, that patient I described was psychotic.

But no, I don't know what the psychiatric disorder would be in that person who wants to appear both as a male and female, who calls himself nonbinary, they have some psychiatric disorder and it's not -- if you want to call it gender dysphoria, go right ahead, if that's the name you want to call it, and they say they identify as nonbinary, that person needs psychiatric help.

You know, they may not seek it, they may instead seek modification of their body.

Q And the goal of that psychiatric help would be to get them to

admit that they are whatever sex they were assigned at birth?

A No, I did not say that.

The goal of that psychiatric intervention is to relieve their psychic distress that they might have, whatever psychic distress that is present, and those people have to have it.

They have to have depression, anxiety, some thing is going on that makes them call themselves nonbinary.

But the goal is not so-called conversion therapy, which is a term used for those who have a different sexual orientation. It's not that.

The goal is to help make them feel less dysphoric, make them feel more positive about themselves and living in the world.

Q What about someone who is nonbinary and who does undergo some form of gender affirming care and then has no more psychic distress about their gender presentation?

A Yes.

Q Would you say that they are still mentally unwell and suffering from a delusion if they continue to identify as nonbinary?

A So, first, I didn't use the word delusion, that's your word. They have psychological disorders in general.

I mean, if they say they are nonbinary, they have some psychological disorder, and that needs to be addressed.

Now, if you are coming up with a hypothetical example of someone who's had some medical intervention, surgery, hormones, and they say they are nonbinary, and they are feeling fine about themselves, no depression, anxiety. I would say that's great.

But I'm not sure what your question was.

Q Sure. Would you still say if they are not experiencing any psychic distress but they are still identifying as nonbinary, is it still your belief that

person is mentally unwell in some way?

A If they say they are nonbinary still, probably there is psychological issues going on there that haven't been addressed, yeah.

But if they are happy, they are feeling great, it doesn't matter what I say, and I don't care.

They shouldn't care if they are -- if life is good, they are not depressed, they are not anxious, they are sleeping well, their energy is good, their job is well, their social arrangements are positive.

It's immaterial, that's great, and I'm glad they are doing well.

Q When talking to patients to whom you provide gender affirming care, would you use their requested name if it differed from the name?

A Oh, sure. There is no reason to hurt people's feelings, insult them.

Q And would you refer to your patients by their preferred pronouns?

A Absolutely.

Q And what about sort of outside of their presence?

For example, if you were discussing a patient with a nurse, would you refer to them by their preferred pronouns?

A I would still try to, because it's the right thing to do, and I don't want to do it one way in one setting and not -- another way in the other setting, because I don't want to offend the person.

Q And what about in the medical records, would you try to use people's preferred pronouns in their medical charts?

A Yes. I actually prefer not to use pronouns in that setting, I just use the first name.

Q So putting aside the issues related to fertility and genital changes, do all of the risks that you identified with respect to puberty blockers exist when blockers are used to treat precocious puberty?

A Let me look in my list again.

Page 32.

One more time, that question?

Q Putting aside issues related to fertility and genital changes that you discussed, do all of the risks you identified with puberty blockers that exist when blockers --

ATTORNEY KORBERG: Withdrawn.

Q Putting aside the issues you identified with regard to fertility and genital changes, do all of the risks that you identified with respect to blockers in a gender affirming care context for minors exist when blockers are used to treat precocious puberty?

A So the data we have primarily is in the setting of precocious puberty when treating minors.

The only caveat I would say is, besides infertility and genital changes, there is orgasm, concern about inability to achieve orgasm if they treat early.

And then the bone density, which correlates to duration of treatment,

reductions in bone density.

Q Do you support banning puberty blockers for precocious puberty?

A No.

Q Do you know anyone personally outside of your patients who is transgender?

A No. In terms of like a friend or aware of people, or in what capacity?

Q Yeah, sure, let's start with friends. Do you have any friends who are transgender?

A No; I don't have very many friends anyway.

Q Have you ever worked with someone who is transgender?

A Yes. I don't -- but in a professional capacity.

Q Do you have any personal biases against transgender people?

A No.

Q Would you have any objection to using the bathroom with someone who is transgender?

A I myself, no. But I think, you know, this is outside the scope of what we are talking here.

But I think females, biologic females might appropriately be concerned about someone who says they are female, but looks like a male or has -- exposes himself and still has his external genitalia.

So I think I would be sensitive to the females' concerns in that regard.

But I have no problem.

Q Do you think that cys gender men should be concerned about transgender men using the same restroom?

A I think it's best that people who retain their genitalia that they are born with go into the bathroom that is appropriate for their biologic sex, and I think it's most respectful and caring for all parties that way.

And if a person doesn't want to do that who is trans, perhaps they can use a bathroom that's unisex.

DANIEL WEISS

Q So you think it's most appropriate for a transgender man with a full beard who is physically presenting as a man in every way to use the women's room, is that right?

ATTORNEY DROZ: Objection, enough. Relevance.

A In that setting, if he looks like a man and he's using -- if he looks like a man, then there is not going to be an issue.

But if he looks like a woman in some ways, he doesn't have the beard and then he exposes himself, his external genitalia, this is a biologic male in the presence of women, that could cause anxiety and concern, because of what you previously stated before, about sexual assaults on females is more common by males.

Biologic males, if they retain their external genitalia, and they say they are women, that could cause distress among biologic females.

Q In the last year, what was

your approximate total income from all sources?

A In the last -- 2022, you mean?

Q Let's do 2022 first, and then 2023.

A 2022 --

ATTORNEY DROZ: I will just object, the relevance.

A Probably -- I'm guessing here, because I don't have my returns in front of me, but probably about $300,000; roughly.

Q And how much of that income comes from your clinical practice at InterMountain?

A So I joined, to clarify, I joined InterMountain in -- my first day of work was the end of January of this year, so I wasn't working, I was not employed with InterMountain last year.

Q Okay, why don't we say then, how much of that income came from your clinical practice in Ohio?

DANIEL WEISS

A Let's see, I would say about 85 percent.

Q And what percentage of your income has come from various agreements with drug and device manufacturers to advise on, present and promote certain treatments?

A Well, last year would have been probably, if I am recalling correctly, the other 15 percent would have been promotional programs for pharmaceutical companies.

Q Okay.

And what about, sorry, in 2022, did you have any other sources of income?

A Not that I recall.

Not from employment. It would have been dividends and that kind of thing.

Q Sure.

So in 2023, what do you expect your income from your clinical practice at InterMountain to be?

A I am salaried, because I came

in as a new person, so it's lower, $220,000.

Q How much do you expect this year to receive from the various agreements you have with drug and device manufacturers to advise, present on and promote certain treatments?

A Probably $60,000.

Q And how much of your income in 2023 is -- are you going to get from your position as a senior fellow at Do No Harm?

A Whatever I -- what did I previously say? Probably like that, maybe a little more, I don't recall.

Q $18,000?

A So it will be probably maybe $5,000 more or something. I am not doing much work with Do No Harm now.

Q So roughly you expect about $20,000 from Do No Harm?

A Yes.

ATTORNEY DROZ: I think the testimony was 12 to 15 before.

THE WITNESS: That sounds right.

A So yeah, 20, roughly 20.

Q And how much income do you expect this year from being an expert witness in gender affirming care cases?

A Probably $80,000.

Q And do you have any other expected income for 2023?

A Expected income, you mean other sources?

Q Yes, that we haven't talked about here?

A No.

Q How does your total expected income this year compare to three years ago?

A Well, last year it was -- it should be similar to last year's. Three years ago I think it was lower because I got a raise when I was with my employer in Ohio.

But this year's should be pretty similar to last year's, it seems like, but we will see.

Q And next year, in 2024, do you expect the amount of income that you receive from Do No Harm to increase,

decrease or stay the same?

ATTORNEY DROZ: Objection, speculation.

Q You can answer.

A Decrease.

Q Decrease?

A Yes.

Q Why is that?

A I don't think -- my role is not important at this point with what they are working on.

Q Do No Harm is no longer focusing on gender affirming care bans for minors?

A No, they are doing a lot of areas of focus, some of which you touched on.

But I suspect my role will be less than -- and my income from them will be less than this year, because I was doing a lot more of those expert testimony submissions, and there will probably be less of that.

Q Do you think there is going

to be less of that because Do No Harm is going to prioritize supporting state bans on gender affirming care or because fewer states are going to be passing bans on gender affirming care for minors?

A Well, it's mere speculation, but I don't think either of those is the case. I think they are working on other issues.

They, for example, are working on affirmative action, I think they have spoken on that, and the systemic racism issues and things like that.

Q So it's your belief that on a relative basis, Do No Harm is going to focus on other issues more than gender affirming care bans for minors, is that right?

A That's right, I suspect that.

Q What's the basis for you suspecting that?

A If you go to their website you see all the other areas they are addressing.

Q And do you expect the income

that you received for being an expert witness in cases regarding gender affirming care cases to increase, decrease or stay the same?

A Again, I don't know. I would think it might stay the same or increase. I doubt that it will decrease, because there are a lot of bans that have been challenged, and they might ask for my input.

ATTORNEY KORBERG: Okay, I have no further questions. I appreciate your time today.

THE VIDEOGRAPHER: Anything else, Mr. Droz?

ATTORNEY DROZ: I don't think I'm going to do a redirect.

THE VIDEOGRAPHER: This is the videographer. The time is 5:56. This ends media file 6, and this concludes this deposition.

(Time noted: 5:56 p.m.)

DANIEL WEISS

I, the undersigned, a Certified Shorthand Reporter of the State of New York, do hereby certify:

That the foregoing proceedings were taken before me at the time and place herein set forth; that any witnesses in the foregoing proceedings, prior to testifying, were duly sworn; that a record of the proceedings was made by me using machine shorthand which was thereafter transcribed under my direction;

That the foregoing transcript is a true record of the testimony given.

Further, that if the foregoing pertains to the original transcript of a deposition in a federal case before completion of the proceedings, review of the transcript [ ] was [x] was not requested.

I further certify I am neither financially interested in the action nor a relative or employee of any attorney or party to this action.

IN WITNESS WHEREOF, I have this date subscribed my name.

Dated: September 25, 2023

Stephen J. Moore
RPR, CRR

DANIEL WEISS

DECLARATION UNDER PENALTY OF PERJURY

Case Name: PAM POE v. LABRADOR

Date of Deposition: September 22, 2023

I, DANIEL WEISS, hereby certify under penalty of perjury under the laws of the State of New York that the foregoing is true and correct.

Executed this _____ day of _____, 2023, at _____.

_____

DANIEL WEISS

DANIEL WEISS
DEPOSITION ERRATA SHEET
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DANIEL WEISS

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Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

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VERITEXT LEGAL SOLUTIONS

COMPANY CERTIFICATE AND DISCLOSURE STATEMENT

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Exhibit C

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UNITED STATES DISTRICT COURT
DISTRICT OF IDAHO

LAURDES MATSUMOTO, NORTHWEST ABORTION ACCESS FUND, and INDIGENOUS IDAHO ALLIANCE,

Plaintiffs,

v.

RAÚL LABRADOR, in his capacity as the Attorney General for the State of Idaho,

Defendant.

Case No. 1:23-cv-00323-DKG

DEFENDANT'S OPPOSITION TO PLAINTIFFS' MOTION FOR A TEMPORARY RESTRAINING ORDER OR, IN THE ALTERNATIVE, A PRELIMINARY INJUNCTION

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INTRODUCTION

This is a lawsuit over the constitutionality of Idaho Code § 18-623, which Plaintiffs call the "Abortion Travel Ban." *See* Dkt. 12-1 at 2. But that is an egregious misnomer. The law does not ban anyone from traveling to another state, much less doing so to obtain an abortion that might be illegal in Idaho. The law prohibits not abortion travel, but rather abortion *trafficking*: recruiting, harboring, or transporting a pregnant minor for an abortion with *intent to conceal from the minor's parents or guardian*. Idaho Code § 18-623(1). It is an Abortion *Trafficking* Ban, not an Abortion *Travel* Ban. Plaintiffs still challenge it: they say they have a First Amendment right to help other people's children go to other states for abortions without their parents' knowledge, much less consent. But the Constitution recognizes no such thing.

To the contrary, the Constitution recognizes the rights of parents to be involved in medical decisions about their children. Plaintiffs' own allegations show that abortion is exactly that kind of decision. They allege that "[p]regnancy, childbirth and parenting significantly impact an individual's physical and mental health, finances, and personal relationships" and that becoming a parent "is extremely personal and permanent." Dkt. 1 ¶ 27. That is why "[a]n intimate decision of this magnitude," *id.*, should be made with the support and wisdom of at least one of a child's parents or guardians. "After all, there is the traditional presumption that a fit parent will act in the best interest of his or her child." *Nelson v. Evans*, 170 Idaho 887, 896, 517 P.3d 816, 825 (Idaho 2022) (internal quotation omitted).

Yet Plaintiffs turn this presumption on its head by taking it upon themselves to determine whether a parent is fit and whether they should get to decide their children's decisions. Plaintiffs believe that they, not a pregnant minor's parents, get to decide what is in her best interests:

- that *they* have a right to hide a minor child from that child's parents if *they* believe that is appropriate;
- that *they* have a right to help transport a minor child across state lines for an abortion while concealing this transportation from the minor's parents;
- that *they* have a right to determine whether it is appropriate to notify a minor's parents about "an intimate decision of this magnitude."

Dkt. 1 ¶¶ 26–30, 32; *see also* Dkt. 12-9 ¶¶ 17–19; Dkt. 1 ¶¶ 26–30, 32, 47–51, 55; Dkt. 12-1 at 14, 21, 25–26; Dkt. 12-7 ¶¶ 43–45, 47–51, 53–54; Dkt. 12-8 ¶¶ 39–41, 50–54; Dkt. 12-9 ¶¶ 12–14, 18–19, 20–23, 26–27.

In any other context, Plaintiffs' statements about their plans would readily be recognized for what they are: the crime of child custody interference. That offense is when one "intentionally and without lawful authority … takes, entices away, keeps or withholds any minor child from a parent or another person or institution having custody, joint custody, visitation, or other parental rights." *See* Idaho Code § 18-4506(1)(a). That is exactly what Plaintiffs want to do here. And if they do it for the additional purpose of helping a pregnant minor to obtain an abortion with an intent to conceal the abortion from the minor's parents, they also commit the crime of abortion trafficking.

In this light, Plaintiffs do not meet any of the requirements for a preliminary injunction. The law does not violate their freedom of speech, but rather regulates their conduct: helping other people's children cross state lines for an abortion with the intent to conceal the abortion from the minor's parents. That does not violate Plaintiffs' freedom of association either. Neither is the law vague, since the conduct it prohibits—recruiting, harboring, or transporting a minor—is the same conduct prohibited by other human trafficking statutes, including federal statutes that Plaintiffs' counsel enforced as U.S. Attorney. The balance of harms and public interest overwhelmingly favor the parents whom the Abortion Trafficking Ban protects, and whom Plaintiffs seek to prevent from knowing about major decisions affecting their children. Finally, Plaintiffs are not even injured with a threat of prosecution. They have not alleged any threat to actual protected speech, and the Attorney General has no authority to prosecute them until a county prosecutor either requests his assistance or refuses to enforce the law. That lack of prosecutorial authority is not just fatal to Plaintiffs' claims on the merits, but also to the Court's jurisdiction.

Plaintiffs' contention that the Constitution gives them the right to get minors to travel across state lines for an abortion without their parents' knowledge is truly shocking. That shocking contention does not entitle them to a preliminary injunction.

STANDARD OF DECISION

"A preliminary injunction is an extraordinary and drastic remedy, one that should not be granted unless the movant, by a clear showing, carries the burden of

persuasion." *Fraihat v. U.S. Immigr. and Customs Enf't*, 16 F.4th 613, 635 (9th Cir. 2021) (internal quotations omitted, emphasis removed). To obtain this extraordinary relief, Plaintiffs must show (1) that they are likely to succeed on the merits; (2) that they are likely to suffer irreparable harm without injunctive relief; (3) that the balance of equities tips in their favor; and (4) that an injunction is in the public interest. *Winter v. Nat. Res. Def. Couns., Inc.*, 555 U.S. 7, 20 (2008). "Likelihood of success on the merits is the most important factor." *Fraihat*, 16 F.4th at 635 (internal quotations and citation omitted). A "possibility" of irreparable injury is not sufficient, rather plaintiffs seeking preliminary relief must "demonstrate that irreparable injury is *likely* in the absence of an injunction." *Winter*, 555 U.S. at 20 (emphasis in original). And a court cannot grant a preliminary injunction if it lacks subject matter jurisdiction. *See Ex parte McCardle*, 74 U.S. 506, 514.

A temporary restraining order follows the same test as for a preliminary injunction, but "should be restricted to ... preserving the status quo" pending a full hearing. *Granny Goose Foods, Inc. v. Bhd. of Teamsters & Auto Truck Drivers Loc. No. 70 of Alameda Cnty*, 415 U.S. 423, 439 (1974). The Ninth Circuit holds that, for a challenge to state law, the status quo presumes that the legislation will go into effect as enacted. *See Golden Gate Rest. Ass'n v. City & Cnty. of San Francisco*, 512 F.3d 1112, 1116 (9th Cir. 2008). Thus, a temporary restraining order here would disturb, rather than preserve, the status quo.

ARGUMENT

I. Plaintiffs are not likely to succeed on the merits.

While Plaintiffs nominally complain about the Abortion Trafficking Ban, their true grievance is with Idaho's abortion policy in general. Thus, they begin their brief with the assertion that "Idaho has some of the most oppressive criminal abortion statutes in the United States," since "'[e]very person who performs or attempts to perform an abortion … commits the crime of criminal abortion.'" Dkt. 12-1 at 1 (quoting Idaho Code § 18-622(1)). But no matter Plaintiffs' views that these laws are "oppressive," the Supreme Court of the United States in *Dobbs v. Jackson Women's Health Organization*, 142 S. Ct. 2228 (2022), held that the U.S. Constitution does not impose any barriers on enacting them. And shortly thereafter, the Idaho Supreme Court held the Constitution of the State of Idaho also does not "protect abortion as a fundamental right," and that Idaho's criminal laws on abortion are constitutional. *Planned Parenthood Great Nw. v. State*, 171 Idaho 374, 522 P.3d 1132, 1148–49 (Idaho 2023). So, there is no question that Idaho can lawfully prohibit criminal abortion. And here too, despite Plaintiffs' many grievances about Idaho's laws, the question is not whether Idaho's Abortion Trafficking law "is good policy," but simply whether it is constitutional. *Id.* at 381, 522 P.3d at 1149. Plainly, it is.

None of Plaintiffs' claims are likely to succeed. They sidestep over the important purposes of the Abortion Trafficking Ban in protecting parents' rights. The law does not threaten their speech—instead, it prohibits only specified conduct that intentionally causes a pregnant minor's abortion with an intent to conceal the

abortion from the minor's parents. The law does not prohibit them from associating with anyone. Nor is it vague: the same three verbs that Plaintiffs challenge—recruit, harbor, and transport—are used in many human trafficking statutes, including the federal statutes that Plaintiffs' counsel previously enforced and the statutes of various State Amici. The Court should deny a preliminary injunction.

A. The Abortion Trafficking Ban protects parents' rights.

The Abortion Trafficking Ban is targeted legislation designed to protect a fundamental right secured by both the Idaho and the U.S. Constitutions—parents' "fundamental right 'to make decisions concerning the care, custody and control of their children.'" *Bartosz v. Jones*, 146 Idaho 449, 465, 197 P.3d 310, 326 (Idaho 2008) (Eismann, J., concurring) (quoting *Troxel v. Granville*, 530 U.S. 57, 66 (2000)). Thus, the Abortion Trafficking Ban does not punish those who take a pregnant minor across state lines for an abortion *unless* they do so with the specific intent to conceal it from her parents or guardian. Doing so is not constitutionally protected conduct.

1. Parents have a right to know about care for their children.

States have an important and compelling interest in protecting a parent's right to make healthcare decisions for their children. For almost 80 years, U.S. Supreme Court precedent has stated that "[i]t is cardinal with us that the custody, care and nurture of the child reside first in the parents, whose primary function and freedom include preparation for obligations the state can neither supply nor hinder." *Prince v. Massachusetts*, 321 U.S. 158, 166 (1944). "The law's concept of the family rests on a presumption that parents possess what a child lacks in maturity, experience, and

capacity for judgment required for making life's difficult decisions." *Parham v. J.R.*, 442 U.S. 584, 602 (1979). "More important, historically, it has recognized that natural bonds of affection lead parents to act in the best interests of their children." *Id.* "Most children, even in adolescence, simply are not able to make sound judgments concerning many decisions, including their need for medical care or treatment." *Id.* at 603. "Parents can and must make those judgments." *Id.* And so "parents have a right arising from the liberty interest in family association to be with their children while they are receiving medical attention." *Wallis v. Spencer*, 202 F.3d 1126, 1142 (9th Cir. 2000).

Idaho law has recognized the same thing for over a century: "[t]he right of a parent to the custody, control, and society of his child is one of the highest known to the law." *Martin v. Vincent*, 34 Idaho 432, 201 P. 492, 493 (Idaho 1921). Idaho law says that parents have a fundamental right to make child rearing decisions. *Nelson,* 170 Idaho at 894–95, 517 P.3d at 823–24 (citing *Troxel v. Granville*, 530 U.S. 57 (2000)). "[T]he interest of parents in the care, custody, and control of their children is perhaps the oldest of the fundamental liberty interests recognized by the Supreme Court of the United States." *Id.* at 896, 517 P.3d at 825 (internal quotations omitted).

Because the Constitution protects these rights *from* governmental interference, legislatures necessarily have authority to enact laws to further these rights. As the Supreme Court of the United States has recognized, because "the parents' claim to authority in their own household to direct the rearing of their children is basic in the structure of our society," a state legislature may "properly

conclude that parents … are entitled to the support of laws designed to aid discharge of that responsibility." *Ginsberg v. State of N.Y.*, 390 U.S. 629, 639 (1968). That is just what the Abortion Trafficking Ban does.

2. The Abortion Trafficking Ban protects parents' right to know.

The Abortion Trafficking Ban protects the fundamental rights of parents to give—and, in turn, their minor children to receive—help and advice to their minor children if they become pregnant. The law does so by making it an essential element of the offense, to be proved beyond a reasonable doubt, that it is done with "intent to conceal an abortion from the parents or guardian of a pregnant, unemancipated minor." Idaho Code § 18-623(1). "Crimes in Idaho are categorized as either 'general intent' or 'specific intent' crimes. *State v. Stiffler*, 117 Idaho 405, 406, 788 P.2d 220, 221 (1990)[,]" and a "specific intent" crime is one that, like this statute, "refers to that state of mind which in part defines the crime and is an element thereof." *State v. Guerra*, 169 Idaho 486, 503, 497 P.3d 1106, 1123 (Idaho 2021). Here, the specific intent required for Abortion Trafficking is the intent to conceal the abortion from the pregnant minor's parents or guardian. Simply assisting a pregnant child in obtaining an abortion, without that specific intent, does not violate the statute.

Plaintiffs largely ignore this important element of the crime. They erroneously assert that the statute "made it unlawful to provide travel assistance within Idaho, including helping minors reach or cross Idaho's borders." Dkt. 1 at 3. And they omit the specific intent element of the Abortion Trafficking statute repeatedly throughout

Plaintiffs' filings.[1] The State Amici make the same mistake, not once addressing the intent to conceal requirement of the statute in their brief. *See generally* Amicus Brief of the States in Support of Plaintiff's Motion for a Temporary Restraining Order, Dkt. 20-1. But Plaintiffs plainly cannot prevail on a challenge to a state statute without acknowledging all of its essential elements.

Still, it is clear that Plaintiffs want to violate the specific intent requirement that they gloss over. Plaintiff Matsumoto, a member of the bar, "would like to provide temporary shelter for pregnant minors … who are traveling to obtain … abortion care … *whether those minors' parents know or do not know*" by "assisting them obtain transportation from Idaho to those states." *See* Dkt. 12-1 at 4 (emphasis added). And Plaintiff NWAAF says that "[p]arents and guardians *may or may not have known or approved* of NWAAF's support of these minors," which support includes "provid[ing] food and lodging assistance" to minors seeking abortions. Dkt. 12-9 ¶¶ 17-19. Plaintiff Indigenous Idaho Alliance states that its mission and belief includes "providing financial, transportation, and logistical assistance to pregnant minors

[1] *See, e.g.*, Dkt. 1 ¶ 26 (stating that "the simple act of driving a minor to the Oregon border to get an abortion without the minor's parent or guardian knowing" is illegal, but ignoring the specific intent element of the statute); *id.* ¶ 74 (stating that the statute "prevents Plaintiffs and pregnant minors from traveling within Idaho to reach a state where abortion is lawful," but ignoring the specific intent requirement of the statute); *id.* ¶ 79 (stating that the statute "prevent[s] minors from accessing abortion care that is legal in Idaho's neighbor states by criminalizing a trusted adult's travel," but ignoring the specific intent requirement of the statute); *id.* ¶ 106 (failing to recognize the specific intent requirement of the statute); *id.* ¶ 116 (failing to recognize the specific intent requirement of the statute); Dkt. 12-1 at 1 (stating that "Idaho criminalized conduct by adults who assist pregnant minors in receiving abortion care," but ignoring the specific intent element of the statute).

within the region seeking legal abortion, *with or without the knowledge or consent of their parents or guardians*." Dkt. 12-8 ¶ 61.; *see also* Dkt. 1 ¶¶ 26–30, 32, 47–51, 55; Dkt. 12-1 at 14, 21, 25–26; Dkt. 12-7 ¶¶ 43–45, 47–51, 53–54; Dkt. 12-8 ¶¶ 39–41, 50–54; Dkt. 12-9 ¶¶ 12–14, 18–19, 20–23, 26–27.

The Amici States note that their laws allow minors to obtain an abortion without parental consent. Dkt. 20-1 at 2–4. But that does not diminish in the least the State of Idaho's choice to protect parents' fundamental right over these important decisions. Indeed, even in the *Roe* era, the Supreme Court of the United States recognized that parental involvement in these decisions is critical. There are "potentially grave emotional and psychological consequences of the decision to abort," which "has potentially traumatic and permanent consequences." *H. L. v. Matheson*, 450 U.S. 398, 412–13 (1981). Consultation with parents is "particularly desirable with respect to the abortion decision—one that for some people raises profound moral and religious concerns." *Bellotti v. Baird*, 443 U.S. 622, 640 (1979). As Justice Stewart so poignantly stated, "[t]here can be little doubt that the State furthers a constitutionally permissible end by encouraging an unmarried pregnant minor to seek the help and advice of her parents in making the very important decision whether or not to bear a child." *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 91 (1976) (Stewart, J. concurring), *abrogated as to the right to abortion by Dobbs*, 142 S. Ct. 2228 (2022). "That is a grave decision, and a girl of tender years, under emotional stress, may be ill-equipped to make it without mature advice and emotional support." *Id.*

Thus, now that the Supreme Court has recognized that no federal right to abortion exists, ensuring that a pregnant minor child receives the advice and support of her parents before making a decision to receive an abortion is all the more compelling. If anything, the laws of the Amici States—not Idaho—risk running afoul of the U.S. Constitution because they reject parental rights in this manner.

B. The Abortion Trafficking Ban does not punish speech.

1. The law criminalizes conduct, not speech.

Plaintiffs are not likely to succeed on the merits because their claims do not implicate the First Amendment's free speech protections. "The first step of First Amendment analysis is to determine whether the regulation implicates protected expression." *Recycle for Change v. City of Oakland*, 856 F.3d 666, 669 (9th. Cir. 2017). That is not the case here: the Abortion Trafficking Ban regulates conduct, not speech, and does not implicate protected expression.

All of the key terms of the Abortion Trafficking Ban relate to conduct, not speech. The conduct it prohibits is procuring an abortion or obtaining an abortion-inducing drug for a pregnant minor "by recruiting, harboring, or transporting the pregnant minor within this state[.]" *See* Idaho Code § 18-623(1). Procuring an abortion is not protected expression—rather, it is a crime, Idaho Code § 18-622, one that the Supreme Court of the United States and the Idaho Supreme Court have concluded the State may lawfully punish. *Dobbs*, 142 S. Ct. 2228; *Planned Parenthood Great Nw.*, 171 Idaho at 380–81, 522 P.3d at 1148–49. Nor does the First

Amendment protect "recruiting, harboring, or transporting" a minor for the purpose of that crime.

Plaintiffs say that their intended activities are "expressive conduct" because their assistance to the pregnant unemancipated minors "conveys a message of support for pregnant minors seeking to obtain lawful abortion care" and "conveys a clear message of support for abortion itself." Dkt. 12-1 at 11–12. But that is true of all criminal conduct. Paying a hitman for a murder conveys a message of support for murder for hire. Propositioning a prostitute conveys a message of support for transactional sexual relationships. Possessing large quantities of methamphetamine conveys a message of support for the drug trade. Everything and anything conveys a message of support for something, but that does not make it protected under the First Amendment. And conduct lawfully criminalized by statute does not become speech simply because it necessarily "conveys a message."

Thus, the Supreme Court of the United States has specifically rejected the argument that "the constitutional freedom for speech and press extends its immunity to speech or writing used as an integral part of conduct in violation of a valid criminal statute." *Giboney v. Empire Storage & Ice. Co.*, 336 U.S. 490, 498 (1949). In that case, the speech at issue, picketing outside a business, was part of a "single and integrated course of conduct" "to compel Empire to agree to stop selling ice to nonunion peddlers" in violation of Missouri law. *Id*. Similarly, in the instant case, to the extent the Abortion Trafficking statute impacts speech, it only does so when that speech is part of a "single and integrated course of conduct" to procure an

abortion or obtain an abortion-inducing drug for a pregnant unemancipated minor child with the intent to conceal that abortion from the minor's parents or guardian.

Nor is there support for Plaintiffs' claims in *Holder v. Humanitarian Law Project*, 561 U.S. 1 (2010). The statute there, which prohibited the material support for terrorist organizations, "regulate[d] speech on the basis of its content," and whether the plaintiffs were able to speak to certain groups depended solely on "what they say." *Id.* at 27. In contrast, the Abortion Trafficking Ban does not prohibit speech of any kind. It does not stop Plaintiffs from sharing their views about abortion, or any other subject, to any person they want, including pregnant unemancipated minor children. But what they cannot do is take certain steps to procure an abortion or obtain an abortion-inducing drug for that pregnant minor with the intent to conceal it from the child's parents or guardian. The mere fact that speech may be used in recruiting, harboring, or transporting the child is immaterial: "[a]n illegal course of conduct is not protected by the first amendment merely because the conduct was in part carried out by language in contrast to direct action." *United States v. Gilbert*, 813 F.2d 1523, 1529 (9th Cir. 1987).

Plaintiffs say they need to take these actions as to *all* pregnant minors because *some* of them may be abused or neglected by their parents. Dkt. 12-1 at 1. But "the statist notion" that Plaintiffs have the unilateral right to substitute themselves for a child's parents "in *all* cases because *some* parents abuse and neglect children is repugnant to American tradition." *Parham*, 442 U.S. at 603. And if Plaintiffs have concerns about abuse and neglect, Idaho already has in effect a comprehensive

statutory scheme for protecting children from parents who abuse or neglect their children. *See* Child Protective Act, Title 16, Chapter 16, Idaho Code. This statutory scheme starts not with Plaintiffs determining for themselves whether parents are fit or not, but a report to the Idaho Department of Health and Welfare or local law enforcement. In fact, Plaintiffs, should they have a "reason to believe" that a pregnant minor they are trying to help "has been abused, abandoned, or neglected," have a *duty* to report the matter, within 24 hours, to the proper law enforcement agency or the Idaho Department of Health and Welfare. Idaho Code § 16-1605(1). Failing to make the report is a misdemeanor. *See* Idaho Code § 16-1605(4).

Plaintiffs do not have a First Amendment interest in frustrating Idaho's presumption of parental custody over children. "It is incumbent upon him who seeks to invade the home and remove a child from its protection, and from the custody of its natural guardians to show facts sufficient to justify his action[s] under the law." *Martin*, 34 Idaho 432, 201 P. at 493. "Parents are not required in the first instance to take upon themselves the burden of proving their fitness to have the care of their children, or that they are properly exercising their parental control." *Id.* That is why Idaho law makes it a crime, not a right, to interfere with a parent's custody, which is what Plaintiffs seek to do here. Idaho Code § 18-4506(1)(a). Plaintiffs' mere speculation that some parents might abuse their children is not sufficient to justify their argument that they should be allowed to remove all pregnant minors from the protection and custody of their parents regarding the decision as to whether to have an abortion or not.

The State Amici, quoting *Bigelow v. Virginia*, 421 U.S. 809, 824–25 (1975), argue that the State of Idaho "cannot 'bar a citizen of another State from disseminating information about an activity that is legal in that State,' even if it does so 'under the guise of exercising internal police powers.'" Dkt. 20-1 at 5. But this is not a situation like in *Bigelow* involving an attempt to prosecute the mere advertisement of something that is legal in another state. 421 U.S. at 815 n.5. The Abortion Trafficking Ban does not criminalize the mere act of publicizing the fact that abortion is legal in another state, but instead punishes specific conduct furthering specific crimes with specific intent. And as long as the defendant commits "any essential element of the crime" within the State of Idaho, Idaho courts have jurisdiction over the crime, even if other elements of the crime are committed outside Idaho's borders. *See State v. Villafuerte*, 160 Idaho 377, 379, 373 P.3d 695, 697 (2016) (citing Idaho Code §§ 18-202(1), 19-301(1), and 19-302). And just as the State of Idaho cannot criminalize abortion in the state of Washington, or any other state, those states cannot force Idaho to allow Plaintiffs, or any other person, to violate Idaho's criminal laws.

2. Any minimal speech restriction passes constitutional scrutiny.

Even if the Abortion Trafficking Ban had some minimal effect on speech, it would easily be upheld under applicable First Amendment standards. Plaintiffs say the law is "subject to strict scrutiny," but they fail to show the critical premise for applying that test: that the law regulates speech by its content. Dkt. 12-1 at 13. That premise is not met here.

"A content-based law is one that targets speech based on its communicative content or applies to particular speech because of the topic discussed or message expressed." *Recycle for Change*, 856 F.3d at 670 (internal quotations and brackets omitted). The first step to determining "whether a law is content based is to consider whether a regulation of speech on its face draws distinctions based on the message a speaker conveys." *Id.* (internal quotations omitted). But the Abortion Trafficking Ban does not reference speech at all, much less do so based on its content. Plaintiffs may express any message they like under the Abortion Trafficking Ban. To the extent the law even implicitly addresses speech, it addresses only its effects, not the message it expresses. Thus, the statute focuses on transitive action verbs—to "procure" or "obtain" an abortion or to "recruit," "harbor," or "transport" a pregnant minor—not on expressive verbs. The law does not discriminate on the basis of the content of any speech, but "on the basis of non-expressive, non-communicative conduct." *Id.* at 672. Speakers may express any message they wish, so long as they do not cause a pregnant minor to obtain an abortion with the specific intent to conceal the fact from the minor's parents.

That this may have "an incidental effect of some speakers or messages but not others" is immaterial because the law "serves purposes unrelated to the content of expression[.]" *Ward v. Rock Against Racism*, 491 U.S. 781, 791 (1989). Here, that purpose is the protection of the fundamental rights of parents to "make decisions concerning the care, custody and control of their children." *Bartosz*, 146 Idaho at 465 (Eismann, J. concurring). And that purpose is unrelated to the content of a message

Plaintiffs, or any other person, may wish to express through their conduct. The law is therefore content-neutral.

So, at the very most, if any speech-related test must be applied to the Abortion Trafficking Ban, the Court should apply the "relatively lenient" standard from *United States v. O'Brien*, 391 U.S. 367, 376 (1968). *Texas v. Johnson*, 491 U.S. 397, 407 (1989). This test applies to statutes in which "speech and nonspeech elements are combined in the same course of conduct." *Id.* (internal quotations omitted). Under this test, "a sufficiently important governmental interest in regulating the nonspeech element can justify incidental limitations on First Amendment freedoms." *Id.* "Under *O'Brien*, a government regulation is sufficiently justified [1] if it is within the constitutional power of the Government; [2] if it furthers an important or substantial governmental interest; [3] if the governmental interest is unrelated to the suppression of free expression; and [4] if the incidental restriction on alleged First Amendment freedoms is no greater than is essential to the furtherance of that interest." *Recycle for Change*, 856 F.3d at 674 (internal quotations omitted, brackets in original). The Abortion Trafficking Ban meets all of these elements.

First, there is no question that Idaho has the power to enact this law. As noted above, a state legislature may "properly conclude that parents … are entitled to the support of laws designed to aid discharge" of their responsibility to care for their children. *Ginsberg*, 390 U.S. at 639.

Second, the Abortion Trafficking Ban furthers an important government interest. The law protects the fundamental right of parents to make medical

decisions for their children, and thus also protects the children themselves by helping ensure that they have the guidance of their parents. The fact that Plaintiffs are so eager to obtain and conceal abortions from children's parents shows the compelling need for a statute like this. Plaintiffs do not believe it is important for minors to have their parents' input in getting an abortion decision. And they believe that they have a right to help traffic children out of state for that purpose, regardless of whether their parents know. The State has a compelling interest in ensuring otherwise.

Third, the State's interest is unrelated to the restriction of free expression. Ensuring that any assistance for out-of-state abortions take place only with the knowledge of a child's parents has no relation to free speech.

Fourth, any incidental restriction on speech is no more than is necessary to protect parental rights. The Abortion Trafficking Ban satisfies this standard with its specific intent requirement concerning parental consent. Idaho Code § 18-623(1). That element goes directly to the interest served by the statute—helping ensure parental involvement in the pregnant minor's decision as to whether to have an abortion. The statute could have been written as a general intent crime, and simply required as an element of the crime that the parents or guardian did not affirmatively consent to the abortion. *Cf. Holder*, 561 U.S. at 17–18. Instead, the legislature narrowed the statute to require an intent to conceal the abortion from the pregnant minor's parents or guardian. That requirement quite arguably removes the conduct at issue entirely from First Amendment protections. *See id.* at 56–57 (Breyer, J.

dissenting). But at the very least, it amply satisfies the lenient *O'Brien* test—the most rigorous test that could apply to the law.

The Abortion Trafficking Ban thus does not infringe on free speech.

C. The Abortion Trafficking Ban does not limit association.

Neither does the Abortion Trafficking Ban violate Plaintiffs' "First Amendment rights of association." Dkt. 12-1 at 12. "The freedom of association protected by the First Amendment does not extend to joining with others for the purpose of depriving third parties of their lawful rights." *State v. Manzanares*, 152 Idaho 410, 424, 272 P.3d 382, 396 (Idaho 2012) (quoting *Madsen v. Women's Health Ctr.*, 512 U.S. 753, 776 (1994)). That is exactly what the statute prohibits by requiring proof the intent to conceal an abortion from the pregnant minor's parents or guardian. Nothing about that offends the Constitution.

At bottom, the law does not prohibit Plaintiffs from associating with anyone, including minor children. What it prohibits is conduct related to such an association: procuring an abortion or obtaining an abortion inducing drug for a pregnant minor by recruiting, harboring, or transporting that minor with the intent to conceal the abortion from the minor's parents or guardian. The Supreme Court of the United States in *Holder* summarily dismissed the notion that the statute there "prohibit[ed] being a member of one of the designated groups," since what it in fact "prohibits is the act of giving material support." 561 U.S. at 39–40. The Court should reach the same conclusion here.

D. The Abortion Trafficking Ban is not vague.

Finally, the Abortion Trafficking Ban does not fall afoul of constitutional vagueness principles. A statute is impermissibly vague if it "fails to provide a person of ordinary intelligence fair notice of what is prohibited, or is so standardless that it authorizes or encourages seriously discriminatory enforcement." *Holder*, 561 U.S. at 18. While a more stringent test applies in the First Amendment context, Plaintiffs have not shown that the law restricts any protected speech. And even in the First Amendment context, "perfect clarity and precise guidance have never been required even of regulations that restrict expressive activity." *Id.* at 19. (internal quotations omitted). As the Supreme Court noted in *Hill v. Colorado*, "while there is little doubt that imagination can conjure up hypothetical cases in which the meaning of these terms will be in nice question, because we are condemned to the use of words, we can never expect mathematical certainty from our language." 530 U.S. 703, 733 (2000) (cleaned up).

Plaintiffs argue that the statute is unconstitutionally vague because it "does not contain or refer to a definitions section that would tell Plaintiffs when their conduct would constitute recruiting, harboring, or transporting." Dkt. 12-1 at 15. But these are not unfamiliar terms used in isolation that only lawyers could understand. Rather, these terms are well within common understanding, which is why they are so commonly used in state and federal criminal trafficking statutes across the country:

Idaho law: In addition to the Abortion Trafficking Ban, Idaho's general human trafficking statute criminalizes those same three verbs—"recruitment, harboring, transportation"—if in furtherance of subjecting a person "to involuntary servitude, peonage, debt bondage, or slavery." Idaho Code § 18-8602(1)(a)(ii). If those verbs are vague when used to prevent abortion, they are also vague when used to prevent slavery.

Federal law: The U.S. criminal code likewise makes it a crime to "recruit[],… harbor[], [or] transport[] … a person … knowing … that the person has not attained the age of 18 years and will be caused to engage in a commercial sex act." 18 U.S.C. § 1591(a)(1). When Plaintiffs' counsel served as United States Attorney for the District of Idaho, she evidently believed the same three words—recruit, harbor, and transport—were clear enough that she could prosecute not just violations of the law, but even attempts to interfere with its enforcement. *See United States. v. Swinson*, No. 1:12-CR-279-EJL, Dkt. 2 at 8 (D. Idaho. Oct. 26, 2012); Press Release, Washington Man Sentenced in Idaho Sex Trafficking Case, U.S. Attorney, Dist. of Idaho (Mar. 25, 2013), https://tinyurl.com/bddbupa2. How she now claims those verbs are unconstitutionally vague is a mystery.

Other states: Several other states, including some of the Amici States, use similar verbiage to criminalize human trafficking. *See, e.g.*, Wash. Rev. Code § 9A.40.100 (2017) ("A person is guilty of trafficking in the first degree when such person recruits, harbors, transports ... by any means another person ....") (cleaned up); Ariz. Rev. Stat. Ann. § 13-1307 (2021) ("'Traffic' means to entice, recruit, harbor,

provide, transport or otherwise obtain another person."); Colo. Rev. Stat. § 18-3-504 (2019) ("A person commits human trafficking of a minor for sexual servitude if the person knowingly sells, recruits, harbors, transports ... by any means, maintains, or makes available a minor for the purpose of commercial sexual activity.").

Sex traffickers have repeatedly argued these terms are unconstitutionally vague. And courts have repeatedly held otherwise. *See, e.g.*, *United States v. Snead*, 2022 WL 17975015 at *4 (4th Cir. 2022) (stating that each of the verbs "recruits, entices, harbors, transports, provides" has an ordinary meaning that would provide a person of ordinary intelligence fair notice of what conduct is prohibited"); *Alonso v. State*, 228 So. 3d 1093, 1101–02 (Ala. Crim. App. 2016) (upholding a statute that assigning criminal liability to an individual who "knowingly obtains, recruits, ... harbors, ... transports, provides, or maintains any minor for the purpose of causing a minor to engage in sexual servitude" and rejecting a vagueness challenge to its constitutionality); *State v. Scotia*, 146 Ariz. 159, 160 (Ariz. App. 1985) (collecting cases regarding the use of the term "transport" for drug transport statute); *State v. Bryant*, 953 So.2d 585, 587 (Fla. App. 2007) (reversing trial court finding of unconstitutional vagueness based on word "transport"). The fact that the statute concerns abortion does not magically transform a plain word into an unclear one. Plaintiffs' vagueness challenge is thus wholly lacking in merit.

Plaintiffs also argue that the "statute fails to provide adequate notice regarding what culpability attaches to communication or the lack thereof with a minor's parents and/or guardians." Dkt. 12-1 at 16. But the many questions they

ask on this point do not move the needle. The elements of the statute do not depend upon any communication or lack of communication with the parents, but rather whether the defendant takes action to procure an abortion for a pregnant minor *with intent to conceal from the parents*. Idaho Code § 18-623(1). A prosecutor must prove that element of specific intent beyond a reasonable doubt. Thus, providing parents with notice and advance knowledge would likely prevent a prosecutor from bringing a case, while a prosecutor might be able to argue the specific intent requirement was met if a defendant provided no notice to the child's parents.

State Amici also raise other hypothetical arguments about what the statute may or may not cover. Dkt. 20-1 at 5. But this case involves challenges from the Plaintiffs, and as such the Court can only look at "the particular facts at issue," since a "plaintiff who engages in some conduct that is clearly proscribed cannot complain of the vagueness of the law as applied to the conduct of others." *See Holder*, 561 U.S. at 18–19; *see also* Dkt. 31 at 3 ("The Amici States … may not initiate, create, extend, or enlarge the issues."). And the Supreme Court of the United States has admonished that "while there is little doubt that imagination can conjure up hypothetical cases in which the meaning of these terms will be in nice question, because we are condemned to the use of words, we can never expect mathematical certainty from our language." *Hill*, 530 U.S. at 733 (cleaned up). One can ask unending questions in an attempt to raise hypothetical situations in which the applicability of the statute might be in question. But the terms the Abortion Trafficking Ban employs have long been used by a variety of different trafficking statutes in a variety of different jurisdictions. So

Idaho Code § 18-623 provides more than ample notice to a person of ordinary intelligence of what it prohibits.

II. The balance of harms and public interest do not favor an injunction.

The balance of equities and the public interest weigh heavily in favor of the Attorney General and against issuing a temporary restraining order or preliminary injunction. The Plaintiffs are asserting the right to determine for themselves whether a parent is fit in order to decide whether it is okay to conceal information about a pregnant minor's abortion from the parents. Allowing the Plaintiffs to decide what is in the best interests of someone else's child and conceal that from the pregnant minor's parents actively undermines a parent's fundamental right and obligation to determine what is in the best interests of their children. Given this fundamental right of parents to direct the care and upbringing of their children and to be involved in the medical decisions of their minor children, the State of Idaho's policy in favor of protecting those rights is in the public interest. The constitutional rights of parents to determine what is in the best interests of their children heavily outweigh the desires of third parties to lead children into such consequential actions without their parents' knowledge or consent.

III. Plaintiffs have no irreparable injury.

Finally, the Court should deny Plaintiffs' motion for preliminary injunction for lack of an irreparable injury. At the outset, Plaintiffs have no irreparable injury because, for the reasons set forth in Section I.B, they allege only an effect on their intended conduct, not on any protected speech that would be otherwise chilled. As

Plaintiffs' own cases acknowledge, they must "present more than allegations of a subjective chill" and must instead show "specific present objective harm or a threat of specific future harm." *Bigelow*, 421 U.S. at 816–17 (internal quotations omitted). They have not made that showing here.

But in truth, and even more important, Plaintiffs have no injury at all, much less an irreparable one. And as will be set forth more fully in the Attorney General's forthcoming motion to dismiss, that deficiency is fatal to jurisdiction—under both the Eleventh Amendment and Article III justiciability—just as it is to the merits.

In the pre-enforcement context here, both Eleventh Amendment immunity and Article III justiciability turn on whether there is a threat of prosecution. The *Ex parte Young* exception to the Attorney General's Eleventh Amendment immunity applies only if he is "clothed with some duty in regard to the enforcement of the laws of the state, and ... threaten and are about to commence proceedings ... to enforce against parties affected [by] an unconstitutional act." *Ex parte Young*, 209 U.S. 123, 155–56 (1908). And proving a justiciable controversy in the pre-enforcement context also requires a threat: for standing, "whether the prosecuting authorities have communicated a specific warning or threat to initiate proceedings," *Twitter, Inc. v. Paxton*, 56 F.4th 1170, 1174, and for ripeness, a "specific and credible threat of adverse action." *Lopez v. Candaele*, 630 F.3d 775, 781 (9th Cir. 2010). That essential threat is wholly absent here.

Aside from the fact that Plaintiffs do not allege the Attorney General has made any statement regarding the enforcement of the Abortion Trafficking Ban, Plaintiffs'

attempt to show injury falters based on a more fundamental proposition of law: the Attorney General *has no authority* to threaten criminal prosecutions of the Abortion Trafficking Ban at this time. Under Idaho statutory law, "the primary duty of enforcing all the penal provisions of any and all statutes of this state, in any court, is vested in the sheriff and prosecuting attorney of each of the several counties." Idaho Code § 31-2227. Thus, while the Attorney General is Idaho's "chief legal officer," he is not its chief law enforcement officer, *Newman v. Lance*, 922 P.2d 395, 399 (Idaho 1996), and county prosecutors do not answer to him. Idaho Code § 31-2604. In fact, Idaho law previously allowed the Attorney General to "exercise supervisory powers over prosecuting attorneys in all matters pertaining to their duties," *Newman*, 129 Idaho at 102, 922 P.2d at 399, but the Legislature struck that provision in 1998, limiting the Attorney General's criminal enforcement authority to the ability to "assist the prosecuting attorney" in each respective county. *State v. Summer*, 139 Idaho 219, 224, 76 P.3d 963, 968 (Idaho 2003).

The Attorney General recently explained and clarified these principles in a formal opinion construing the limits on his own prosecutorial powers. Att'y Gen. Op. 23-1 (April 27, 2023). As he explained, he has prosecutorial authority only "if requested by county prosecutors and approved by a state district judge" or "if specifically conferred by the Legislature." *Id.* at 2. That definitive construction of the limits of his own powers supersedes the Ninth Circuit's interpretation of Idaho law in *Parenthood of Idaho, Inc. v. Wasden*, 376 F.3d 908 (9th Cir. 2004), which held that the Attorney General was a proper defendant to a challenge to the State's

abortion laws.[2] And neither of the two conditions for the Attorney General's prosecutorial authority—referral by a county prosecutor or a specific legislative grant—are met here.

First, no county prosecutor has referred any case under the Abortion Trafficking Ban to the Attorney General, and Plaintiffs do not allege otherwise. The Attorney General would not have referral authority to prosecute violations of this statute unless there were a specific case considered by a specific county prosecutor who asked the Attorney General for help. Plaintiffs do not allege that such a case exists. They want to violate the law, sure enough, but they do not allege any specific circumstances in which they intend to do so. Nor have they sued any of the county prosecutors who would have direct prosecutorial authority if they did violate the law. Instead, they have only sued the Attorney General, whose purely derivative authority has not yet been triggered.

Second, the limited legislative grant of prosecutorial authority to the Attorney General under the Abortion Trafficking Ban has not been triggered here. *See* Att'y Gen. Op. 23-1 at 2–3. That limited authority is still contingent on actions by county prosecutors: he "has the authority, at [his] sole discretion, to prosecute a person for a criminal violation of this section *if the prosecuting attorney authorized to prosecute* criminal violations of this section *refuses to prosecute* violations of any of the

[2] Judge Winmill ruled to the contrary in *Planned Parenthood v. Labrador*, but refused to consider the effect of the Att'y Gen. Op. 23-1 in construing the limits of his own authority. Case No. 1:23-CV-00142-BLW, Slip. Op., 2023 WL 5237613 (D. Idaho August 15, 2023), Judge Winmill's decision is now on appeal to the Ninth Circuit.

provisions of this section by any person *without regard to the facts or circumstances*." Idaho Code § 18-623 (emphasis added). Thus, the Attorney General does not have any prosecutorial authority unless a county prosecutor first refuses to exercise his or her authority. Plaintiffs have alleged no facts that indicate that *any* prosecutor in Idaho has so refused to enforce this section of code. Indeed, none have. The Attorney General thus lacks any prosecutorial authority under the Abortion Trafficking Ban at this time.

Because the Attorney General would have authority under this statute only based on actions of county prosecutors that have not yet occurred, he is not a proper defendant under *Ex parte Young* and Plaintiffs have not alleged a justiciable controversy against him under Article III. There is no "special relation" between the Attorney General and the law as required to overcome sovereign immunity, *Los Angeles Cnty. Bar Ass'n v. Eu*, 979 F.2d 697, 704 (9th Cir. 1992), much less "a '*genuine* threat of *imminent* prosecution'" by the Attorney General as required for ripeness. *San Diego Cnty. Gun Rts. Comm. v. Reno*, 98 F.3d 1121, 1126 (9th Cir. 1996) (citation omitted). The case is not fit for review because any individuals with whom the Plaintiffs intend to engage are not "identifiable" and the case presents no "concrete factual scenario" to which the law applies. *Thomas v. Anchorage Equal Rts. Comm'n*, 220 F.3d 1134, 1141 (9th Cir. 2000) (citation omitted); *Hodgers-Durgin v. de la Vina*, 199 F.3d 1037, 1044 (9th Cir. 1999). Plaintiffs have not shown any irreparable injury that warrants an injunction—in fact, they have not alleged any injury at all, and the Court lacks jurisdiction.

CONCLUSION

The Court should deny Plaintiffs' motion for a temporary restraining order or preliminary injunction both on the merits and for lack of jurisdiction.

DATED: August 28, 2023

STATE OF IDAHO
OFFICE OF THE ATTORNEY GENERAL

By: /s/ *Lincoln Davis Wilson*
LINCOLN DAVIS WILSON
Chief, Civil Litigation and
Constitutional Defense

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on August 28, 2023, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system which sent a Notice of Electronic Filing to the following persons:

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Exhibit D

UNITED STATES DISTRICT COURT

DISTRICT OF IDAHO

SOUTHERN DIVISION

LOURDES MATSUMOTO, et al,	)	Case No. 1:23-CV-00323-DKG
	)	
Plaintiffs,	)	
	)	Boise, Idaho
vs.	)	September 14, 2023
	)	
RAUL LABRADOR, et al,	)	
	)	
Defendants.	)	
	)	
. . . . .	)	

VOLUME I OF I
MOTION HEARING
BEFORE THE HONORABLE DEBORA K. GRASHAM
UNITED STATES MAGISTRATE JUDGE

COURT RECORDER:	TRANSCRIPTION BY:
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Proceedings recorded by electronic recording. Transcript produced by transcription service.

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I N D E X

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(Proceedings begin.)

CLERK: All rise. The United States District Court for the District of Idaho is now in session. The Honorable Debora K. Grasham presiding.

COURT: Please be seated.

CLERK: The Court will now hear Case CIV23-233-S-DKG, Lourdes Matsumoto versus Raul Labrador, et al. Counsel, please state your appearances for the record beginning with counsel for the plaintiff.

MS. OLSON: Yes. Thank you. Good afternoon, Your Honor. Wendy Olson from Stole Rives, LLP, for the plaintiffs along with my co-counsel Wendy Heipt and Kelly O'Neill who are with the Lawyering Project and Jamila Johnson and Paige Suelzle -- sorry, they're for Legal Voice. Jamila Johnson and Paige Suelzle are with the Lawyering Project. Thank you, Your Honor.

COURT: Thank you.

MR. WILSON: Good afternoon, Your Honor. Lincoln Wilson with the Idaho Attorney General's Office and here with my Deputy Division Chief, James Craig, who will be presenting argument today.

COURT: All right. Well, good afternoon, counsel. And everybody, welcome. It's good to see you all here. I've been (inaudible) your briefs so it's good to see some of the faces that are behind these briefs.

All right. Counsel, as you know, this is the time set

for the hearing on plaintiffs' motion for temporary restraining order or in the alternative for a preliminary injunction. It's seeking to enjoin Defendant Labrador from enforcing Idaho Code Section 18-623.

Counsel, I can assure you that I have spent a considerable amount of time reviewing your briefs and your submissions and I am familiar with your arguments presented here today.

And so (inaudible) there's a lot to cover if we're going to cover everything. My hope is that we don't have to spend all day doing this and that we can cover what's most important or specifically I'm going to be asking you to address a couple of different issues that I see as particularly important for the Court's consideration as I move forward.

Now, I know I've told or I've informed you that I'd like to (inaudible) this argument to 30 minutes because I just fear that this case could go on and on and on and we could keep talking about it. Now, that said, I'm asking you questions. I'll be giving you as much time as you need to answer those questions but that is my hope to kind of get to the heart of the matter and some of the key issues that are going to be presented here today.

Now, as I said, the plaintiffs are here today contesting the constitutionality of Idaho's criminal abortion trafficking statute found in Idaho Code Section 18-623 which

went into effect on May 5, 2023.

Now, specifically the plaintiffs have asserted four claims for relief in support of that argument that that statute is unconstitutional. They claim that the statute is void for vagueness under the due process clause of the 14th Amendment, that this statute infringes on the fundamental right to both inter and intrastate travel and then finally that the statute violates the First Amendment and their right to freedom of speech, expression and/or association.

The plaintiffs have filed a motion for the TRO or, alternatively, for a preliminary injunction seeking to enjoin just Defendant Labrador from enforcing the statute.

Now, as I mentioned, I had (inaudible) the submissions in this case which are excellent and I want to commend both parties for their excellent briefing on these very important issues. I do want -- just in terms of the motion itself, the plaintiffs have not addressed the travel inter or intrastate arguments that they've asserted in their Complaint and rather have focused on both the First Amendment and their due process arguments.

Now, for purposes of today's hearing, you're free to present the arguments that you think are most important for the Court. There are a couple of key issues that should not be a surprise to you that the Court is specifically interested in hearing about from each of you.

The first relates to standing. Now, I see that the plaintiffs have not (inaudible) Idaho's 44 elected prosecutors in this case and I want the parties to specifically address the effect, if any, of that decision on standing. And whether the Court does issue a preliminary injunction, the Court's ability to enjoin enforcement of the statute by (inaudible) prosecutors. So standing is obviously something very essential to today's argument.

And (inaudible) to the First Amendment and due process arguments that have been presented, I want the parties to address and answer the question very simply put does the statute regulate speech, expression and association or is it just conduct? That seems to be central to both of your arguments. I'd like you to go into that and then specifically once you give me your positions what I don't think is going to be a surprise to this Court, I would like you to address the standard that applies to the Court's consideration of the issue given your stance on that. And then I'd also like the plaintiffs to talk about whether or not the challenge is statute as applied or facially. So that is as to the First Amendment.

As to the due process, the big argument there is whether or not the statute is vague. And so, again, I'd like the parties to specifically look at that. I may have specific questions or examples that highlight the Court's questions in that area and it will come up but I hope that we can keep this

not all day, this argument, even though I think they're very interesting arguments and we could be here but hopefully we can get right to the heart of the matter.

Ms. Olson, are you going to be arguing on behalf the plaintiffs?

MS. OLSON: I am. Thank you, Your Honor.

COURT: Very well. Please proceed.

MS. OLSON: May it please the Court, as the Court recognized, the plaintiffs here (inaudible).

COURT: Ms. Olson, hold on.

CLERK: I'm having difficulty with audio, Your Honor.

COURT: If you can remain just one second.

I'm sorry, Ms. Olson. Please proceed.

MS. OLSON: Thank you, Your Honor. And I think -- I don't know if I need to start completely over again or if I should start from where we left off.

COURT: You can go where -- I was following you. They may not have heard you but --

MS. OLSON: Okay. All right. Well, Your Honor, I wanted to take the opportunity to introduce the Court to the plaintiffs in this case. The plaintiffs are organizations with long histories of assisting pregnant persons seeking abortion care, including minors, and an individual with a long history of working with sexual violence survivors, including minors, and with advocates who assist pregnant minors.

The plaintiff Lourdes Matsumoto who is here in the courtroom is an attorney who works for a nonprofit that provides emergency assistance, counseling and resources to victims of domestic and sexual violence.

The Northwest Abortion Access Fund which has a representation here today provides emotional, financial, logistical, practical and informational assistance to pregnant persons who may need or who may choose to obtain an abortion. NWAAF is the only independent abortion fund in the Pacific Northwest and covers the largest geographic area of any abortion fund in the United States.

Its work includes booking and paying for bus tickets, plane tickets and ride shares and providing volunteers to drive patients to abortion appointments in states where abortion is legal.

The Indigency Idaho Alliance is an Idaho nonprofit organization that is centered around asserting the sovereignty of indigenous people and there are representatives from the Indigenous Idaho Alliance here today as well.

The Indigenous Idaho Alliance's work serves the five tribes whose traditional, usual and accustomed lands encompass territory within Idaho and whose traditional usual and accustom lands are often recognized as transecting and incorporating land within the United States/Canadian province -- provincial boundaries of Washington, Idaho, Montana, Nevada, Utah, Wyoming,

California, British Columbia and Alberta.

They have coordinated the travel of pregnant people, including minors, from locations across the region, including Idaho, to and across state lines to access abortion where it is lawful and they have provided a financial assistance. The defendant, as he made clear in his opposition brief, sees these people as criminals.

Your Honor, at the heart of plaintiffs' challenge is their desire to engage in lawful and constitutional conduct and to do so free from the threat of prosecution for engaging in that lawful and constitutional conduct.

Your Honor, a fundamental and significant difference between the parties and their understanding of this statute also includes the understanding of where and whether abortion is lawful reproductive health care and where it is a crime. The plaintiffs well understand that abortion has been made a crime in almost all instances by the State of Idaho. But it's also undisputed, Your Honor, that abortion is lawful in Washington and it is lawful in Oregon and it is lawful in the majority of states in the country. And it's also undisputed that in Washington and Oregon, minors, persons under the age of 18, can obtain an abortion without a parent's consent.

Now, the Court asked about standing in this case and of course standing has three components. Plaintiffs have to demonstrate that they have suffered an injury in fact that is

concrete and particularized and actual and imminent. With respect to that element of standing, we would submit the threat of prosecution is precisely that. And then the second part of that is the --

COURT: Ms. Olson, on that threat of prosecution, what I hear the defendant saying is we haven't threatened anybody. There's no specific threat out there and what I know they're going to say is that we're not the ones to do it. It's going to be the local prosecutors who are going to do it. And when and only if they decide not to prosecute, not for looking at the facts of the case but because they won't do it, then we'll have the ability to step in and prosecute then. That's the threat of prosecution but it's not an imminent threat. It's not something that anyone has been threatened with at this point in time.

MS. OLSON: Well, Your Honor, I would submit that the existence of the statute which has criminal penalties for activities that our clients, the plaintiffs, have traditionally engaged in where they're trying to engage in lawful conduct that the statute itself and the notion that the -- you know, frankly the defendant in this case was already given an opportunity to say I'm not going to prosecute under that statute even while the Court waited to hear this particular motion and he did not avail himself of that.

And then, Your Honor, I think the question I anticipated is the Court's real concern with standing is this

argument that they have made that the Attorney General is not the appropriate defendant in this case. And I would submit to Your Honor, first of all, that question has already been addressed by the Ninth Circuit in the Wasden case from 2004 and it was addressed by Judge Winmill I think just last month in the decision that he issued with respect to the Planned Parenthood versus Labrador case.

The fact that there is the ability for the defendant, the Attorney General, to prosecute under this statute is sufficient to find, first of all, the ex parte young exception applies but also that there's that threat of prosecution.

There was -- and this Attorney General has made statements that he would prosecute people who obtain abortions in other states and I would submit, Your Honor, that's enough to show that the threat is imminent and that this defendant is the right defendant.

And I think the other question that the Court posed at the outset was whether -- why aren't the other -- why aren't the 44 county prosecuting attorneys charged in this as well. Well, there's several reasons for that. One, that's a lot more defendants. That's a lot more expense in a lawsuit so that's 45 defendants instead of one. Second, Your Honor, the Attorney General is the only one who can prosecute this case in any part of the state. The individual district attorneys -- prosecuting attorneys can only prosecute in their counties.

And I think, Your Honor, given the nature of the work that plaintiffs do that they could be assisting a pregnant minor or a pregnant person in any part of the state and any county of the state, it would be difficult to predict where some event that might trigger investigation and prosecution because it's hard to know also what investigation and prosecution would be, it would be hard to predict where that conduct would occur.

But it's the Attorney General who can do this at his sole discretion so even if a county prosecutor said, "I don't think this set of facts violates the statute," the Attorney General could swoop in and say, "You know what? I have the authority under the statute to do this," and he certainly hasn't disavowed that at all, Your Honor.

And then just as a practical matter, Your Honor, I would anticipate that the 44 county prosecuting attorneys in the State of Idaho, if this Court were to enjoin enforcement of the statute as to Attorney General Labrador, they would also, for reasons it's unconstitutional, they being people who would follow the law would also not prosecute under it.

COURT: And that's kind of -- this is a much later question but let's just assume for that argument using that right there, if the Court did issue an injunction as requested, it's going to be just against the defendant, against Raul Labrador. It will not be against the 44 prosecutors. So what would prevent the prosecutors from enforcing this statute even

if the defendant is enjoined. And does that defeat basically the ability for this Court to redress any harm that the plaintiffs have alleged?

MS. OLSON: No, Your Honor, not at all. Again, for the reason that if this Court were to enjoin Attorney General Labrador, presumably the Court would enter an order that explains its reasoning and the grounds that we have asked the Court to do so on or that the statute is not constitutional and, again, I would contemplate that those 44 prosecutors who have followed that order from the federal court, otherwise it wouldn't take much back to get into court with that particular defendant so it's -- it is a remedy that addresses conduct that the Attorney General could engage in at any part of the state and I think it would have the effect of -- even though they wouldn't technically be enjoined, it would be exceptionally unlikely for someone else to prosecute and say, you know, it's really constitutional when I do it. It was just when Attorney General Labrador did it that it was unconstitutional.

COURT: No. And I follow that and I would hope that any prosecutor in the state would follow valid decisions out of any court but technical or not, I have no ability to enjoin any of the 44 prosecutors, correct?

MS. OLSON: Understood, yes.

COURT: Okay. Very well.

MS. OLSON: That's not the relief that we requested

here --

COURT: All right.

MS. OLSON: -- Your Honor.

COURT: Thank you.

MS. OLSON: All right. And so, Your Honor, that's the plaintiffs' position with respect to the questions that the Court posed on standing. I think for a more detailed legal analysis of why Attorney General Labrador is the correct defendant, it's in our reply brief at the very end and it's in detail in the Wasden case and in detail in Judge Winmill's decision in Planned Parenthood versus Labrador.

So, Your Honor, sort of to go back to that place that I was before I talked about standing, what the plaintiffs in this case seek to do when they're engaged in the activity they want to engage in is to provide assistance to pregnant people in Idaho, including minors, who want to obtain a lawful abortion in a place where it is lawful.

That assistance may take the form of providing information about where abortion is lawful and it's abundantly clear that providing information regarding lawful abortion is a First Amendment right. In Bigler versus Virginia, the Supreme Court overturned the conviction of a Virginia newspaper editor for publishing advertisements about lawful abortion care in New York. So that speech which is speech, not conduct, that speech is protected by the First Amendment and it's a core component of

what plaintiffs do. And it's also a core component of what 18-623 attempts to criminalize.

So, Your Honor, I would submit that, for example, recruiting. Recruiting is something that typically involves talking to other people about an activity. Here, the activity they would want to talk about is how to obtain lawful abortion.

When we talk about recruiting sort of generically, we might talk about recruiting, you know, for a position on a basketball team somewhere or a volleyball team somewhere. We might talk about you're trying to bring somebody into our law firm. That all involves direct speech, Your Honor. And that's one of the activities that is prohibited under 623. We submit that that's in violation of the First Amendment.

COURT: Ms. Olson, I understand that argument and that is a straight forward argument but I see the defendants muddy the water on that argument. They're saying, look, it's not just providing information. It's providing information with the intent to conceal an abortion from the parents or guardian of a pregnant unemancipated minor which results in either an abortion or obtaining the abortion-inducing drugs.

And so -- and they're saying, look, you can talk all you want but really when you do it with that specific intent, that's when we have the power to criminalize activities that happen in our state. How do you respond to that?

MS. OLSON: Two things, Your Honor. When they talk

about with the intent to conceal, we would submit that that too is vague under -- as it's written in the statute. And the way they argue about it in their brief illustrates that it's a vague term.

The phrase "intent to conceal," in and of itself, we might try to figure out what that means but what they say it means is that you didn't tell the parents. The parents don't know. This statute is really about the parents' need to know what their kid is doing.

There's two problems with that, Your Honor. So that's different from the intent to conceal. I mean knowledge about something is -- you're providing knowledge is different from intending to conceal. And even in one of the examples the defendants give in their brief, they talk about, well, you know, maybe a prosecutor would have an argument that there was the intent to conceal if you just didn't tell the parents.

But they didn't choose -- the legislature didn't choose those words in the statute. They didn't say anything about whether you have to tell or don't tell. They chose this phrase "intent to conceal." But what they're telling us it means, at least with respect to them prosecuting it, it means you didn't tell the other person. They don't know about it. And that's how they phrase their whole justification for this -- you know, their parental rights compelling interest is the parent has the right to know about the care of their kid.

The other reason, Your Honor, that you can't really -- that the speech is not relating to intent to conceal and is not relating to the end result is the end result is not criminal conduct. It's not one long crime. The end result is a lawful abortion in a state where it is lawful. So I guess they're criminalizing First Amendment speech because you didn't speak enough to tell the parents that they need to know what their kid is doing and then it's only part of the crime if -- that we call the crime if the kid then goes and has the -- the minor has the abortion.

So you can talk to people about something and you have a First Amendment right I guess but if that person then goes and gets an abortion, you really don't have a First Amendment right to begin with.

So I think -- so I think it's -- I understand that they're linking it up, Your Honor, but I don't think that's really the way it would work and I don't think you can really link speech with this, you know, vague specific intent and then lawful conduct at the back end. There is -- there is no doubt that this is lawful conduct at the back end. These are lawful abortions.

COURT: And on that point, is that how you distinguish the defendants' arguments that this is just like sex trafficking? And so all these terms that have been used for years and years and you yourself as U.S. Attorney enforced those

laws that that is the same. Are you saying, no, it's not because at the end, it's not a crime that is being committed but rather lawful conduct?

MS. OLSON: Absolutely, Your Honor. I spent, as the Court knows, a long time prosecuting cases. Some of that involved responsibility for sex trafficking statutes. There are drug trafficking statutes. There's harboring a fugitive. And the difference, Your Honor, is that in each of those instances, these words are connected with what at the back end is clearly other criminal conduct.

I mean you can have harboring a fugitive and when you're harboring a fugitive and that person has committed a crime, I mean you don't get to help people who commit crimes hide out. But it's all about criminal activity.

When you have drug trafficking, when the drugs are transported across state lines, it's the product that is illegal and is being trafficked. Here, what they're saying -- I think, you know, as we said in our brief, Your Honor, abortion trafficking isn't a thing because abortion is lawful in the places where these people are traveling to. It's not -- it's not inherently criminal conduct.

In Idaho, as you know the Supreme Court said they could, Idaho made it a crime. And in Washington and Oregon and the majority of states, it's just not. And I think that's the difference, Your Honor.

It's also, Your Honor, one of the problems when you take words from one criminal statute and just drop them into another criminal statute without thinking through the context and why they would make sense in one criminal statute and why they don't make sense in another criminal statute. Because, Your Honor, the words "harboring," "recruiting" and "transporting," that's not inherently criminal conduct.

I mean I'm going to drive to Portland, Oregon tomorrow and take one of my daughter's dogs with us and we're going to transport that dog across state lines. That transportation is, you know, I don't think -- that is not inherently criminal conduct, Your Honor. So it's not always that the terms that we think might be everyday language, harboring, recruiting, transporting, become ways to execute a crime.

The only ways they come to be executing a crime is if the thing at the back end is criminal and that's why when you have sex trafficking or human trafficking, that person is being moved, harbored, recruited into something that is illegal and is against their will. And you also have the human trafficking sometimes they'll end -- ends up in labor trafficking or bring somebody to work. You don't pay them. It's that kind of activity but, again, abortion trafficking just isn't a thing, Your Honor.

COURT: I understand that argument. Thank you, Ms. Olson. One of the questions I had is to ask -- and I'm going to

ask each of the parties -- is what is their position on what is the kind of speech that the statute prohibits? I understand the providing of information. That is -- that is pure speech as I -- just providing information. Truthful information. But the statute doesn't just say recruiting. It says harboring and transporting which involves some type of conduct. So even if the statute only regulates conduct, does it still implicate the First Amendment from your perspective?

MS. OLSON: It does, Your Honor. And for two reasons. One, harboring and transporting may both involve expressive conduct. It may also involve the First Amendment right to association which is -- it's right there in the First Amendment along with speech, same right. If an adult is driving a minor in Idaho and, you know, they're clearly taking them in their car, does that become transporting for purposes of 18-623? So there's that associational right. With respect to harboring, there would be an associational right.

If I have a pregnant minor in my home as a place for them to stay perhaps before they travel to another state to have a lawful abortion, does giving them that place to stay, associating with them there, that's a First Amendment right.

And then I think, Your Honor, there's the expressive conduct part of this and that's where the -- it's important to know who the plaintiffs are and why I provided the Court that description of the plaintiffs.

These are not people who once 18-623 was passed said, you know, let's chin up a group and see if we can thwart the State of Idaho. These are two organizations and an individual who have long been involved in trying to help people access lawful abortion including minors. And they're known for that and when they provide that assistance, they are expressing support for lawful abortion and access to lawful abortion.

COURT: I ask you what kind of speech it is because there's different standards that the courts apply --

MS. OLSON: Right.

COURT: -- depending on the speech that's at issue. So maybe you can address the standard that you think the Court should be applying in this instance.

MS. OLSON: Well, Your Honor, I think the Court should be applying strict scrutiny which would require then to show that they have a compelling government interest that is narrowly tailored to achieve that compelling government interest.

And the reason for that, Your Honor, is two-fold. Certainly, Your Honor, pure speech, that is always strict scrutiny and I think, Your Honor, probably the best discussion of it that I found that sort of summarizes it well is in Holder versus Humanitarian Law Project which we refer to in our brief. It's 561 US 1 and there are some discussion there. The statute was also challenged on vagueness and First Amendment grounds.

And there, there was a -- there was a speech part of

the whole thing and the Supreme Court said, look, people are talking. That's speech so it's just not this intermediate scrutiny that you get from O'Brien. And then later on when they're discussing, you know, what standard applies, they get to strict scrutiny. Now in that case, it's correct. The Court said, you know, the government's compelling interest in preventing terrorism, you know, justifies this particular infringement on speech. It's narrowly tailored. It gets at just those things because the speech is prohibited with groups that are known to be terrorist groups. So that's I think, Your Honor, why we look to strict scrutiny.

I would also say, Your Honor, the point I didn't touch on yet on what kind of First Amendment violation there is or infringement they were alleging, the statute also discriminates by viewpoint and content. So only -- only if an adult, you know, harbors or traffics -- excuse me, harbors or transports or recruits a pregnant minor and then they end up getting abortion care, we don't like that so we don't want you to express support for abortion because the state disagrees with that. But it doesn't prohibit any other sort of adult taking a pregnant minor and harboring, transporting or recruiting, whatever those things mean, across state lines to get prenatal care or to go to a birthing center that's, you know, nicer in Ontario, Oregon, than you have in Boise, Idaho or any other place. It's directly aimed at this support for this speech about abortion care in

places where it's lawful.

And so for that reason, Your Honor, we think because it's content based, viewpoint based, another reason the Court has to provide -- has to apply strict scrutiny review, Your Honor.

I think, Your Honor, hopefully we've covered the things that the Court listed out at the beginning but I want to just emphasize to the Court and it's in our brief -- you said you looked at our briefs -- that the terms in the statute are -- violate the First Amendment and they're vague in part -- well, in part because they were adopted sort of wholesale from some other statute where it made sense. And then again to just emphasize that here, we're talking about lawful conduct at the back end and the state statute should not be able to get at that kind of conduct by infringing on the First Amendment rights and creating vagueness.

Your Honor, with respect to the state's asserted state interest, there are a couple of things I want to touch on before I cede the floor to Mr. Craig and would possible, if possible, like to have some time for rebuttal, Your Honor.

The State's asserted compelling interest is that parents have a right to know about care for their children. I think that -- you know, that comes. That's one of the headings out of their brief. And also, Your Honor, I think that's an important interest and I think parents, there are case law --

there is case law that stands for the proposition that there are certain things that the state can't interfere in when a parent is trying to parent their child. And they rely on Troxel versus Granville but that case didn't hold that parental rights are unlimited. The (inaudible) there recognized that there are situations where intervention in a family is warranted. And courts really haven't extended that beyond visitation.

And again, Your Honor, the Court in Troxel was dealing with a statute passed by the state that infringed on a parent's right to provide care, custody and control of their child. So the concern with the statute was that it infringed on those parental rights. So it's those parental rights vis-a-vis state action. That case doesn't stand for the proposition that the state can pass statutes that give parents more rights than they might otherwise have.

And Your Honor, also, with respect to how this parental rights issue plays out in the State of Idaho, you know, as we argued in our brief, it's a selective rationale. The same legislature and the same session passed a statute that says, "Guess what, parents, you don't have a right to provide gender affirming care to your child." So that's -- apparently parents need to know whether their child is going to cross state borders to obtain lawful abortion care and they can maybe weigh in on that.

But if it's trans -- if it's gender affirming care for

minors, sorry, parents, we know better than you do. And there are plenty of places within Idaho Code that the legislature has said minors do have the right to make certain medical decisions for themselves. And we set those out on pages 13 and 14 of our brief. Minors 14 or older can consent to medical treatment for affordable, infectious, contagious or communicable diseases and the consent of the parent -- parents or legal guardian of the minor shall not be necessary. Minors 16 and older can request drug treatment medical services.

COURT: Ms. Olson, I understand those line of cases as minors have certain rights to do certain things even under Idaho law. But we don't have a plaintiff that is a minor here asserting to get those rights, to recognize those rights. I understand that's part of the argument about why the state's interest is maybe not as strong or in your view as valid as they would otherwise do.

But in this instance, we're not having -- we don't have a plaintiff that's saying, "Look, I'm 16 and I have a right to get this information. I have a right to receive lawful information, truthful information so that I can make choices about my own care." That's not the case we have.

MS. OLSON: It's not, Your Honor. The Court is both right on the law. There are absolutely -- minors absolutely have those rights particularly with respect to free speech but the plaintiffs here are not asserting any rights of the minors.

And the reason we bring this to the attention of the Court is just to simply say this notion of parental rights that -- and when they say that the parents have a right to know about care for their children, again, first of all, that's not what the statute says but it's also -- it's just not quite as complete and absolute as they paint it to the Court in their argument, Your Honor.

And so we would submit that because this asserted state interest is not -- is narrowly tailored to the right they assert which is to know if my kid's going to get an abortion, then it means it failed strict scrutiny analysis, Your Honor.

And so, Your Honor, with all due respect to the legislature and learned honored counsel on the other side, it's plaintiffs' position that Idaho Code 18-623 is not about the state's compelling interest in parents having a right to know about care for their children. It's about the state seeking to criminalize abortion care that is provided in states where it is lawful.

And it is about a statute that infringes on the rights of these plaintiffs to speak freely about that abortion care in another state, to provide resources to people who seek abortion care in another state, whose donors express their First Amendment rights by providing funding to these organizations to support lawful abortion.

And, Your Honor, because that infringes on plaintiffs'

First Amendment rights and because there is not a compelling state interest that is narrowly tailored in this case, we would ask the Court to enjoin its enforcement. And we'll rest on our briefs, Your Honor, for the other three portions of the standard for a preliminary injunction or TRO.

COURT: Thank you, Ms. Olson. All right. Mr. Craig.

MR. CRAIG: Thank you, Your Honor. It's a privilege to represent the State of Idaho, the Attorney General and appear in front of Your Honor, so thank you.

COURT: You're welcome.

MR. CRAIG: This case is not about abortion. This case is about parental rights and who has the authority to make decisions concerning the care, custody and control of minor children.

I think the question presented in this case is really quite simple. Does an uninterested third party have a constitutional right to procure a medical procedure for a minor with the intent to conceal that medical procedure from the minor's parents or guardian?

If we are talking about any other medical procedure other than abortion, we wouldn't be here to even talk about it because the answer would be so clear. Can an uninterested third party take a minor to procure a tonsillectomy for the minor with the intent to conceal that tonsillectomy from the minor's parents? Of course not. Can an uninterested third party take a

minor to one of the neighboring states where medical marijuana is legal to obtain medical marijuana for a minor child with the intent to conceal that provision or the obtaining of the medical marijuana for the child from the parents? Of course not. There's nothing about abortion that changes that context or that standard.

The plaintiffs, as we've just heard, are trying to make this case about abortion talking about how the State of Idaho is trying to criminalize abortion in other states and in their brief, they use the word "oppressive." They refer to Idaho's abortion laws as the oppressive abortion laws. They argue that this statute, Idaho Code 18-623, quote, criminalize conduct by adults who assist pregnant minors in receiving abortion care.

But the statute does no such thing. Under Idaho Code 18-623, minors can still get an abortion in another state. The plaintiffs can still help minors get an abortion in another state.

In fact, in some circumstances, minors can even get an abortion legally in the State of Idaho. What the plaintiffs cannot do is procure an abortion for a minor or obtain an abortion-inducing drug by recruiting, transporting or harboring a minor with the intent to conceal that abortion from the minor's parents.

COURT: One second, Mr. Craig. I want to make sure I'm following you here. You said that the plaintiffs could help

minors get an abortion in another state but what they can't do is -- basically cited the statute. I think what plaintiffs are arguing is trying to figure out where assistance turns into illegal or prohibited activity under 18-63 (sic) is not defined and is just telling a minor you can go to Oregon where abortion is provided legally and you can seek those services in Oregon. Is providing that information, does that amount to recruiting even if they have the intent to keep it from their parents?

MR. CRAIG: Well, that's where you can go through all the elements of the statute. One, did they procure an abortion for a minor child or did they obtain an abortion-inducing drug for the minor child? If they're simply talking about an abortion in another state, that it is legal in another state, are they procuring the abortion for that child? No, they're not. They're not obtaining the abortion for that child in another state if you're just giving information about what is legal in another state.

COURT: So okay. I'm trying to figure out where this is because you're saying just providing information -- truthful information about where minors may go to obtain an abortion lawfully, that doesn't fall within 18-623. Okay.

MR. CRAIG: That's correct.

COURT: So we got that as a standard. Just providing that information. So there must be something more. There's got to be more than just providing truthful information. There's a

clinic in Ontario, Oregon where you can seek legal abortion care. That's not enough. So what more? Now, again, let's just presume that whoever's assisting that minor has the intent to keep it from the parents. So what is the activity then that then triggers 18-623?

MR. CRAIG: So I will go through some hypotheticals that I think will meet that. But first, I think it's clear that when we're talking about vagueness standard that, you know, the Supreme Court has said we can always come up with hypotheticals to muddy the water and make it unclear and all that. That's not the standard for determining whether it's vague or not. But what we'll assume, that the plaintiffs intend to conceal an abortion from the minors. Now, that is bad --

COURT: From the parents.

MR. CRAIG: Or from the parents. Thank you. Now, that's bad enough but if they're intending to conceal abortion from the minor's parents and they, for example, transport the minor to an abortion facility in Oregon or Washington or any of the other places and pay for the abortion for example. I think that would clearly violate the statute. They're procuring the abortion by transporting the minor to the other state with the intent to conceal it from the minor's parents.

COURT: And then tell me about the intent to conceal. You heard Ms. Olson talk about -- and I saw in their briefing that they take issue with those words. The statute says, "With

the intent to conceal an abortion from the parents." So -- and I think the plaintiffs have raised a couple of questions about when you were describing that in your brief how it wasn't just intent to conceal. But is not telling the parents not enough? Is it just not seeking the parents to be involved in it and just kind of passively just not even asking the minor child, "Do your parents know about this? Do we need to --" just providing that without asking the question do your parents know, do we need to do that, is that intent to conceal?

MR. CRAIG: So Idaho law requires there to be a union of act and intent obviously for there to be a prosecution and a criminal conviction and Idaho statutes -- case law when you're talking about an intent, a specific intent, you look at the totality of the circumstances and so you'd have to evaluate the totality of the circumstances as to what their actions are.

Are they taking steps to affirmatively conceal it from the parents? You know, for example, not allowing the minor child to call the parents or, you know, transporting them immediately without giving them an opportunity to consult with their parents, some of those, that's what you would all consider as part of the totality of the circumstances.

COURT: So there's got to be an affirmative action. Something affirmative on the plaintiffs to not inform the parents. Not just I'm not going to tell them, I'm not going to ask about them but I'm going to affirmatively prevent that minor

or I'm not -- I'm affirmatively choosing not to inform the parents.

MR. CRAIG: Again, you have to look at all of the totality of the circumstances. I think that there could be situations -- and again, we're getting into the hypotheticals that the Supreme Court warned us against getting into the hypotheticals.

COURT: Well, vagueness -- I mean the whole point about vagueness is it's supposed to give people, you know, fair notice of what they're going to be held criminally accountable to. So if there's not a clear answer about what is intent to conceal or if you guys have a different interpretation of what that means, it's worth asking. It's what does that mean? I'm asking you what does that statute intent to conceal mean? What is required to hit that?

MR. CRAIG: Well, the intent to conceal, I mean I'm just going to repeat the statute because it's plain. Means an intent to conceal from the parents and so, again, you'd look at the totality of the circumstances. Did they try to inform the parents or not? Do they have a pattern in over and over and over again of purposely not informing the parents? Did this child have an opportunity to talk to the parents but the plaintiff took that away from the child? Again, you look at the totality of circumstances in all those things.

Now, to directly answer your question, is simply not

informing the parents by itself an intent to conceal, if that's all you have, probably not. But it's very unlikely that in any case that that's going to be all that you have.

COURT: Okay.

MR. CRAIG: So again, the plaintiffs are calling this an abortion travel ban and they're talking about Idaho Code 623 criminalizing conduct but, as we just talked about, it doesn't criminalize abortion. It doesn't criminalize the ability of a minor to get an abortion. It doesn't criminalize the ability of the plaintiffs to transport a minor somewhere to get an abortion.

And so they're asking the Court to rule on a statute that does not exist and they're asking the Court to declare unconstitutional a statute that the legislature has not passed because it does not prohibit a minor from getting an abortion. It does not prohibit the plaintiffs from helping a minor get an abortion.

COURT: Well, to an extent, right? So you just said it doesn't prohibit the plaintiffs from helping a minor get an abortion. Isn't exactly what this is supposed to be done?

MR. CRAIG: Only if they do it with the intent to conceal that abortion from the parents.

COURT: So if the parents know about it, it's okay?

MR. CRAIG: Yes, because that would defeat -- well, for two reasons. One, it would likely defeat the intent to conceal

from the parents and then, two, that's also an affirmative defense to the statute as well.

COURT: And I think you just said that the statute isn't making abortion illegal. I don't think that's what the plaintiffs have argued. I think what they're arguing is exactly the opposite. That you're criminalizing protected conduct that is related to First Amendment speech and associational rights. So let me ask you that question I started at the beginning, Mr. Craig.

MR. CRAIG: Sure.

COURT: What kind of speech is at issue in this case?

MR. CRAIG: There is no speech at issue in this case because the statute does not affect speech. It affects conduct. You look at the five elements of the statute. The adult must procure an abortion or obtain an abortion-inducing drug for a pregnant unemancipated minor. That's conduct. Procuring an abortion or obtaining an abortion inducing drug, that's conduct.

They then must do that by -- so the next part, recruiting, harboring or transporting is kind of a subcomponent of the procuring or obtaining abortion. They have to procure the abortion by recruiting, harboring or transporting the pregnant minor within the State of Idaho.

Again, recruiting, harboring and transporting is conduct. It's conduct that's used in statute after statute by the federal government, by the State of Idaho, by the state --

by the (inaudible) states, probably every state in the union uses that language. Recruit, harbor or transport.

COURT: Well, two questions about that, Mr. Craig. So recruiting, how do you recruit without speech?

MR. CRAIG: Well, there's a number of different ways but case law also makes it clear that conduct is not governed by First Amendment free speech standards just because you have to use speech to engage in that conduct. That doesn't --

COURT: I get that. I know those line of cases but I'm just trying to figure out how do you recruit someone without speech?

MR. CRAIG: Well, again, it could be through speech. It could be through your actions in terms of offering rides to people to abortion clinics. That could be recruiting. It could be paying for the abortion in other states. That could be recruiting as well. So there's a number of different ways that you can recruit without speech in addition to using your speech and not under the First Amendment speech because of the case, it says using speech for conduct is not speech. But you could also talk to people. Hey, I can get you an abortion. Let's go get you an abortion as well.

COURT: Mr. Craig, respond to the plaintiffs' argument that because of the particular plaintiffs at issue in here, it's not just speech. It's their associational rights. That they have this interest as reflected in their members to associate

with these individuals to provide support for them in those situations and to assist them in making those tough life decisions. How do you respond to that aspect of their speech argument?

MR. CRAIG: Well, under Idaho Code 18-623, they can still associate with anyone they want to. They can still associate with pregnant unemancipated minors. They can still associate with members of their organizations. They can still take pregnant unemancipated minors across state borders to get an abortion in another state. So it doesn't prohibit any of that association. What it prohibits -- and you're probably going to get sick of me saying this. It prohibits them taking those actions with an intent to conceal the abortion from the parents.

Now, state -- U.S. Supreme Court case law and Idaho Supreme Court case law is clear that the right of association does not extend to joining with others to deprive third parties of their rights. And in this case, as I stated in the beginning, this case is not about abortion. This case is about protecting the parental rights.

It is clear that in Idaho, in the U.S. Supreme Court and in the Ninth Circuit, the parents have a fundamental right to make decisions concerning the care, custody and control of their children. And in fact, America legal tradition has a presumption that the minor's parents are going to act in the

best interest of their child and that they're going to use the wisdom that they have for their life experience and this unique knowledge that they have as the child's parents to make a decision in the best interests of the children.

COURT: Mr. Craig, I think that is a very important interest for the state and for parents to be able to raise their children and to raise them the way that they think and to be involved with their families. Now, what the plaintiffs have said is unfortunately not every minor has the ideal situation and they're in places where they can't rely on their families.

The one question I wanted to push back on you, Mr. Craig, is you keep telling me that 1863 (sic) is not about abortion and while it doesn't prohibit abortion because it's already prohibited in this state, the only thing it relates to in terms of speech and conduct is if it results in an abortion.

It doesn't say parents are supposed to be provided with information any time a child is seeking any type of medical -- medical intervention whatsoever. It's specific to abortion. It doesn't -- and I agree with you. Parents have a right to know. But that's not what this -- this statute doesn't say parents have a right to know whenever their child is going to get any kind of medical procedure. It says parents have a right to know and we're singling out this one activity of abortion which is legal in a different state but through the actions that otherwise occur in Idaho to assist that minor in obtaining that

legal abortion.

So I understand that it's not prohibiting abortion but it's all about abortion. It's all about activity related to trying to prevent abortion in another state with a minor whose parents don't know.

MR. CRAIG: With the plaintiffs acting with an intent to conceal the abortion from the minors.

COURT: Right.

MR. CRAIG: So absolutely. Idaho Code 18-623 is related to the abortion procedure. Absolutely. This case is not about abortion though. This case is about parental rights. The parental right to know when their kids, when their children are undergoing a medical procedure, an abortion. The state doesn't believe in most cases that abortion is an appropriate medical procedure but that's what the plaintiffs are referring to this, as a medical procedure.

So this is -- the statute absolutely applies to abortion. This case is not about abortion though. This case is about parental rights.

Now, the plaintiffs in their argument conceded that the rights of parents in this case, the fundamental right of parents to control the care, custody and control of their children is an important interest. And so they have just conceded the first element of the O'Brien standard. You were asking what standard might apply. Well --

COURT: You're saying the O'Brien standard applies because you're saying it's conduct, not speech, pure speech, so we should apply the lesser standard.

MR. CRAIG: At most, the O'Brien standard should apply. I actually think that this is not affected by the First Amendment at all so you would apply rational basis. But at most, you would apply the O'Brien standard with the important interests. And the plaintiffs have conceded that that is an important interest. That the first element has been met in terms of that statute.

And so you simply have to look at, you know, the next statute. I'll even argue the strict scrutiny standard that the plaintiffs argue that it is narrowly tailored to further that interest and it's narrowly tailored because of the specific intent part of the statute.

The legislature could have written this as a general intent crime. They could have written it as you can't help a minor procuring abortion unless the parents consent to it or without the parents' consent. That would have been a general intent crime. They could have written it like that.

But instead, they narrowly tailored it. They narrowed the statute by adding in the specific intent to conceal the abortion from the minor's parents. That's a much tougher standard for a prosecutor to meet in terms of the general intent versus the specific intent.

And so they've narrowed it even further and so it meets that narrow tailoring to further the government's important interest of -- all right, I would even say compelling interest of furthering parental rights in this case.

And you know, clearly, the government has the authority to enforce these statutes, to impose the statutes. The U.S. Supreme Court has stated that when we're talking about the fundamental rights of some parents, state legislators have the ability to pass laws to help protect those rights. They have the ability to protect parental rights.

So the government has the authorized. It's an important government interest and, again, I'll use the higher standard of strict scrutiny and it's narrowly tailored to further that important interest.

So even under the O'Brien standard or the lenient standard that is the most the Court should apply, it meets that for the First Amendment free speech.

COURT: Mr. Craig, I have a couple -- I just am looking back at the statute and I made a note to myself that the statute starts off with it's an adult --

MR. CRAIG: Correct.

COURT: -- who does this. So if the minor's 17-year-old boyfriend or best friend that's under 18 decides to take that minor who's pregnant across state lines, provide harboring, transport, support, all those things and purposely

doesn't want to tell mom and dad, they're not affected by this statute.

MR. CRAIG: That's correct.

COURT: And then the other -- so I'm asking the beginning of the end of no. 1. So at the end, there's this sentence that I'm trying to get my head around. "As used in this subsection, the terms 'procure' and 'obtain' shall not include the providing of information regarding a health benefit plan." I'm not entirely sure what that means but what I'm concerned about is if the statute says that this does not -- providing of information for this purpose doesn't fall within the statute, does that mean that everything else in providing information does?

MR. CRAIG: I don't think so. I think by saying that one thing is prohibited, it doesn't mean everything or one thing is allowed that nothing else is allowed or prohibited. And I think that that's actually a case that's not presented in this situation. The plaintiffs aren't health care providers. They're not planning on providing information about a health care plan or anything like that. And so when you -- when the Court's evaluating this case and the Court's asking about at the beginning, is this a facial challenge or an as-applied challenge and I think this is a good example. This is an as-applied challenge.

Under the United States versus Salerno case, that

requires a facial challenge to show that there are no circumstances in which the law's constitutional and the plaintiffs haven't pled that. They've made no argument to that so this is clearly an as-applied challenge and as applied to their circumstances, that provision of the statute is inapplicable because they're not a health care plan. They're not talking about providing information about a health care plan.

COURT: I'm sorry. If I miss -- I'm probably mis-communicating this. I'm not suggesting that the plaintiffs are claiming that they're a health benefit plan. I'm trying to look at it from the vagueness perspective what all of this means and what does "procure" and what does "obtain" and what does "providing of information" mean? What is allowed? What isn't allowed? Those are the words of the statute.

MR. CRAIG: Correct.

COURT: This is the one place where the statute tells me what they think providing of information means or doesn't mean and is allowed. And it tells me here that it shall not include providing information regarding a health benefit plan. It specifically for whatever reason called that out.

MR. CRAIG: Correct.

COURT: So that's not included. But does that mean that any other information that's provided could constitute procure and obtain which is pure speech? Providing of

information. That's why I'm asking.

MR. CRAIG: Right, right.

COURT: I'm not claiming that the plaintiffs are a health benefit plan but I'm looking at the statute and trying to grapple with is it vague? Are the terms defined? What did the legislature mean?

MR. CRAIG: Yeah. So by itself, providing information about an abortion with nothing else going along with it, would not be procuring an abortion, no.

COURT: Okay. Very well.

MR. CRAIG: So the Court has also asked what is essentially the burden of proof in this case and that was one of the questions at the beginning is what -- what burden should be applied in this case and, you know, the standard for preliminary injunction is pretty clear. That the plaintiff has the burden -- the quote from the (Inaudible) vs. U.S. Immigration Customs Enforcement case is that a preliminary injunction is an extraordinary and drastic remedy, one that should not be granted unless the movant by a clear showing carries the burden of persuasion. So they have this burden of showing by clear showing that they are entitled to it.

And when you look at what we have here, they haven't met that burden. They have not shown that this statute violates their First Amendment free speech rights or their free association rights. Even if this statute affects speech, we

have a fundamental right of the parents to control the care and custody of their children. And the plaintiffs concede that that is an important right and it is narrowly tailored to further that right.

Now, when we're talking about the balance of equities and public interest, I think that concession regarding the importance of the parents' fundamental rights is critical because the fundamental right of a parent is one of the oldest, if not the oldest of the fundamental rights recognized by the Supreme Court. It existed decades before Roe v. Wade was ever decided and it still stands today after Roe v. Wade has been overturned.

This is an extremely important fundamental right of a parent and when we're talking about the plaintiffs who want to interfere with the rights of a parent to know about the medical procedures of their kids, the balance of equities has to tip in favor of the parents. The parents are the ones who are presumed to know -- to act in the best interests of the parents. There's no presumption that the plaintiffs are going to act in the best interests of somebody else's children.

And in fact, the law -- any such presumption would not be viable. Plaintiffs don't know the situation of children, their medical history, their mental health history, their psychological history. All those things that a parent will know that a parent will be able to apply.

Now, the plaintiffs will say, well, sure. That's fine. But then some parents will actually abuse or neglect their kids and for that reason, they should be able to act as an entrusted adult. Well, Idaho statute already has a comprehensive scheme for dealing with those cases and that starts with a phone call to the Idaho Department of Health & Welfare or the local law enforcement to report their reasonable belief about the abuse or the neglect or the abandonment.

It doesn't involve the plaintiffs deciding whether a parent is fit and then taking it upon themselves to conceal information from the parents. That involves a trusted adult. The Department of Health & Welfare, the police, the law enforcement and, in appropriate circumstances, the courts through a Child Protection Act.

So the balance of equities in this case has to fall in favor of the parents and the parental rights in determining what is the best interests of their children.

So you'd asked at the beginning about standing so if the Court's okay, I'll move on to the standing argument.

COURT: That will be great. Thank you, sir.

MR. CRAIG: And the Court's specific question was whether -- how they should be affected that the plaintiffs did not name all 44 of the county prosecutors. And frankly, that's fatal to their case, fatal to their standing in this case. And that's simply because the Attorney General has no authority at

this time as it stands today to prosecute violations of this statute. In fact, the Attorney General has specifically disavowed his authority to prosecute without a referral from a prosecuting attorney. And that goes both to standing and the Attorney General's 11th Amendment immunity.

Now, the plaintiffs write in their reply brief, quote, defendant Raul Labrador acknowledges in his opposition that he intends to prosecute plaintiffs for exercising their First Amendment rights to assist pregnant Idaho minors obtain lawful abortion in neighboring states. That's the exact opposite of what the Attorney General wrote in his brief.

On page 26 of his brief, the Attorney General wrote, quote, the Attorney General has no authority to threaten criminal prosecutions on the abortion trafficking ban. Now, if that wasn't clear enough, on page 38, the Attorney General wrote that, quote, he lacks any prosecutorial authority under the abortion trafficking ban at this time.

COURT: And I see "at this time" which means the AG has authority in limited circumstances to do these prosecutions so he doesn't have no authority. He has some authority and isn't that enough under the Wasden case and more recently Judge Winmill of this court's decision saying that that's enough. And in Judge Winmill's case, you didn't even have the language that we have here in 623 that does give the Attorney General authority to prosecute when the local prosecutor declines to do

so. So how is that not enough under either Wasden or Judge Winmill's most recent decision?

MR. CRAIG: So the Wasden case uses language and Judge Winmill quoted the exact same language so his decision is based on that same language from Wasden that the Attorney General can essentially -- and this is the language, quote, deputize himself to prosecute cases. So the Ninth Circuit decision was based upon the assumption that the Attorney General can deputize himself or the governor can deputize him to go forward. The Attorney General has specifically disavowed that authority and said I have no authority to deputize myself. That's what the Attorney General has said. That the only way he can come in and prosecute these cases is with a referral from the prosecuting attorney or in those limited circumstances in 18-623(4) where a prosecuting attorney refuses to prosecute the violations without regard to the facts or circumstances.

So that's not just looking at a case and saying, I don't think this person has met the elements of the crime beyond a reasonable doubt so I'm not going to go forward. That's a prosecutor saying I'm never going to prosecute any violations of this statute under any circumstances.

The plaintiffs have not alleged that those circumstances are present here and there are none of those circumstances. No prosecutor has referred one of these cases to the Attorney General and there's no evidence that it has. And

so because of that, the Attorney General has no authority to deputize himself to prosecute these cases.

And so at the time when Wasden was decided, the Ninth Circuit believed that the Attorney General could deputize himself. That's the language right in that statute. The Attorney General has disavowed that authority and says I don't have the authority to deputize myself and therefore the Attorney General's not the proper defendant. He still enjoys the 11th Amendment immunity in this case and the plaintiffs lack standing in that situation.

COURT: So Mr. Craig, I appreciate the Attorney General's opinion on his authority. This Court is governed by the Ninth Circuit and the U.S. Supreme Court unless and until that authority is overruled. And so I appreciate that but I am bound to follow the law right now. And the law as I said is the Wasden case and most recently is Judge Winmill's. I realize that's up on appeal as well, sir.

MR. CRAIG: Correct.

COURT: And so of course I'm going to look at that but I can tell you what is binding on this Court is the Ninth Circuit and the U.S. Supreme Court decisions on that area.

MR. CRAIG: Right. And in the Ninth Circuit case in Wasden, you did not have the situation where the Attorney General specifically disavowed that authority so that's what distinguishes this from Wasden. I'm not saying you're not bound

by Wasden or not saying that you're not bound by the Ninth Circuit case. I'm saying that the situation is different now because the Attorney General has specifically disavowed that authority to deputize himself and that's what was critical to the holding in the Wasden case.

COURT: I understand. Thank you, Mr. Craig.

MR. CRAIG: So to conclude, I just want to make a final point about the plaintiffs' likelihood of success on the merits and I think this also goes to the balance of equities.

So in this case, the plaintiffs challenged only Idaho Code Section 18-623. But Idaho Code 18-623 is but one statute in a suite of numerous statutes that Idaho has passed that's designed to protect and uphold parental rights and make decisions concerning the care, custody and control of their children.

So if they have a constitutional right to violate the parental rights like they're arguing that they do in this case and if the Court issues the injunction that they're requesting against Idaho Code 623, then the Court needs to ask the question do they have a constitutional right to violate Idaho's other statutes relating to parental rights that they have not challenged but their actions also violate that they have talked about.

You know, in our brief in opposition to the plaintiffs' motion, we talked about child custody interference. Idaho Code

18-4506 and the plaintiffs acknowledge that in their reply brief and say, well, but the Attorney General didn't talk about the kidnapping statute. And the reason the Attorney General didn't talk about the kidnapping statute they speculated was because that required somebody to be held against their will.

Well, what the plaintiffs did not do is then, quote, the second subsection of the kidnapping statute, subsection 2, which makes it illegal to, quote, lead, take, entice away or detain a child under the age of 16 years with intent to keep or conceal it from its custodial parent, guardian or other person having lawful care or control thereof.

So if they have the right to act with an intent to conceal an abortion from the minor's parents in this case and to transport the minor with the intent to conceal that abortion, does that then call into question the constitutionality of the kidnapping statute?

We have Idaho Code Section 18-1510, providing shelter to a runaway child, which makes it illegal to, quote, knowingly and intentionally provide housing or other accommodations to a child 17 years of age or younger without -- without the authority of, A, the custodial parent or guardian of the child, B, the State of Idaho or a political subdivision thereof or, C, the one having legal custody of the child.

The plaintiffs have already mentioned in their briefing and in the Complaint and in their declarations an intent to

violate this. That they want to provide shelter to children going to get an abortion without the knowledge of the parents. That's a violation according to what they're saying in their Complaint of providing shelter to a runaway child, 18, section -- Section 18-1510. So if they have a constitutional right to violate 18-623, do they have a constitutional right to violate 18-1510.

And then we also have Idaho Code Section 16-1605, subsection 1, which requires people to make a report to law enforcement or the Department of Health & Welfare if they have a reason to believe that a child has been abused, neglected or abandoned.

Now, the plaintiffs say that many of the children that they help, they have reason to believe that they were subjected to abuse, neglect or abandonment but nowhere do we see in their complaint or in their declarations or in their memos that they have complied with their obligation to report that to the Department of Health & Welfare or to local law enforcement.

So if they have the right to violate 18-623 as they're talking about in this situation, do they have the right to withhold that information from the Department of Health & Welfare or from local law enforcement contrary to Idaho's Child Protection Act.

So the plaintiffs described actions in their case violate numerous Idaho statutes. Statutes which they have not

challenged in this case. So they're coming before this Court as a court of equity asking the Court to grant them equitable relief while indicating and providing information that they want to violate numerous Idaho statutes that are not before this Court.

This indicates that, one, they're not likely to succeed on the merits and, two, I think the Court then has to question whether they're coming to the Court with clean hands given their stated intention to violate all these other statutes.

If the Court grants the plaintiffs their request for relief, it calls into question the constitutionality of the run-away statute, Idaho Code 18-1510; the kidnapping statute, 18-4501; the child custody interference statute, 18-4506, and probably numerous other Idaho statutes.

COURT: Mr. Craig, you were coming down to the end here and I think we've hit the 30-minute mark but I've given both parties plenty of time because I want to make sure we get the questions answered.

MR. CRAIG: Correct. Thank you.

COURT: I do have one follow-up question that I forgot to ask. You're using the word "disavowed." I'm coming back here to something you talked about. You talk about the Attorney General has not disavowed his authority to self-deputize under 18-623. Has he disavowed his intent to prosecute under that statute?

MR. CRAIG: So he has disavowed his authority to prosecute at this time.

COURT: I understand that. That's not my question.

MR. CRAIG: Right. Oh, I understand that.

COURT: Yeah, yeah.

MR. CRAIG: So if a prosecutor appropriately refers the case to the Attorney General which we have no allegations that that's met in this case or if a prosecutor says that, you know, he or she's not going to prosecute the statute under any circumstances meeting that Idaho Code 623(4), then the Attorney General in those limited circumstances could have the authority to do it and he has not disavowed in those circumstances.

But the plaintiff has not pled that those circumstances are present in this case. So as we stand here today or -- and actually I think the Court has to look at at the time the Complaint was filed, as we stand at the time that the Complaint was filed, the Attorney General has no authority to prosecute cases under 18-623.

COURT: I understand that argument but he also hasn't disavowed at the time the Complaint was filed that he's not going to prosecute if he was referred that case? Correct?

MR. CRAIG: That's correct, yes.

COURT: All right. Anything further, Mr. Craig?

MR. CRAIG: Thank you.

COURT: Thank you, sir. Ms. Olson.

MS. OLSON: Thank you, Your Honor. And at the outset, I will apologize because it dawns on me there was one of your questions that you posed at the outset that I didn't answer and that was whether we were opposing the facial or as-applied challenge. And Your Honor, I think it's pretty clear ours is a facial challenge to the statute. We're alleging that the terms are vague and that it infringes on First Amendment rights. And there's no particular as-applied because there's not a specific circumstance yet where the statute has sought to be enforced. And it may be because the conduct is so chilled by the statute that no one has -- that it has not been identified publicly yet, Your Honor.

I want to sort of go in somewhat reverse order of Mr. Craig's comments. And I would say first, Your Honor, this opinion that the Attorney General wrote and I wrote the Court it's not binding on this Court and we said that in our reply but if he disavowed it with the stroke of a pen, he can also undisavow it with the stroke of a pen. That would mean -- that would make things solely within his discretion and I don't think that -- one, I don't think he has the ability to overrule the Ninth Circuit and, two, I think then it would be -- you know, he could change it just as he did when he changed it to this particular thing.

And then, Your Honor, with respect to all these other statutes he discussed and of course no one's challenging those

other statutes but I'll say one thing about those that is significantly different than the statute that plaintiffs challenge is that those are sort of general applicability statutes. And 18-623 is not. The only thing that 18-623 purports to criminalize is when the adult does these things that may be speech, expressive conduct, and are vague and then the person gets an abortion.

The rest of those statutes are, you know, we really don't want people who aren't the kids' parents taking care of them and there's some other parts of that but it's -- this is specific to abortion so it gets us back to that argument, Your Honor, about the viewpoint and content based.

And then, Your Honor, with respect to this argument about this is also -- it's narrow because of this intent to conceal element. Your Honor, what I would say to the Court about that is, Your Honor, first of all, what the defendant said in their brief is different from what Mr. Craig argued at the outset and then different what he ended on which was, well, you know, the parents need to know about this.

Those words truly are not in the statute but if to them intent to conceal means not informing the parent, then those are two different things and for sure that term is vague, Your Honor.

And he gave this description of, you know, if the person who -- the adult who recruits, harbors or transports

doesn't let the minor call their parents, well, that might be intent to conceal. Well, Your Honor, that probably also would be like kidnapping and we said in our brief that we're not -- we're not asserting that the kidnapping statute is no longer enforced. In fact, the kidnapping statute is there. The Attorney General is free to prosecute under that statute if he finds facts that violate that. But the conduct that we're talking about here and the free speech that we're talking about here and the association that we're talking about here is not kidnapping.

These are young people who come to people who express that message of support for abortion who are looking for that assistance and then the plaintiffs and others like them provide that assistance and they help those young people get lawful abortion care. And Idaho Code 18-623 takes direct aim at those people because of the message of support that they provide, because of the information that they provide, because of the funding that they get from their donors for that precise message.

Abortion is the only thing, the only subject matter of this statute. It's not (inaudible) neutral. It is vague and we would ask the Court to enjoin it. Thank you.

COURT: Thank you, counsel. This is -- it's clearly very important issues that have been presented. I appreciate the good argument of counsel.

Before we go, I do want to -- I want to address one thing while I have the parties here. I see that the defendant filed a motion to dismiss plaintiffs' Complaint earlier this week on September 12, 2023, and that motion raises many of the same issues that we have here but in greater detail. Namely subject matter jurisdiction of this Court, standing and sovereign immunity claims under the 11th Amendment among others.

I'd like to hear from the parties as to what their positions are with respect to whether or not the Court should take up both motions together at the same time or to go ahead with the preliminary injunction and then obviously go through the briefing schedule and address that at a later time.

So Ms. Olson, I know that this is taking probably longer than your clients would already like but I don't know if you've thought about that at all and what are the parties' positions on that.

MS. OLSON: Yes, Your Honor. May I stay?

COURT: Yes, of course.

MS. OLSON: Those are sort of tight quarters. Your Honor, our position is that the Court should hear -- it's heard and decide the motion that is ripe before it. The state decided to wait a substantial period of time before filing their motion to dismiss. They kept saying they were going to do it. That is a tactic, Your Honor, respectfully. That in fact does impose greater harm on the plaintiffs in this case. So we would ask

the Court to decide this motion first and then we will -- I think our response is due October 3 on the motion to dismiss?

COURT: Yes.

MS. OLSON: We will respond by that deadline and then they can file their reply and then the Court can decide whether it should dismiss the action or not and if the Court enjoins the enforcement of the statute and then decides from looking at the briefing on the motion to dismiss that in fact there is a reason to dismiss the lawsuit, I assume that the Court would just, you know, get rid of its injunction. But we would ask the Court to make a decision on the motion that's currently before the Court.

COURT: Thank you, Ms. Olson.

MR. WILSON: Your Honor, our position would be that since our motion to dismiss raises issues of the Court subject matter jurisdiction, the Court would be constitutionally obliged to decide that challenge to its jurisdiction before reaching the preliminary injunction motion in connection with it.

I'm flattered that Ms. Olson thinks that we are making tactical decisions. I wish we were but we're really just overwhelmed with about nine preliminary injunction motions right now and we actually filed one week before the deadline that we had based on the waiver of service that she gave us for our motion to dismiss. So we're actually ahead of schedule at this point.

COURT: All right. I appreciate that from the parties.

Mr. Wilson, I understand that, sir, and I understand the plaintiffs' argument. They are both valid arguments. The Court is always worried about issues of jurisdiction. Obviously I don't want to act outside the bounds of what I am otherwise set to do.

This motion is now ripe and so the Court will take this motion under advisement and issue a decision in due course.

Again, I truly want to thank counsel here today for some excellent argument and briefing. The Court again has spent an inordinate amount of time trying to get up to speed on these arguments and good counsel always make for good arguments and good cases and so we clearly have a good case here. So I want to thank everyone that's been involved in this in presenting the arguments here today.

So with that, the Court will be in recess. Thank you.

CLERK: All rise. The Court is adjourned.

(Proceedings concluded.)

I, court-approved transcriber, certify that the foregoing is a correct transcript from the official electronic sound recording of the proceedings in the above-entitled matter.

/s/ Tamara A. Weber 9/29/23

Signature of Approved Transcriber Date

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