IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF ARKANSAS
CENTRAL DIVISION

DYLAN BRANDT, et al.,
Plaintiffs,

v.

LESLIE RUTLEDGE, et al.,
Defendants.

No. 4:21CV00450 JM

October 19, 2022
Little Rock, Arkansas
9:03 a.m.

TRANSCRIPT OF BENCH TRIAL - VOLUME 3
BEFORE THE HONORABLE JAMES M. MOODY, JR.,
UNITED STATES DISTRICT JUDGE

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(Proceedings continuing at 9:03 a.m.)

THE COURT: Where are we this morning other than on the record?

Yes, sir.

MR. JACOBS: So, Your Honor, a couple of things that we would like to bring up. So, first, on the scheduling, so we indicated to the Court we would check our witnesses's availability, report on that. So we've done that. We've got three witnesses who have availability on Friday. It's Dr. Ho, Cathy Campbell and Dr. Janet Cathey. So those are collectively sort of -- I describe them sort of adverse witnesses who we subpoenaed to come rather than sort of our witnesses.

THE COURT: When you mean adverse witnesses --

MR. JACOBS: These are providers of treatments that are the subject of this case. A couple of them treated the plaintiffs in the case, so they are not like our experts or anything.

THE COURT: Understood.

MR. JACOBS: So they are available. That being said, on Monday, after we kind of got the scheduling news and everything, the Court indicated the plaintiff was going to be able to use, you know, what time we had this week, including the defense calling whatever witnesses we could. I think after, you know, we've seen what witnesses are available, we've kind of reviewed what we have. So I think what we would propose to the

Court and ask is that, instead of doing that, that when the plaintiffs close their case, whether that's today, whether that's tomorrow, that we, the defense, just be allowed to present our entire case when the Court reconvenes rather than doing these three so we can get through those three witnesses on Friday.

So our position is that we ought to be able, to the extent we can, to call our witnesses and present our case in the way that we decided to do it as a matter of sort of our trial strategy, which the plaintiffs have been able to do, and haven't been, you know, sort of impaired from doing based on the scheduling stuff.

Like the plaintiffs sort of did in their case, our plan was to start with a couple of expert witnesses before we got into some of the lay testimony. In particular, I think we were going to open with Dr. Levine as our psychiatrist expert. A lot of his testimony is sort of going to be about what is necessary for an appropriate psychological evaluation informed consent process.

And, in particular, for the three witnesses that are available on Friday, I would say sort of the bulk of their testimony is about what happens in Arkansas with regard to that and in particular what has happened with some of the plaintiffs in this case.

Part of the reason we scheduled, aside from availability,

in that order is so that we could have Dr. Levine's testimony finished before we had to question these sort of adverse witnesses on those topics. We thought that was part of our trial strategy, and we would like to still be able to do that.

We don't think that there is prejudice to anybody from doing it that way since we're already going to have to reconvene. And it's not clear that the three witnesses who could go on Friday would sort of add or subtract an additional day. They are not experts. In all likelihood, on our side, we'll be on the shorter end, and they will kind of be sprinkled in across the week depending on who is available. So I don't know that us doing this on Friday is actually going to subtract a day from whatever setting the Court has to do whenever that ends up being available.

So I think our thought is that we ought not have to bear the brunt of the scheduling fallout for something that ultimately wasn't our fault and sort of bear the sole brunt. You know, I think when we came in on Monday, everybody thought it was a ten-day trial.

THE COURT: So that being said, Mr. Jacobs, how long do you anticipate your case-in-chief lasting, keeping in mind that we move a lot faster than people anticipate?

MR. JACOBS: I think we had scheduled for five days. It's possible we could go down to four.

THE COURT: So did the plaintiffs, and we're doing two

and a half. Therein lies the scheduling problem. I didn't think realistically this case was ever going to take ten days to try, and that's bearing out, so nobody's fault. But what happened was I anticipated this case would conclude in five days. And it would have but for -- nobody's fault -- the fact that some of your witnesses were flying in next week.

It's usually my position, and it would be unrealistic in this case for me to tell you that y'all need to be prepared to call your next witness or rest because we move faster. That's no fault of yours. I'm not laying any of this at your feet. But I didn't make it clear to the parties of that in the event we move faster.

I can't assume, if I honestly believe that this case could have been put to me in five days, leave an entire week just on the mere chance that y'all might use it, when realistically and experiencially, if that's such a word, that nobody -- and I understand why. Nobody takes as long as they ask for because they don't want to get caught short, and that's fair.

But after this case went up and the designations were made, it was my estimation that this case probably could have gotten done. I mean, we were done at 3:30 yesterday instead of eight like we scheduled. And usually I say find somebody. And I'm not putting anybody at fault on this except me probably for not saying y'all need to be flexible enough to have your people here in the event we move more quickly.

So all of that said, if I'm going to allow you to put your case to me in the order which you want to, it will help me to get a realistic expectation of how much time you need because two or three days is a lot easier to find than an entire week --

MR. JACOBS: Right.

THE COURT: -- especially when we're talking about a month from now.

MR. JACOBS: So we had identified I think 12 witnesses at first. Two of those are witnesses the plaintiffs are calling, and we don't have any plans to recall them at this point. So we've shaved off two witnesses from that. Bear in mind that the Court has allowed the parties just to sort of rest on the experts' CVs instead of going through what can be pretty long -- I mean, I can talk to everybody. We're not going to need the whole five days probably based on that shortening, whether it ends up being four that we sort of request and can try to pare down. It's kind of hard to say because some of it is just controlled by cross-examination. And I think, you know, maybe our cross was shorter for some witnesses than the plaintiffs anticipated. It's hard to know.

But I think I would reiterate that, as far as Friday, the three witnesses, those are shorter. I don't know that's going to plus or minus a day of court time at the end of the day. I get the scheduling thing. What I would say is the last communication we got from the Court on the number of days was in

July.

THE COURT: I'm not blaming you for that at all.

MR. JACOBS: I understand that. I don't know the blame is really on anybody. It's trial, and that's what happens.

THE COURT: I'm trying to explain my expectations of what I thought it was going to take time-wise. Usually I'm not hamstrung, so to speak, not meaning I'm casting aspersion on you at all, that witnesses simply are not available until the following week, which is days from now. So usually everyone either knows that, despite how inconvenient it might be, to have your witnesses traveling or treading water, on the clock. And the expense that's occurred in all of that on the chance that they might get called is a challenge of litigation between you and me.

But here I anticipate we're done with two days left in a week where people were saying there's no way we can get this done in ten days, and now it looks like we could have gotten it done in five. That's all just discussion. That doesn't have anything to do with what I'm going to do. We're just explaining why we are where we are.

So I am inclined to grant your request to allow you to present your case-in-chief and your order of proof as you see fit. But I need an effort on your part to put a fine pencil on the time that you think you are going to need, realizing that we

work a little faster and a little longer and a little harder than some.

Yes, ma'am.

MS. GOLDSMITH: Lauren Goldsmith for the plaintiffs. Your Honor, defendants have suggested that plaintiffs have not been impaired at all in the presentation of our case by the change in schedule. You know, that's simply not true. Plaintiffs have made every effort to streamline the case, the presentation of the evidence. We have changed the order of witnesses to make the best possible use of the Court's time.

We've been able to present our case with 11 witnesses. We anticipate concluding our case today, leaving two full days for the defendants to present their case. There are three witnesses who potentially could testify on Friday. We've confirmed their availability as well. That's a third of defendants' witnesses. And while we're all assembled here in Arkansas, we think that it makes sense to make as much progress as we can. As Your Honor noted, it's much easier to accommodate us for an additional two days than it would be to accommodate all of defendants' anticipated witnesses in three or four days at some later date around the holidays presumably.

And, of course, this is a bench trial, so the presentation of the evidence doesn't matter in quite the same way as it would if we were all sitting here in front of a jury. You know, it was always a possibility that defendants would have to start

their case on Thursday or Friday, as Your Honor noted. You know, it was an estimate that each side needed five days. There were no assigned days here, so defendants should have been ready to go on Thursday or Friday if the plaintiffs concluded their case earlier than anticipated.

In fact, the three witnesses that are available on Friday were subpoenaed to testify on the first day of trial and are under subpoena now, and they are local. So we see no reason why we shouldn't go forward here and accomplish as much as we possibly can while the parties are all convened.

THE COURT: Mr. Jacobs, have you already confirmed that all of your witnesses are available the week of the 28th?

MR. JACOBS: So from the ones we have talked to --

THE COURT: I guess what I'm saying is, to grant your request, I need a commitment that all of your witnesses are going to be available to rock and roll starting November the 28th and to be on deck so I'm not in this similar situation within your case-in-chief.

MR. JACOBS: So we've been trying to confirm our experts first before we get to the lay witnesses, and I haven't talked to the lay witnesses. But for experts, we've got --

THE COURT: It's a yes or no.

MR. JACOBS: The answer is no. I have one expert --

THE COURT: Then I can't rule on your question right now. I need to know that, if you want all of your case packaged

in one neat bundle, without taking some that we know are available now, I need a commitment from you that you will be ready to proceed in your case-in-chief without a break, meaning I'm going to have my next witness ready when the first one ends, before I can grant your request.

MR. JACOBS: So we've been asking about the week of the 28th. I think the Court had mentioned the week of the 5th. I know there are jury trial issues with that. So I've got one -- so I know three experts' availability out of four.

THE COURT: For which?

MR. JACOBS: So Dr. Hruz can --

THE COURT: I meant not which expert but which date.

MR. JACOBS: Out of the three I know, only one can go during the week of the 28th, and it's one day. It's December the 1st, the Thursday. The other two aren't available at any point during the 28th. They do have availability the week of the 5th. They have travel. They have clinic schedules. We have stuff we can't -- it's too far out to really change at this point based on the information I have now. Maybe I can harangue them into --

THE COURT: Well, we're not in any better situation based on your availability for either of those dates then.

MR. JACOBS: Well, I mean, I guess it depends on what the Court's schedule is in terms of when there are -- you know, if it's four days, if it's three days that you can give us, and

we can keep going back to our witnesses and work with what we can.

THE COURT: That's why I started there. You are saying four maybe. We're not any closer to being less than a five-day week on your estimation.

MR. JACOBS: So we've asked about the week of the 28th and the week of the 5th because those are the only two weeks that the Court has indicated --

THE COURT: Short of going into January.

MR. JACOBS: -- short of going into January if we have to. You know, I think we would be fine if we had to have a witness do sort of a one-off remote appearance if everybody is okay with that. I think we're not going to object to doing that, you know, if there's one day out of a week that the Court has available and nobody can sort of travel in and out for one day. I mean, we're willing to be sort of flexible with that, but I just can't make my expert witnesses available when they are not -- you know, when they are not available.

THE COURT: I guess you can't have it both ways. You can't say, I want to present my case the way I see fit, but I'm not going to commit to any particular week to get them all done at one time. I mean, you are piecemealing, I can put one guy here and one guy there or one woman -- I'm not being specific on that. But you have to come to me with an option that I can get my case done efficiently in this amount of time at this period

of time before I can decide whether or not we're going to move forward on Friday or not. I understand what you are telling me, that you don't want to do it this week. But you have to bring me an option that makes sense so I can weigh what we're doing right now. And right now you are not telling me -- you have one guy on the 28th or one expert on the 28th and some maybe the 5th, depending on whether it's Thursday, which is well into the week.

MR. JACOBS: To be clear, we have availability generally the week of the 5th for two of our experts. Dr. Hruz, our endocrinologist, the only date in the entire period from the week of the 28th and the 5th, that ten-day calendar period, he has one day out of that that will work for him. That's December 1st, the Thursday, the week of the 28th. That's kind of where we're at. It's kind of holiday season, December. It's hard.

MS. GOLDSMITH: Your Honor, if I may, it sounds like any week we choose it will be difficult to schedule these witnesses. And the more witnesses there are to schedule, the more difficult it will be. Plaintiffs are willing to come back day by day if defendants want to present their case on nonconsecutive days. They offered to do it remotely. We're happy to do so as well. But the more we can accomplish now, the better for all here. And we think there's no reason not to proceed on Friday with whatever we can do because it sounds

like, in any event, it's going to be very difficult for them to present the case in their chosen order given conflicts among their witnesses.

MR. JACOBS: I'm not saying we have to present our case in the chosen order we chose for next week. I would just like the opportunity, after we get some days, to at least have a chance to do what we can at that point.

MS. GOLDSMITH: Well, if they are not wedded to a particular order, then I see no reason why we couldn't move forward with any witnesses who are available now.

MR. JACOBS: I'm not saying we're wedded to a particular order. I do think, of the ordering decisions that we made, having Dr. Levine testify prior to the testimony about the psychological evaluations and informed consent that actually happens in Arkansas is a particularly important scheduling decision. I mean, Dr. Levine is available in the week of December 5th.

THE COURT: Why can't he testify today, tomorrow or Friday by Zoom or otherwise?

MR. JACOBS: My understanding is he has scheduling conflicts. We didn't see any sort of realistic -- so I'll back up. The understanding that we had from the Court the last I checked was in July, that we had ten days blocked off and that we weren't sort of contingent on that second week, maybe using it, maybe not. That was the last communication we got. So when

we confirmed our witness availability, we confirmed it based on that.

THE COURT: I understand how we got here, and I'm not being critical of any of that. I'm moving forward now because in July you hadn't gone to the Eighth Circuit. You hadn't made your deposition designations, and it hadn't been clear to me that this case was in a wholly different posture after July time-wise than it was in July by my estimation. I will take responsibility for not communicating to the parties about it.

Now that we're in a different place, I need a reevaluation of how long it's going to take you. I'll take that responsibility for not telling you I need y'all to be prepared to go straight through no matter how fast we take it. That's how we got here. And I want to make clear that I'm not putting that on any of the parties or blaming them.

But now that we find ourselves here, you are asking to move forward so you can try your case in the manner you see fit, but you haven't given me an option which to move to. So unless you can get that to me, something to consider, pretty soon, we're going to proceed on Friday with the three witnesses. And I'm open to inventive and novel ways to present your testimony, or you can give me an option that works. So I don't know that I can answer your question about Friday right now because I don't have an option to consider.

MR. JACOBS: Okay. I'm told that Dr. Levine can do

the 28th. So he is available Monday, the 28th. I know Dr. Regnerus, he says he's out of the country the week of the 28th. I don't know if the Court is willing -- we could do a day remote session with him. We could fly him in some other day, depending on how much of the 28th is actually available for court time or if it's the whole week the Court has open.

We'll have some staff back at the office try and keep getting in contact with some witnesses and try to nail down schedule-wise what's available.

THE COURT: I will tell you, if we're talking about the 28th and Levine is only available on the 28th --

MR. JACOBS: And the week of the 5th. We're trying to keep this in a single week.

THE COURT: Let me work through this. If we're going to do it the week of the 28th and Levine is only available on the 28th, we're starting Monday, and we're not going to go a couple of days and take a day off and then go back into Thursday. That's not doable. So you can either start on Monday, the 28th, and get your case done, in what I estimate, and we can talk about. But I can't imagine, based on the pace and what we're doing here and what's been presented to me otherwise, you can't get your case done in three days.

And if you can look me in the eye and tell me without dragging your feet that you can't get that done, I'll take your word for it. But the proof is going to be in the pudding, and

we're finished halfway through Wednesday, and you said I needed four or five days. That will be what it is. As to the 5th, I need commitment that you can get it done in a similar period of time, but I can't even commit to you on the 5th right now and won't be able to give you a definite time on the 5th until November the 4th.

MR. JACOBS: I think, as far as the 28th, assuming we start on Monday, we have Dr. Levine. And we go, so Dr. Hruz's availability is that Thursday, the 1st. So I think that, if we're trying to fit everything in that week, we would at least -- we would need the Monday. We would need the Thursday just for availability -- that's my understanding -- because that's the day he can make it. As far as fitting everybody else, then, like I said, we can have staff confirm that while we're doing this this morning. The only problem with that is Dr. Regnerus is out of the country the week of the 28th.

THE COURT: He is either available or not. That's fine. But what I'm saying is, if you are telling me this is going to be piecemeal, we're taking these witnesses on Friday. If it's not going to be and you can package your case in a consecutive form without me having to not understand the days I have available to do other work, then that's not going to work. We're not going to go Monday, Tuesday, Thursday. I need you to be able to either provide me an option where your people can all be there at one time, or we'll do it piecemeal, and we'll work

on Friday.

MR. JACOBS: Why don't I --

THE COURT: You can get back to me later on what those are.

MR. JACOBS: We'll try to confirm if we can make the 28th, that Monday through Thursday, work -- how about this -- for everybody but Dr. Regnerus. And then, if we have to do a remote at some point with Regnerus, since he's not able to fly in that week, then that may be what I end up coming back and proposing if we can get people to confirm.

MS. GOLDSMITH: Your Honor, if they are suggesting that they want Dr. Levine's testimony to be taken before the three available witnesses on Friday and also that they are willing to take this testimony remotely, we understand that the scheduling issue here isn't a conflict. It's travel. And if Dr. Levine could testify remotely tomorrow, there should be no issue from defendants' perspective I would assume.

THE COURT: My understanding of asking Mr. Jacobs about that is he's not available remotely or otherwise this week.

MR. JACOBS: My understanding is there's a conflict tomorrow. This is not just travel in.

THE COURT: What about Friday?

MR. JACOBS: Both tomorrow and Friday. That's my understanding.

THE COURT: That's what I was saying, Mr. Jacobs. I thought you and I chased down that potential and resolved that. I don't know if anyone other than you and I were on that page. But I had understood Dr. Levine wasn't available this week video or otherwise.

MR. JACOBS: What I'll do, we'll try to confirm if we can make the 28th of November to the 1st of December happen with the caveat that we may have to do something different for Regnerus. And I'll try to confirm that and then raise the issue of Friday when I have better information on that, Your Honor. Does that work?

THE COURT: Yes, it will. And I guess the default is going to be that we handle these three witnesses on Friday unless you can give me an option where all of your people can be packaged in a consecutive period of time, either the 28th, the 5th, or you can submit to me a date other than those that's beyond the 5th, which would mean '23, 2023, where that can get accomplished. But I'm not interested in waiting that long.

MR. JACOBS: Understood.

THE COURT: But it will be an option to consider.

MR. JACOBS: Okay. That's what we'll do. Do you want to go ahead and discuss the stipulation?

THE COURT: That was going to be my next question. Let me get to that sheet in my notebook.

For the record, we are discussing Document 183-1, which is

entitled "Joint Stipulations of Fact," but it is not. It is a plaintiffs' proposed stipulations of fact but may evolve into a partial joint stipulation of fact.

So if you can just take me by paragraph, Mr. Jacobs, I'll follow along.

MR. JACOBS: So generally I'm looking at paragraphs 8 through 31, which is like the family information. So I think, to the extent that the plaintiffs want us to stipulate to this -- and we haven't talked about this since we exchanged these in August, so I don't know whether that's the case or not. I'm fine with stipulating to the family information if they will look at it and sort of update it. I think one of the cities was maybe wrong for one of the witnesses. As far as the ages, I think I would prefer if --

THE COURT: What paragraphs can you stipulate to or not to? Did I understand you to say you didn't even talk to them about this since July?

MR. JACOBS: I think since August was when the parties exchanged these and tried to negotiate it. Then we submitted it to the Court. To my knowledge, there haven't been any discussions since then because we're kind of at an impasse. Our, I guess, thought was that was sort of --

THE COURT: So what paragraphs can you stipulate to?

MR. JACOBS: Paragraph 8. As far as paragraph 9 and the other birthdays, what I was about to say is I would prefer

that the parties stipulate to like a birth date.

THE COURT: Come back to me when you are ready to tell me what you can stipulate to and not as opposed to I would prefer we talk about it because that doesn't get me anywhere.

MR. JACOBS: 8, 10, 11, 12, 13, 14, 15, 17, 18, 19, 20, 21 through 25, 26 -- excuse me -- so 26 through 31. On the ages, I guess if we're doing this, so No. 9 and 16 as well. But I will say for the ages, what I would rather do than stipulate to a number is if the parties could maybe just give it to the Court, the birth date, because we've had some ages in the complaint. We've had some ages with the preliminary injunction stuff. The age that was on this stipulation for one of the witnesses yesterday was different. By the time the Court enters its order, the ages are going to be different, so I would rather have a birth date.

THE COURT: What is Dylan Brandt's birthday?

MR. JACOBS: We're fine with that being confidential.

THE COURT: I'm asking right now. Anybody in the room can tell me Dylan Brandt's birthday.

UNIDENTIFIED SPEAKER: [redacted].

THE COURT: Sabrina Jennen's birthday.

UNIDENTIFIED SPEAKER: [redacted].

THE COURT: Brooke Dennis's birthday.

UNIDENTIFIED SPEAKER: [redacted].

THE COURT: Parker Saxton's birthday.

UNIDENTIFIED SPEAKER: [redacted].

MR. JACOBS: And we're fine stipulating to that. I think that's better than trying to deal with ages that can change.

THE COURT: We're on paragraph 32.

MR. JACOBS: As for the rest of the stipulations, I'll go to paragraph 41. We talked about --

THE COURT: You are not willing to stipulate to anything that's in paragraph 32 to 40?

MR. JACOBS: No.

THE COURT: Are you going to present any evidence to the contrary?

MR. JACOBS: So I think whether we do or not, there's a lot of this information that is sort of legal conclusions or sort of legal issues that aren't factual issues. Our position is that we talked about 41 in terms of the authenticity. We're stipulating to that.

THE COURT: You are moving past my question, Mr. Jacobs.

MR. JACOBS: No. We're not stipulating to that.

THE COURT: Some of this stuff is clearly not legal conclusions. And are you going to present any evidence to the contrary if they presented evidence too? And if you don't want to stipulate to it, that's fine. But if you don't have any contrary evidence to it, that's fine too. But I don't

understand why you are not stipulating to the facts that you are not going to present any evidence to the contrary that appear to be facts that I could virtually take judicial notice of.

So we're moving on. 41.

MR. JACOBS: 41, we discussed, again, the authenticity issue. We'll stipulate to the authenticity. We're not going to stipulate to the admissibility of that. As far as all of the other stipulations, our answer is no. And if the plaintiffs would like to request judicial notice for any of that information, what we would suggest is that be done, you know, in a post-trial brief or maybe just an appendix and a list. We can respond to the ones that the plaintiffs want, at the end of the case, the Court to take judicial notice of, and then the Court can take it under advisement.

THE COURT: So just so I'm clear, while you are not stipulating to it, you also are not denying any of these at this point.

MR. JACOBS: We haven't presented our case, Your Honor.

THE COURT: Do you anticipate denying any of these?

MR. JACOBS: I don't know the answer to that. Even if we're not, our answer is we're not going to stipulate to it.

THE COURT: I'm trying to determine how long this case is going to last, Mr. Jacobs. And I suspect you know exactly what your case is going to be. And the notion that you don't

have to stipulate to anything is fine. But when I ask you a question about what your testimony is going to be about on it, I think I'm entitled to know that to know how long I think your case is going to last. We can disagree about my questions to you. But I get to ask them, and you get to answer them. So I'm going to ask you one more time. Do you anticipate that you are going to have testimony on these issues? And I've given you two and a half days to look over the stipulations to decide which ones are actually in dispute. Do you anticipate calling witnesses to refute any of these stipulations that are left?

MR. JACOBS: If we want to go line by line --

THE COURT: No, sir. I don't. I want to know are there any in there. You can tell me which ones you do anticipate and those which you don't, but I don't need to go line by line. I can read in here what is apparently a matter of record on a lot of -- just the page I'm on now, which begins at paragraph 41 -- and either you can stipulate that these statements were made on the record or not or certain other -- I mean, some of them are factual issues that I can see are in dispute, but I'm not asking you to stipulate to any of them. And if we're ending at 41 and the rest you are not going to stipulate to, I need you to give me an honest estimate on when it is, how long you think you are going to take to dispute the rest of them.

MR. JACOBS: So I think the answer --

THE COURT: You don't need to give me that right now because it's apparent you are not prepared to.

MR. JACOBS: I wouldn't say I'm not prepared to. I would say that we've got the testimony we're going to present, and that doesn't, to me, really have an impact on whether we would stipulate to this. I think in general --

THE COURT: What you stipulate to makes an impact on how long your case is going to take. It's a whole lot faster to stipulate to a fact than to try it. If we stipulate to things, that speeds things up. In large part, that's why I thought the case was going to go much quicker because -- not your fault -- but I was misled that a joint stipulation of fact didn't mean that. I took it for granted that all of Document 183 had been stipulated to and the parties had worked together since August or before August to come up with these stipulations.

Now I learn that all of these things may or may not be disputed. And to determine how long I think the case is going to last, I asked you two days ago to determine which ones you were actually going to dispute. And while you don't have to stipulate to them, I'm entitled to know how long you anticipate it's going to take to dispute these.

MR. JACOBS: Again, I think the length of our case, even if there's a fact in here to which we might not dispute it per se, I think we're entitled to have our expert give his opinion on what it is and have that be the record. So even if I

stipulated to some of this, we still might have our expert talk about it. So I don't know that there's this shrinking of the case that would happen if I agreed to half of these stipulations.

THE COURT: I disagree. I think stipulations shorten the length of a trial, but you can disagree with that just fine.

MR. JACOBS: I think we would put on the testimony we want to put on and have in our record, you know, to go up with sort of regardless of the particular, you know, stipulations that we might agree to. And there's some of these that aren't disputed because they are sort of legal things. They are sort of things that just aren't relevant. So, I mean, I think, at the end of the day, plaintiffs have their case. If these are material, they can put it on. If it's not, they can not put it on. If there are remaining stipulations after the close that are convenience items, I'm happy to look at those.

THE COURT: Thank you. I appreciate you being happy to look at them because they should have been looked at before. And I've asked you to look at them since the beginning of this trial. And the notion that you are going to let the plaintiffs rest, then decide what you are going to stipulate to after the fact, isn't satisfactory. I will assume that you are not going to look at these any further because I've asked you to do so for two days now, and you've gotten down to the family statistics and essentially paragraph 41.

We'll continue with the trial.

MR. JACOBS: The Court asked if we would stipulate to the rest of them. We reviewed them. I think we've given our answer. The answer is we will not.

THE COURT: Understood, Mr. Jacobs. You can have a seat, and we'll proceed.

Call your next witness.

MR. BODAPATI: Yes, Your Honor. Arun Bodapati. Your Honor, before plaintiffs call their first witness, Dr. Michele Hutchison, to the stand, we just have a few points on that first.

THE COURT: On what?

MR. BODAPATI: Regarding her testimony. So defendants have represented to plaintiffs that they would ask Dr. Hutchison about certain information contained in the sealed medical records. So we expect that there will be a portion of Dr. Hutchison's testimony that we would need to conduct in a closed setting.

THE COURT: Will that be restricted to cross-examination?

MR. BODAPATI: Plaintiffs do not intend to take any direct testimony that would touch upon the sealed records.

THE COURT: Thank you for the heads-up. We'll discuss that between your direct and their cross.

MR. BODAPATI: Sure. Just two other small points.

So, as defendants mentioned earlier, they had originally had both Dr. Hutchison and Dr. Stambough on their witness list. So I believe I understand them to say that they will not plan to call these defendants separately but would take whatever testimony they need in this setting right now.

THE COURT: Well, even if they make that representation, they are still entitled to recall them in their case-in-chief if they decide to. I appreciate their efforts to do what they need to do while they are here, but I don't think they waive their right to recall them in their case-in-chief. That's why I allowed wider discretion during cross-examination so they wouldn't have to call them back in their case-in-chief.

MR. BODAPATI: Sure, Your Honor. We understand that. But, in the interest of efficiency, we would like to note that Dr. Hutchison actually has moved to New Mexico. So if defendants were to call her again, that would create another scheduling conflict insofar as they would need to bring her back to Arkansas as well.

THE COURT: Okay.

MR. BODAPATI: Plaintiffs' last note, just briefly, originally when plaintiffs brought this case, Dr. Michele Hutchison was a named plaintiff in the case. However, because she moved to New Mexico, as plaintiffs noted in their pretrial disclosures, she is no longer a plaintiff in the action.

MS. TEMPLIN: Your Honor, there is nothing on the

record moving to withdraw her as a plaintiff. In fact, when we checked CM/ECF and PACER yesterday, she had not been removed as a plaintiff. We've been treating her as a plaintiff. So if they would like to move to remove her, that would be one thing, but she has not been formally withdrawn. We just wanted to note that.

MR. BODAPATI: Again, Your Honor --

THE COURT: With regard to her testimony today, what does it matter?

MS. TEMPLIN: Well, for the hearsay exception, it does matter whether someone is an opposing party or not. And we've been treating her as an opposing party for purposes of preparation. We would still ask that, because she was an opposing party through the deposition, that those statements come in under that exception still. But that is why it matters to us.

THE COURT: We'll take that up between direct and cross as well.

MR. BODAPATI: Your Honor, plaintiffs made clear in their pretrial order. I can point out at page 17, footnote 6, that Dr. Hutchison moved out of state and was no longer a plaintiff. If defendants want plaintiffs to move now, plaintiffs would move now to dismiss Dr. Hutchison as a plaintiff because she is no longer a provider of medical care in Arkansas.

THE COURT: Okay. That will be granted. What effect that has is another issue. I don't know one way or another because I haven't given it any thought. But we'll discuss that between direct and cross as well.

MR. BODAPATI: Understood. With that out of the way, Your Honor, plaintiffs would call Dr. Michele Hutchison to the stand.

MICHELE HUTCHISON, PLAINTIFFS' WITNESS, DULY SWORN

DIRECT EXAMINATION

BY MR. BODAPATI:

Q. Good morning, Dr. Hutchison.

A. Good morning.

Q. Would you please state your full name for the record.

A. Sure. Michele Rebecca Hutchison.

Q. Can you tell the Court your educational background?

A. Yes. I attended college at Wellesley College in Wellesley, Massachusetts, where I got a B.A. in both biochemistry and political science. I then attended what's called an MSTP program -- that's a combined M.D./Ph.D. program -- at the University of Texas Southwestern Medical Center in Dallas. Following that I did my residency in general pediatrics at Dallas Children's Hospital and then followed that up with a fellowship in pediatric endocrinology.

Q. Now, can you summarize your professional experience since completing that fellowship?

A. Yes, of course. I joined the staff at UT Southwestern, which is to say I was a faculty member there for ten years, during which time I did some basic research. I also saw patients for both general endocrinology, pediatric endocrinology, diabetes and did some teaching. And then I was briefly in the Medical University of South Carolina in Charleston, South Carolina, after which I moved here to Little Rock and joined the faculty at the University of Arkansas for Medical Sciences, or UAMS, here. And I worked here for about six years and have recently --

THE COURT: Can you slow down just a little.

THE WITNESS: Sorry. And I was here at UAMS for about six years doing, again, pediatric endocrinology. And then I have recently taken a position at the University of New Mexico in Albuquerque, New Mexico, where I'm the chief of pediatric endocrinology there.

BY MR. BODAPATI:

Q. Have you specialized in pediatric endocrinology since your fellowship?

A. Yes.

Q. And are you board certified?

A. I am.

Q. In pediatric endocrinology?

A. Yes.

Q. Dr. Hutchison, when did you first begin working in

Arkansas?
A. I believe I came here in October of 2016.
Q. And when did you leave here?
A. My last day I believe was July 6th of 2022.
Q. Why did you leave?
A. I was offered a wonderful opportunity. It was hard to leave. I'll be honest. I had set down a lot of roots and made a lot of friends here. But I was offered an opportunity to be the chief of the division of pediatric endocrinology in New Mexico.
Q. Focusing back on your time in Arkansas, what position were you hired for when you first came here?
A. Associate professor in the department of pediatrics division of pediatric endocrinology.
Q. Where was that position?
A. Sorry?
Q. With what organization was that position?
A. Sure. That's the University of Arkansas for Medical Sciences, or UAMS.
Q. Did your position involve teaching?
A. Yes.
Q. Did it involve patient care?
A. Yes.
Q. In what settings did you provide patient care?
A. Sure. Solely within the confines of the Arkansas

Children's Hospital, ACH.
Q. Was that solely inpatient or any clinics involved?
A. Yes. Both inpatient and outpatient within the pediatric endocrinology clinic.
Q. What kind of conditions did you treat at that pediatric endocrinology clinic?
A. Sure. About 50 percent of what we do there is pediatric diabetes, both type 1 and type 2 diabetes. Then general endocrinology includes a wide swath of conditions such as growth failure, pubertal disorders, thyroid, adrenal disorders, hypoglycemia, calcium and bone and mineral metabolism disorders and that sort of thing.
Q. Now, while you were at Arkansas Children's Hospital, did there come a time that you began to treat patients with gender dysphoria?
A. Yes.
Q. When was that?
A. I believe the clinic opened in February of 2018.
Q. And what prompted the creation of that gender clinic?
A. Several things. One was that I had been told by colleagues that there was a need here, both by folks who worked here in Arkansas and also by some providers who were at the time providing gender-affirming care outside of the state and who had relayed to me how far their patients were having to travel to access care. And that made me realize that there was a pressing

need here within the state, and I wanted to serve that need.
Q. Was the gender clinic a pediatric-only clinic?
A. Yes.
Q. Up to what age would the clinic see patients?
A. So we would accept a patient into our clinic. Generally they had to be under 18 to be accepted into the clinic, in other words, pediatric age range. But we might see them past 18 in certain circumstances.
Q. And roughly around what age would you usually transition them out of the program?
A. We would usually try to encourage them and help transition them to an adult practice usually by 20.
Q. What was your position at the clinic?
A. I was the medical director of the clinic.
Q. And since you've left Arkansas Children's Hospital, who is the medical director of the clinic?
A. That would be Dr. Kathryn Stambough.
Q. Had Dr. Stambough been providing care at the gender clinic prior to becoming director?
A. Yes. She had joined our team prior to my leaving.
Q. Dr. Hutchison, what was your role in the creation of the clinic?
A. So I was involved from the beginning and helped guide the creation of the clinic with help from a lot of other people. I did not do it on my own.

Q. Now, in creating the clinic, did you develop any treatment protocols?
A. Absolutely. We wanted to make sure that we had a protocol in place prior to opening the doors of the clinic.
Q. How were those protocols developed?
A. So I worked with a number of people both within and without the university. I worked with other providers who were providing gender-affirming care in other cities and got guidance from them. I also used the available Standards of Care, as published by WPATH, 7 at the time and the Endocrine Society Guidelines.
Q. You mentioned collaborating with other providers in other cities. Were any of those providers working at other university's gender clinics?
A. Some were, yes.
Q. And you mentioned that you also consulted some guidelines. What guidelines would those be?
A. That would be the WPATH, I believe it was 7 at the time, and the Endocrine Society Guidelines.
Q. And were the clinic's protocols that you ultimately developed generally aligned with the recommendations of the Endocrine Society Guidelines and the WPATH Standards of Care?
A. Yes. That was our goal.
Q. Did the protocols that you developed provide for any particular medical treatments that could be provided if deemed

appropriate for a patient?
A. Yes.
Q. And what were those?
A. So a range of medical options were available. For example, menstrual suppression for kids who had significant dysphoria with menses or menstrual bleeding, testosterone -- what are known as testosterone blockers. Those are medications to help lower testosterone levels in some patients and then what we call cross-sex hormone or hormone replacement therapy, which would generally be testosterone for transgender males or estrogen for transgender females.
Q. Would the protocols have ever provided for treating with puberty blockers?
A. Yes. Puberty blockers as well, although we had very few patients that we started on puberty blockers.
Q. Now, are all of these medications -- are these medications that you use for other purposes besides treating gender dysphoria?
A. Yes.
Q. Could you just name a few conditions that you would have used these for?
A. Sure. We use puberty blockers quite extensively in the condition known as precocious puberty, such as a very young child starting puberty at a young age, which would affect both their physical development and potentially their psychological

health.
Q. Okay. How about for testosterone suppression, any other conditions?
A. Sure. We use testosterone suppression in girls with polycystic ovarian syndrome, where their bodes might be making an abnormally high level of testosterone. We use testosterone in what are called hypogonadal males. It's a fancy way of saying that the testicles may not be working properly, so they cannot make testosterone on their own and can't go through puberty on their own. And the same would be true for some girls who will not go through puberty on their own or be able to make estrogen on their own. We have to give them estrogen. A common example would be Turner syndrome.
Q. Did the gender clinic protocols provide for surgical treatments?
A. No.
Q. Did the clinic provide any surgeries?
A. No.
Q. Approximately how many patients have you treated or did you treat during your time at the gender clinic?
A. I think it was around 300, somewhere between 300 and 320.
Q. And just generally speaking, about how many of them did you see?
A. Probably the majority of those I had seen at least one time.

Q. Is there a single treatment plan that applied to all patients at the clinic?
A. No, sir.
Q. So how were the treatment plans sort of designed?
A. Well, just as we do in every branch of medicine, we're taught to individualize therapy for the patient. In our case, especially we're very family centered in our program, so the plans would be tailored to not just the patient but the family as well.
Q. Now, I think you mentioned this before. But just to confirm, during your time at the gender clinic, how many patients did the clinic treat with puberty blockers?
A. We had, I believe, a total of four, if recollection serves. Two had come to our clinic already on puberty blockers for a previous diagnosis of precocious puberty, so that medication had been started by one of my colleagues in the endocrine clinic. Then I believe we, within the clinic, started two additional patients on puberty blockers for the gender dysphoria, so I believe that's a total of four.
Q. Was it more common to treat patients with cross-sex hormone therapy than puberty blockers?
A. Yes. I would say that's accurate.
Q. Why were so few treated with puberty blockers compared to cross-sex hormone therapy?
A. That's simply a matter of the demographics of our clinic.

The vast majority of our patients came to us well into puberty, so a puberty blocker really would not be appropriate for those patients since they have already progressed well into puberty.
Q. Did every clinic patient receive medical treatment for their gender dysphoria?
A. With medication, no.
Q. In your experience, under what circumstances might patients not undergo any medical interventions for gender dysphoria?
A. Sure. Well, any prepubertal patient would not be eligible for any medical therapy because they are prepubertal. A patient may not request medical therapy. They may just want to talk. There are patients who work through the program and may decide at some point that they are not, in fact, transgender for an example. And that would be a patient who would not be eligible for medical therapy.
Q. Are there any instances where, besides the patient deciding it, someone else would feel that it wasn't appropriate for the patient to receive a treatment at that time?
A. Sure. So we take very much a team approach. So if any member of the team felt that the timing was not right or that the patient was not ready, that would be a reason to either not treat or delay treatment. And, if I could point out that the parents are part of that treatment team, so parental consent is required. So if the parents were not ready to move forward, that would delay treatment as well.

Q. During your time at the clinic, how did patients come to you?
A. You mean how did they find us?
Q. Yes.
A. A number of ways. Many of them were actually referred by their primary care physician, their provider. Some were -- we had quite a few who were referred by their counselor or therapist, and then some of us -- some of them, especially early on, heard about us word of mouth through peers.
Q. When a patient would come in for their first visit, was there any assessment of the patient done?
A. Yes, of course. As I would with any patient who is coming to see me, whether it's for diabetes or general endocrine or gender dysphoria, I do a full and thorough what's called a family history. That means gathering any medical problems that may exist within the family. That can give us clues about the genetic makeup of the person, then their own personal medical history. That lets me know what medical problems they may have struggled with in the past. That includes any mental health history as well.

Then a physical history, which is done to make sure that I'm assessing for any current medical problems that they may have. And then talking with the family to get a sense of their psychosocial background, in other words, what sort of social support do they have, do they have support from their family,

how are they doing at school, are they struggling, are they being supported at school, what bathroom are they having to use, for example, getting an idea of their personal experience with their gender.

I want to know when did they start having those thoughts initially, how have they coped with the gender dysphoria and who have they talked to about it, have they sought counseling, etc. So it's a pretty thorough assessment. We also routinely would screen for depression and anxiety as well.

Q. I think you mentioned this. Just so I'm clear on it, were the parents involved in that process?

A. Oh, always, yes.

Q. How frequently would you see patients after the first visit?

A. We requested that the patients come every three months.

Q. I want to focus now on the requirements for particular medical treatments. So let's start with cross-sex hormone therapy. Did the clinic protocols that you developed have any requirements before a patient could be prescribed cross-sex hormone therapy?

A. Yes, quite a few. It's a list.

Q. Sure. Could you list some of those?

A. I'll do my best to enumerate them. Well, first and foremost, they had to meet the criteria for a diagnosis of gender dysphoria, and we use the DSM-5 criteria. Secondly, they

had to have parental consent. So consent is at least one legal guardian or parent, custodial parent. They had to be in ongoing counseling with a therapist. That is something that we required. They had to meet with our clinical psychologist for a thorough psychological assessment. They had to show consistent and persistent gender identity in their affirmed gender, and they had to show mood stability. In other words, if they had came to us with a diagnosis of depression, they had to demonstrate that they were under treatment for that and that they were mood stable. And we confirmed that by speaking directly with their therapist to make sure we hadn't missed anything. So I hope I hit all the points, but I think that sums it up.

Q. Sure. Maybe just one or two that I'm curious about. Did the protocols have a minimum age for starting hormone therapy?

A. Yes. Fourteen was our minimum age.

Q. Did it include also any kind of medical assessment?

A. Yes. Of course. So, at the first visit, we would do what we call baseline lab work. And that is to get a sense of the patient's overall metabolic health. The reason for that is that sex hormones, such as estrogen and testosterone, can make changes to the patient's metabolic profile. That's true for both cisgender and transgender patients. So one example would be perhaps cholesterol levels. So these medications have the potential to change your cholesterol panel, so we want to check

that at baseline. And, if it's not normal, we're going to address that before starting any medication.
Q. Also, did the protocols provide for understanding whether or confirming whether adolescents understood the treatment and the possible risks it might have?
A. Yes. Absolutely. So we had an informed consent process, and we wanted to make sure that not only did the parent provide consent but that the patient was able to agree with the treatment and understand it.
Q. Now, I would like to walk through some of those requirements one by one, starting with the minimum age that you mentioned. So you mentioned that the protocols provided that a patient should be at least 14 before starting cross-sex hormone therapy. Was that the typical age for patients at the clinic to start hormone therapy?
A. Yes. The typical minimum age. The average age was actually a bit over 16 years.
Q. You also mentioned a psychological evaluation. Who would perform that evaluation?
A. We had a clinical psychologist who was a part of our team. It was actually really very helpful that we had a single person doing all of those evaluations to provide some consistency.
Q. Did that psychological evaluation include an assessment for gender dysphoria?
A. Yes, it did.

Q. Did it involve any other assessment related to gender dysphoria or gender identity development?
A. So some of the assessment tools she used would actually assess for degree of dysphoria and would go so far as to delineate what parts of the body were triggering that dysphoria to help us better understand the patient. Additional evaluations would be tailored to the patient. For example, if they had a history of depression, we would want to get a sense of how severe, was it mild, moderate or severe, was it under control. And then the parents would occasionally ask for additional evaluations just depending on any particular concerns they may have about their child.
Q. Okay. And you mentioned that the patient must have a gender dysphoria diagnosis before initiating hormone therapy. I think you mentioned this before. But what diagnostic criteria were used?
A. We used the DSM-5, the diagnostic -- oh, gosh. Now I'm embarrassed that I don't remember what DSM-5 stands for -- diagnostic standards manual, I believe. It's a psychiatric manual for diagnosing mental health issues.
Q. Did you ever use the ICD-10 transsexualism diagnosis in treating patients?
A. We did not. I'm not sure I could delineate how to diagnose transsexualism. That is -- the ICD-10 is a billing code that shows up in charts, but we don't actually use that diagnosis.

Q. Okay. So am I right in understanding that patients had to have a gender dysphoria diagnosis under the DSM-5 before hormone therapy would be considered?
A. That's correct.
Q. You also mentioned that before considering cross-sex hormone therapy a patient must have a persistent and consistent gender identity. How was that determined?
A. Sure. Well, first and foremost, information collected from the patient themselves, because they are the only ones that can tell us about their internal identification and timing and explain how they feel. But the parents are a valuable resource because, of course, they are living with that child and can corroborate a lot of that and let us know how the patient is doing. Then there's the therapist, who is meeting generally quite frequently with the patient, that can give us a better sense of, you know, is this patient mood stable, has this gender identity been consistent over time. And then there's my own opinion from meeting with the patient multiple times and then, of course, meeting with the clinical psychologist.
Q. Was it common for clinic patients to have a long-standing transgender identity by the time they first came to the clinic?
A. Yes. In fact, looking at our patient population, the average length of time between when one of our patients first identified as transgender and when they told a parent was six and a half years.

Q. Did you have any patients who had just recently discovered their gender incongruence?
A. That's really rare in our clinic. I, off the top of my head, can think of only a couple, maybe one or two, that would fit that description.
Q. With those patients, would your approach be any different?
A. Yes, it would. In fact, we would take -- well, we did -- took a lot of time with those patients, did a lot of talking. Time I think is the real element there because part of the criteria for diagnosing gender dysphoria or being eligible for therapy is showing consistence and persistence over time. So we need to give those patients time and space to, you know, explore their own gender identity.
Q. So, relatedly, was it common to see patients who first experienced dysphoria well after puberty started?
A. That's really uncommon in our clinic in my experience, yeah.
Q. For those clinic patients who were treated with cross-sex hormone therapy, about how much time passed between their first clinic visit and the start of hormone therapy?
A. So it varies by patient because, as stated before, there might be conditions or issues that would make that period of time longer. But the average within our clinic is actually about 10 1/2 months.
Q. You also mentioned that before providing treatment the

patient had to be in therapy with a mental health professional and that the clinic would consult with the patient's therapist. Can you describe what that consultation entailed?
A. Certainly. We would first ask permission to speak with that therapist, so that's a release of information form that we would collect from the family to make sure that we had permission to speak with their therapist. Then we would reach out to the therapist and set up a time for a phone conversation to confirm that had the patient been coming regularly to see the therapist, yes or no, did the therapist confirm that there was persistence and consistence of the gender identity over time, that they had specifically discussed potential fertility and any desire for biological children and, fourthly, did they feel that the patient was mood stable and ready to start therapy.
Q. Has a therapist ever had concerns about a patient starting treatment?
A. Yes.
Q. What kind of concerns would those be?
A. So primarily we've heard feedback such as I don't think this patient is mood stable or that they haven't been coming to see me regularly or that they are just not emotionally mature enough to make decisions regarding therapies that have permanent changes.
Q. And what would happen in those cases?
A. We would delay treatment, and we would say come back and

keep -- work with your therapist. I mean, there were cases where the patient just wasn't interested in going to therapy. And we would have to say, we can't treat you if you are not going to stay in therapy, and be very firm about it. And they would go to therapy and benefit from it, and then we would reconsider later, for example.

Q. So am I right that the therapist would need to confirm their readiness to start hormone therapy?

A. That's correct.

Q. Who else besides the therapist would need to confirm the treatment was appropriate before a patient would be prescribed hormone therapy?

A. Most importantly, the patient and the parent, so that's required. Myself and our psychologist.

Q. You mentioned that the clinic would obtain informed consent from the patient's parents before initiating cross-sex hormones. Did that process involve informing the families of the potential risks and benefits of treatment?

A. Yes.

Q. Did you inform families about the risk to fertility?

A. Yes.

Q. Did you inform families about potential adverse health risks?

A. Yes. As we do, as physicians, we perform informed consent whenever we start a medication on a patient.

Q. What are some of the potential health risks you would tell families about?
A. Okay. It differs a bit between whether it's estrogen or progesterone, for example. Some of the most severe concerns with estrogen would be an increased risk of what we call thrombotic events. That would be a stroke or a blood clot, which is the same risk that you would see in a cisgender female taking exogenous -- exogenous means a medication you are having to take as opposed to endogenous, meaning made within the body. So those are the same risks that we go over with a cisgender female starting estrogen. And another is particularly concerning with oral estrogen preparations, and that would be irritation of the liver. So we are screening for those things and discussing them prior to starting therapy.
Then, for testosterone, some of the adverse effects that we see might be increase in your cholesterol, your LDL, which is the bad cholesterol in your cholesterol panel, or mood changes, for example, acne, that sort of thing.
Q. And I think you mentioned this. But when you use testosterone and estrogen for non-trans patients for other purposes, do you inform them about these risks?
A. Absolutely, yes, uh-huh.
Q. Did you inform families about the reversible and irreversible effects of treatment?
A. Yes. We separate out the effects of these therapies into

reversible and irreversible categories so that we can kind of help separate that in the family's mind.
Q. And did the informed consent process include informing families about the limitations on what's known about the effects and risks of treatment?
A. Yes. Specifically, with every family I would point out that the length of time that we've been -- when I say we, I mean the world's medical community -- has been treating patients with cross-sex hormones is limited and that we will learn more as time goes on but that we have to base our decision-making today on what we know today.
Q. When would these discussions about informed consent take place?
A. So for most families, they are coming in on day one with lots of questions, so they usually want to jump right to what is testosterone going to do to me. And I have to say, slow down, we have a lot to talk about before we get there. But we start answering those questions as early as the first visit. So these are ongoing conversations. But what I would consider to be the formal consent process, which is sitting down face-to-face and going point by point through all of the changes, risks, benefits, side effects, etc., that happens generally in one sitting.
Q. Okay. And when you go over that stuff point by point, was the information provided in any kind of document for the

families?
A. Yes. We created two different written consent documents, one for what we call the feminizing consent -- that's for the use of estrogen -- and one being the masculinizing consent, and that's for testosterone.
Q. Why did you do that?
A. I felt -- personally, I'll confess. I actually use it as a way to make sure that I hit every single point. I use it as a checklist to make sure that I hit all the points. I don't want to miss anything. That way also the family has something they can take home and read over later. Selfishly, it was a way for me to have just documentation that I had reviewed all this information with each family.
Q. Now, you mentioned the consent forms for testosterone and estrogen. Did you inform patients about any risks associated with the puberty blockers?
A. We would, of course, do informed consent, as we would for any other medication. But I did not use a written consent form for that medication.
Q. What are some of the potential risks associated with puberty blockers?
A. So the biggest risks -- and note that I've been using puberty blockers for over 20 years for kids with precocious puberty. The biggest side effect that we see is pain of the injection site, because it is an intramuscular injection. It's

a pretty big needle, and it hurts a bit. Second would be sometimes we see a slowdown in their linear growth while they are on the medication, so we watch for that. Thirdly -- those are really the only side effects that I see in practice. There are some theoretical side effects that we discuss, such as the fact that what we call bone mineral density, which is different from growth. We, as humans, get most of our -- a lot of our bone mineral density during the time of puberty. So when you put somebody on a puberty blocker, you are delaying that, so there's a theoretical risk that it might affect bone growth -- not growth, but density. And we discuss that. Most data has shown that that risk hasn't really panned out in the literature.

Q. Now, some of defendants' experts mention a risk of brain development related to delaying puberty. Is that not a risk you identify to families?

A. I personally do not think of that as a significant or measurable risk. And the reason for that being, in my general endocrine clinic -- and I don't know what it is about the state of Arkansas. There's an epidemic of boys developing late puberty here that I haven't seen in other states. But I've taken care of a large number of kids --

MS. TEMPLIN: Your Honor --

THE WITNESS: -- with delayed puberty. I'm sorry.

THE COURT: Stop talking.

THE WITNESS: Oh, I don't hear very well.

MS. TEMPLIN: Before we finish this, as I understand it, Dr. Hutchison is not an expert witness. And under 702, a lay witness may not opine on expert testimony. We object under 702.

MR. BODAPATI: Your Honor, I don't believe that Dr. Hutchison here is providing expert testimony. She's explaining why she would not inform patients about this theoretical risk to brain development as a matter of her practice and experience. It bears on how patients were being treated here in Arkansas.

MS. TEMPLIN: Plaintiffs explicitly asked her about some of defendants' witnesses, which is why it sounded to us as though it was about expert testimony.

MR. BODAPATI: That was just a bit of context.

THE COURT: Overruled. Go ahead.

BY MR. BODAPATI:

Q. Now, I believe you were mentioning that you had seen some patients I think in your general endocrine clinic who had also been on puberty blockers. Could you just pick that back up?

A. Yeah, sure. I've treated a large number of patients with puberty blockers for precocious puberty.

Q. And did you see any adverse effects on their brain development in your clinical experience?

A. None that I could detect, no.

Q. Did you inform families of any potential risks related to testosterone suppression for trans girls?

A. Yes.
Q. Could you list a couple of those risks?
A. Sure. We have a couple, two different medications that we use sometimes in combination. One is called spironolactone or Aldactone. It is a mild diuretic, which means sometimes it can increase your urine output. So I will caution them to be aware of that, make sure they stay hydrated and, you know, have access to the bathroom, because sometimes it increases their need to go to the bathroom. It can, in rare instances, increase your potassium level, so we check that at baseline. And then, once the patient has started on that medication, we repeat labs at one to two weeks to make sure that they are tolerating the medication well.

The other medication that we use is a form of progesterone. And, as I would counsel any person starting progesterone, whether they are cisgender or transgender, that medication has the potential to cause mood changes or worsen depression and can also cause some weight gain. So that is a medication, for example, I would not recommend in somebody who had severe untreated depression.
Q. You also mentioned risks related to fertility. What did you inform patients and their families about that?
A. You mean with regards to the testosterone blockers?
Q. Sure. Or just the medications generally.
A. So testosterone blockers are considered fully reversible.

So I generally would not discuss fertility implications with that medication, although it can -- we use it primarily in our transgender girls to decrease, for example, spontaneous erections because girls don't like that. But it doesn't have impact on long-term fertility to my understanding.

In terms of the cross-sex hormones, there is the potential over the long term for it to affect fertility. So the specific conversation that I have with the patients is that if they are interested in having their own biological children, we need to discuss fertility preservation. If they are not interested in having their own children, we still need to talk about ways of preventing pregnancy because there's no guarantee that these therapies will actually prevent you from being fertile. So we actually have to talk about it from both angles.

Q. Okay. Just cycling back to puberty blockers for just a couple of quick questions, when you've used blockers for gender dysphoria, did you delay puberty beyond the normal age range for puberty?

A. No.

Q. So I thought you had mentioned before, but just to confirm so I didn't miss it, did you ever encounter any patients in your general endocrinology practice who had naturally delayed puberty into their teens?

A. Yes. In quite a few. It's actually not uncommon in white natal males.

Q. Just to confirm, for those patients, did you see any adverse effects on their brain development?
A. Not that I could discern.
Q. You mentioned that, in addition to requiring informed consent from the parents, the clinic protocols you developed required that you first determine that the patient has the capacity to understand the risks and benefits of cross-sex hormone therapy before providing such treatment. How did you determine if they had that capacity?
A. Sure. So at that point I will have met with the patient on multiple occasions, so I have my own assessment to rely on. Very importantly is the assessment of the parent who lives with that child and can share with us their understanding of whether they think their child is ready to make that sort of assessment. Thirdly, there's the visit with our clinical psychologist; and then, of course, their community therapist with whom they have been meeting regularly.
Q. Did you ever have any patients who you felt did not have the ability to understand the potential risks and benefits of treatment?
A. I've certainly had patients that I felt were not ready at that time but that might be able to do so later, yes.
Q. And so what did you do in those situations?
A. We deferred treatment and asked them to keep working with their therapist and follow up with us on the regular clinic

schedule.
Q. Now, I would like to focus a few questions on the requirements before initiating pubertal suppression and testosterone suppression. What were the requirements under the clinic protocols you developed for initiating pubertal suppression?
A. Okay. So for pubertal suppression, they must show evidence of pubertal development. So I would not consider using those medications in somebody who is still prepubertal. And evidence of puberty having started would be either physical signs or, if the patient is unwilling to have a physical exam done, we might draw blood to look for biochemical evidence that puberty has started. Secondly, there has to be parental consent. And thirdly would be persistence of the gender identity once puberty has started.
Q. And what were the requirements under the clinic protocols you developed for initiation of testosterone suppression?
A. So because that's a fully reversible therapy, the criteria are not as strict as it would be for, say, testosterone or estrogen. So, again, it's parental consent and evidence of gender dysphoria and them being pubertal. If they were prepubertal, there would be no reasons to use those medications.
Q. Now, you mentioned that the requirements here wouldn't be as extensive as for the cross-sex hormone therapy like testosterone. Why is that?

A. Because testosterone causes permanent changes to the body. And so, in my mind, you need to have a higher degree of confidence in your diagnosis for that, whereas with a testosterone blocker, because it's reversible -- when you stop that medication, the physiology goes back to what it had been prior to the medication. So there's a lower -- I guess you could say a lower bar to meet for those medications.
Q. Is that true for the puberty blockers too?
A. Yes, in general.
Q. At Arkansas Children's Hospital, how long have your patients on blockers for gender dysphoria remained on that treatment?
A. Remained on puberty blockers?
Q. Yes.
A. Generally until it's -- either until such time as they decide they don't want to continue it or it's time to consider cross-sex hormone therapy. So the minimum age for that would be 14.
Q. If you had to give a rough estimate, about how many years would they be on the blockers for gender dysphoria?
A. So if puberty started at, say, 11 and, you know, maybe you are looking at three years, something like that.
Q. Okay. You mentioned that you also used puberty blockers for patients with precocious puberty. About how long would those patients stay on blockers?

A. So that's also a variable number that depends on when puberty starts. But, for example, if I have a girl who is showing signs of puberty at six, she may be on that puberty blocker from age 6 until 11 or 12, so five to six years, something like that.
Q. During your time treating patients at Arkansas Children's Hospital's gender clinic, can you describe how gender dysphoria manifested in your patients before they began treatment?
A. Sure. This is a conversation that I have with every new patient because I want to get to know them. But the types of stories that I hear are things like having to cover up all the mirrors in their room so they don't see themselves because it makes them upset or having to take a shower without ever looking down because they don't want to see their genitalia. Even though they may want to play sports, they are avoiding sports because they don't want to change clothes in the gym in front of other people. And then the depression and anxiety that results from that is generally what most of our kids are struggling with when they come to see us.
Q. You mentioned depression and anxiety. Would that ever escalate or manifest in self-harming ideation or behavior?
A. Yes, yeah. We would ask those questions. Yes, it was common for patients to have either a history of suicidal ideation or self-harming behavior.
Q. And had any of your patients made attempts at suicide

before coming to the clinic?
A. Unfortunately, some of them had.
Q. What has been your experience regarding how your patients have responded to the cross-sex hormones you provide?
A. The experience has been very gratifying. Watching these kids start smiling, go back to school, doing better in school, interacting better with their friends, interacting better with their siblings and not fighting as much with their parents, these are the sort of things that I hear, not just from the patients, but from their families when they come back to see us. Seeing kids go from being sort of taciturn, quiet, withdrawn, to confident, happy, smiling, thriving people, who -- this is something that occurred to me the more I thought about it was very rarely did I ever have a patient come in on that first visit talking about their future. It's really striking how these kids, once they start seeing themselves in their gender and feeling more peace, that they start talking about the future. They start talking about going to college or enrolling in a program to become a master electrician or whatever. That's I think really striking to me.
Q. Did the treatment have any impact on co-occurring mental health issues like the anxiety and depression you mentioned before?
A. Sure. We definitely saw a decrease in anxiety scores once the kids start therapy, hormone therapy specifically. And many

of the kids were able to either decrease their antidepressant dose or come off the medications altogether.

Q. And so testifying about these patients who are treated who saw benefits to their mental health and well-being, how common was that?

A. It's pretty common. That's really the vast majority of the patients. You know, there's a few stoic kids who, if you ask them, hey, are things better? You know, I guess. These are teenagers, okay? For the most part, these kids are coming in and telling, giving me examples and stories of how they are doing better.

Q. But do some of your patients still struggle with any mental health issues even after starting hormone therapy?

A. Sure. Being a teenager is hard. Being transgender is hard. Doing both at the same time is hard. So, in fact, one of the things that we talk about in the consent process is I want to make sure that the families understand and the patient understands that the depression and anxiety may not just magically melt away just because they are starting hormone therapy and that that's something they are still going to need to work on and potentially deal with later.

Q. Do you have any information about how your patients do after they age out of the clinic as they get into their 20s?

A. Yes. We are very fortunate, I think, that a lot of our patients stay in touch with us. Just two weeks ago I got an

email from one of my very first patients. She's a sweetheart, and that was lovely. So a lot of them stay in contact, swing by, say hi, send us emails, that sort of thing. But in addition, before I left the state, I wanted to do some due diligence and make sure that any patients that we hadn't seen in a while were either receiving appropriate care or, if they needed resources or needed to come back to see us, that we could arrange that.

Q. So who did the outreach?

A. It was our staff. Our team did the outreach.

Q. And why did your staff reach out to the patients who were no longer coming to the clinic?

A. Because I asked them to do it. And, like I said, I wanted to make sure that they were doing okay and that if they needed to get back in to see us that we could arrange that and if that they needed any resources we could help them with that.

Q. And when you did get in contact with them, did you ask if they had any mental health concerns?

A. Yeah. We asked them generally, how are you doing? And, to be clear, if they were under 18, we spoke to the parent. And, if they were over 18, we spoke directly to them and just asked them in general how are they doing, are you still on your medication, are you under -- do you have a physician, just generally how are you doing?

Q. About how old were these former patients? About how old

were these former patients at the time you contacted them?
A. I think their ages ranged something like 16 to early 20s. The oldest may have been 23 or 24, something like that.
Q. Approximately how many patients did the staff reach out to?
A. We attempted to reach out to about 60. And, if memory serves, I think we got ahold of 42 or 43, something like that.
Q. When you reached out, what did you learn from the outreach about these former patients' well-being?
A. We learned that quite a few of them had moved out of state to go to school or they were in state going to school. So I was really gratified to hear that a lot of them were actually going to college, that they -- almost all of them were under the care of a physician. A couple of them we had to kind of bring back in, make sure they were receiving oversight. They all said they were doing well. And I want to say really we just got a lot of positive feedback.
Q. Did anyone voice regrets about the treatment?
A. No one voiced regret, no.
Q. You mentioned earlier, when discussing the informed consent process, that there are a number of potential risks associated with cross-sex hormone therapy that you advised families about. In your experience with your patients, have serious adverse health consequences been an issue?
A. It's certainly something we talk about. In terms of serious side effects, we have had a couple of patients show an

increase in their cholesterol profiles, so an increase in their LDL that we had to respond to. A couple of patients had a bump up in their blood pressure that we needed to address. That's on the testosterone side. On the estrogen side, I've had a couple of patients show some irritation to their liver on the oral estrogen, so we had to switch them over to what would be called a transdermal form of estrogen, such as a patch.

Q. Are there ways you can limit those risks to the patients when they present?

A. Sure. And we go over this in detail in the consent process. What I explain to them is the biggest ways that we can prevent complications are you need to come and see us on clinic schedule. Don't miss your visits. You need to call us if you have a problem. If something is hurting, you know, if something is wrong, let us know. Don't sit on it. Do not take more than I prescribe you. That's a big one that I wag my finger at them about. And then we monitor them in the clinic visits with checking their blood pressure, checking their weight and then, of course, repeating lab work to make sure we're not missing a change in their metabolic profile.

Q. Are you familiar with the term "detransition"?

A. I have heard the term. Where I get a bit confused is I think sometimes people use it to mean slightly different things.

Q. What does the term mean to you?

A. My understanding of the term "detransition," it would be

used to describe somebody who identified as transgender, started hormone therapy, like, for instance, started estrogen as a trans female and then, at a later date, decided to stop the estrogen and return to living as a male.

Q. You mentioned earlier that you treated about 320 or so patients at the gender clinic. Are you aware of any of your patients who received cross-sex hormone therapy and later detransitioned?

A. No. We haven't had anybody that fits that description, no.

Q. Now, you mentioned earlier you had some patients who came to the gender clinic and later came to realize that they weren't trans. Right?

A. That's correct.

Q. Had any of those patients initiated cross-sex hormone therapy before they came to that realization?

A. No. By talking to us and working with their therapist, we had a few kids who decided that they weren't transgender. I have always said I personally consider that to be a win, that we help these kids out on their journey, and they figured out who they were.

Q. Have you learned that any of your gender clinic patients who had been on hormone therapy had come to regret that care later?

A. We have not had anybody voice regret, no.

Q. Based on your experience treating your patients, for those

currently undergoing hormone therapy, do you have any concerns about what would happen to them if Act 626 took effect and they had to discontinue treatment?

A. Yes. Yes, I do. And I've seen evidence of it unfortunately. When House Bill 1570 was first introduced, there was just a ton of phone calls that we had to take from panicked patients and panicked family members. We saw an increase in anxiety scores following the introduction of the bill and an increase in suicidality. So, I mean, I've seen with my own eyes what happens to these kids just at the prospect of losing access to care.

My specific concerns, if Act 626 were to go into effect, are twofold. One is that -- these kids are resourceful. I mean, teenagers are resourceful. And my fear is that a lot of these patients will find ways to get these medications, and they will be doing so without the care of a physician. And I worry for their health doing that. Secondly, and not to sound crass, but I'm generally worried that we're going to lose some kids.

Q. Now, you mentioned around the time that House Bill 1570 came about receiving some panicked calls. Were those just from the patients, or did you also hear from their families too?

A. It was from both patients and parents.

Q. And you mentioned some reports of suicide attempts. Could you tell me how many clinic patients were hospitalized for suicide attempts during that time?

A. I personally know of four of our clinic patients who were hospitalized at our own facility. I subsequently was told of two or three more that had been hospitalized outside of the facility, outside of my own hospital. And that's specifically for actual suicide attempts. There were a number of other patients who were hospitalized at mental health facilities for threatening suicide, for example.

Q. So, in other words, suicidal ideation?

A. Yes.

Q. I think you mentioned this before. But, just to be clear, do you have any data from the clinic quantifying the impact of House Bill 1570 on the mental health of the gender clinic patients?

A. Yeah. At every first patient visit, we do a screener for both depression and anxiety as a way to get to know them better. I didn't notice it until I went back and reviewed the data later. But there was a distinct increase in the anxiety scores of our new patients following the introduction of HB 1570.

Q. Would you be able to roughly quantify what that increase was?

A. So roughly, prior to the introduction of the bill, our new patients were scoring positive for anxiety at a rate of about 40 percent. And that went up to over 60 percent, like in the low 60 percent range after the bill.

Q. Dr. Hutchison, why couldn't your patients and other

adolescents with gender dysphoria just wait until they are 18 and get hormone therapy then?
A. Well, for one thing, their bodies will continue to develop the sexual characteristics, the gender characteristics, that are not in keeping with their gender identity, which is just going to increase their dysphoria and their depression and anxiety, which means that they are going to have to live additional years with that preventable stress and distress. So that just seems kind of cruel. And, secondly, I generally -- these kids are at a high risk for self-harm and suicidal behavior. And I think forcing a child to have to wait until 18, I just worry that some of these kids are going to hurt themselves.
Q. Did the gender clinic change its protocols at any point in the past years?
A. Yes. In I believe it was early February of this year.
Q. What changes were made?
A. We specifically changed the protocol such that any new patients who came in, we would not treat them with medication, so no puberty blockers or cross-sex hormones. And any established patients who had not yet started cross-sex hormones would not be able to do so within our clinic. But any patients who were already on either estrogen or testosterone would be able to continue.
Q. Who made that decision?
A. It was the leadership of the hospital, Arkansas Children's

Hospital.
Q. So it wasn't a medical decision made by the doctors in the gender clinic?
A. No.
Q. Did the hospital leadership inform patients and their families of the reason for the change?
A. Yes. I saw a copy of the letter that was sent to the families.
Q. And what reason did they give?
A. My recollection from seeing the letter was that their concern was that this bill might go into effect in the near future and cause disruption in the patients' care. I think they used the word "disruption" of care if memory serves. And so rather than wait for that to happen, they wanted to kind of -- the way I explained it to the families is that they wanted to get out ahead of that and go ahead and be proactive and make the changes rather than waiting for that to happen.
Q. You mentioned under the protocol changes that patients who had already been initiated on therapy could continue therapy. Did the clinic continue to provide hormone therapy to those patients who had already been receiving such treatment?
A. Yes, we did.
Q. I would like to now turn to specific patients at the clinic, some of the plaintiffs in this case. Was Dylan Brandt one of your patients?

A. Yes.
Q. How old was Dylan when he first came to the clinic?
A. I believe he was around 14 1/2, something like that.
Q. Did you meet Dylan during that initial visit?
A. Indeed. I met Dylan and his mother.
Q. Did there come a time at some point when you prescribed Dylan hormone therapy?
A. Yes.
Q. Approximately when was that?
A. It would have been testosterone. And I believe it was about eight months, seven, eight months later, something like that.
Q. Now, earlier you discussed the clinic protocols that you followed before initiating hormone therapy with adolescents. Did you follow those same protocols with Dylan?
A. Yes.
Q. Was a psychological evaluation done?
A. Yes.
Q. Did the psychologist find that Dylan met the criteria for gender dysphoria?
A. That was her conclusion, yes.
Q. Was it determined that Dylan had a persistent consistent gender identity?
A. Yes. And he had so for several years at that point.
Q. Do you remember approximately from what age?

A. So, as I recall, Dylan had expressed to me that he had first identified as a male at around age 10 or so.
Q. Did the psychologist do a general mental health assessment of Dylan?
A. Yes.
Q. And was Dylan seeing a therapist?
A. Yes.
Q. Did the clinic consult with Dylan's therapist about his readiness for hormone therapy?
A. Yes.
Q. Did the therapist have any concerns with Dylan beginning therapy?
A. I don't believe the therapist voiced any concerns.
Q. Did you inform Dylan and his mother of the potential risks associated with taking testosterone?
A. Yes. We reviewed the informed consent document.
Q. And did that conversation also include a discussion of the potential risks to fertility?
A. Yes.
Q. Did you determine that Dylan was able to understand and weigh the risks and benefits?
A. Yes.
Q. What led you to reach that conclusion?
A. Meeting Dylan myself, speaking to Dylan's mother and speaking to Dylan's therapist and also the assessment of the

psychologist.
Q. At what age did Dylan start hormone treatment?
A. I believe he had passed his 15th birthday at that time.
Q. After Dylan started hormone treatment, did you continue to see him at the clinic?
A. Yes.
Q. For what purpose?
A. For surveillance to make sure that he was doing well. We're looking, as we do for any medication that we start a patient on, looking for efficacy, meaning is it working as intended, and monitoring for side effects. So, for example, those baseline labs that we did at the first visit were repeated after he had started on the hormone to make sure that he was tolerating the medication well.
Q. And did Dylan have any adverse health consequences related to taking testosterone?
A. Not that I recall. Dylan I don't even think got acne. I think he did very well.
Q. The last time you saw Dylan, how was he responding to treatment?
A. Very, very well.
Q. Would you be able to say a little more about how he was?
A. Gosh, yes, happy to do so. So Dylan, when I first met him, was just obviously a sweet kid, maybe a little shy. After starting testosterone, just watching him gain confidence,

smiling, happy, thriving, this is a patient who had actually decided to home school for a while when I first met him because of some issues he had been having at school. And after starting testosterone, he was back in school, doing well, happy. I remember seeing a picture that he showed me of him in his tux with his date going to prom, I mean, just thriving and happy and talking about his future, you know, just all the great things you want for your child.

Q. And did his mother share with you her thoughts on how he was doing?

A. Sure, yeah. Just corroborated what I was seeing with my own eyes, which is that he was thriving and happy and doing well.

Q. Now, moving on to another clinic patient, did you treat Parker Saxton?

A. Indeed, yes.

Q. How old was Parker when he first came to the gender clinic?

A. I think Parker was a little older, maybe 15 when I first saw him I think.

Q. Did you meet Parker during the initial visit?

A. Yes. I believe I met Parker and his father.

Q. And did there come a time that you prescribed hormone therapy for Parker?

A. Yes. I think it was a little longer than it was for Dylan, closer to a year, maybe 11 months, 11, 12 months, something like

that.
Q. Did you follow the clinic protocols for initiating hormone treatment with Parker?
A. Yes.
Q. Was a psychological evaluation done?
A. Yes.
Q. Did the psychologist determine that Parker met the criteria for gender dysphoria?
A. Yes.
Q. Was it determined that Parker had a persistent consistent gender identity?
A. Yes.
THE COURT: You are reading your questions. And when you read, you go a lot faster than you just speak, so be mindful that when you read you are going a lot faster, whether you realize it or not.
MR. BODAPATI: Absolutely, Your Honor. I will slow down.
BY MR. BODAPATI:
Q. Since what age?
A. I believe Parker related to me that he became aware of his gender identity at around 9, I think.
Q. And was Parker seeing a therapist?
A. Yes.
Q. Did the clinic consult with Parker's therapist about his

readiness for hormone treatment?
A. Yes, we did.
Q. What did the therapist say? Did they have any concerns?
A. The therapist did not voice any concerns.
Q. Did you inform Parker and his father of the potential risks associated with taking testosterone?
A. Yes.
Q. Did you determine that Parker was able to understand and weigh those risks and benefits?
A. Yes.
Q. And how did you know that?
A. So at that point I had met with Parker multiple times myself. I had the opportunity to speak with his father and get his father's opinion on that. We, of course, reached out to the therapist, and then there was the psychologist's evaluation as well.
Q. And how old was Parker when he started hormone treatment?
A. I think he had passed his 16th birthday at that point.
Q. After Parker started on treatment, did you continue to see him?
A. I did.
Q. For what purpose?
A. As with Dylan, it was to monitor efficacy and safety, make sure that he was doing well, make sure that his cholesterol stayed in the normal range, that his blood pressure was normal,

that his testosterone levels stayed in the normal range, that sort of thing.

Q. And did Parker have any adverse health consequences related to taking testosterone?

A. I think there might have been an increase -- I can't remember if he had a baseline high cholesterol or it increased after starting testosterone. I think there might have been a mild cholesterol issue. As I recall, it was mild.

Q. So the last time you saw Parker, how was he responding to the treatment?

A. He was doing great. So this is a kid, again, a little different from Dylan. When I first met him, I would definitely put him in that taciturn teenager category -- I think we all know some of those -- didn't smile a lot, was kind of grumpy and quiet. But this is a kid that -- he is a smart kid. You could see the wheels turning, like he thinks. He's a deep thinker, I think, really thinking about things. And he was asking really probing questions like from day one, always had good questions, always challenging me. And with him, getting to see him really open up and start smiling and his dad telling me he's smiling and doing well in school and has friends and just showing that confidence that any parent wants for their child, it's just really -- I feel very privileged to get to watch that happen.

Q. Finally, I would like to ask you about one more clinic patient. Did you ever see Brooke Dennis?

A. Yes.
Q. How old was Brooke when she first came to the clinic?
A. I think she was eight.
Q. Did you see her with her parents?
A. Yes.
Q. Was any medical treatment considered during that visit?
A. No. Brooke was prepubertal at that visit, and we wouldn't have even considered using any medical therapy for gender purposes at that point.
Q. So what was discussed at the initial visit with Brooke?
A. Sure. We answered a lot of questions, not so much from Brooke, because she's quite young, but from parents. We discussed the potential for what might happen when she started puberty, that we needed to watch for signs of puberty and what I wanted them to watch for, that as we got closer to the time when puberty would start naturally, we might want to see her more often so that we can evaluate how she responds to that and that if she continues with her female gender identification once puberty has started that at that point we could discuss using a puberty blocker.
Q. Now, just one final line of questioning. When you heard about House Bill 1570, did you speak with the legislature about it?
A. I did.
Q. Did you testify against the bill?

A. I did.
Q. And why did you do that?
A. I had a genuine fear of how the bill would affect my patients. Just getting to know these patients and seeing the challenges that they face, I genuinely feared that they would not do well if this bill were to go into effect.
MR. BODAPATI: Nothing further, Your Honor.
THE COURT: We probably need to take a break to discuss how we're going to handle the transition between the direct and cross that we mentioned before. I don't know that we need to take a break to do that.
Doctor, I would ask that you sit tight and listen because it may affect what you say or don't say in the presence of our audience. We're talking about HIPAA issues and whatnot. I don't know if you were present in the room when we discussed those.
MS. TEMPLIN: Your Honor, we have split out our questioning into stuff that is not confidential and then a second portion that covers medical records. Some of it the plaintiffs already discussed with the doctor just now. But we, of course, are willing to clear the courtroom. We've agreed to keep that confidential. And I will let the Court know when we get to that section of questioning.
THE COURT: Okay. And you mentioned something about party-opponent versus not party-opponent. Is that going to

affect anything you plan to do here today?

MS. TEMPLIN: It won't affect the medical records. The parties have stipulated to that. There is one potential evidentiary thing we have considered offering, and I guess we'll get to that point in cross. Our position would be that because they didn't move until right before questioning --

THE COURT: Well, we can get to that when we argue that. I'm going to let you go ahead and tell me when you think you are getting to the point that we need to consider clearing the courtroom.

MR. JACOBS: And if I could just briefly kind of update the Court on the scheduling. Assuming Dr. Regnerus is allowed to testify remotely from being overseas -- we've accounted for the time difference -- currently we can have everything done between November 28th and December 1st -- that's the Monday through Thursday -- subject to we are waiting to hear back from Dr. Ho and Dr. Cathey, two of the three subpoenaed witnesses. But assuming that those two are available at some point during that four-day period, we can be done in the four days between November 28th and December 1st based on what we've confirmed with all of our experts while we've been trying to sit here. We don't have to do anything about that yet in terms of decision-making.

THE COURT: Until you hear from everybody, I don't have an option.

MR. JACOBS: Understood, Your Honor.

THE COURT: Thank you for the update.

MS. TEMPLIN: Your Honor, was your plan to take a break right now or continue with questioning? I know you mentioned a break a couple of minutes ago.

THE COURT: Now is as good a time as any. We're going to go until about 12:15, if you will recall, because of my 12:30 criminal matter. So we'll take a roughly ten-minute break. We'll come back then. Court will be in recess.

(Recess from 10:59 a.m. until 11:15 a.m.)

THE COURT: We are back on the record. You may begin your cross-examination.

MR. JACOBS: Your Honor, this is Dylan Jacobs. Before we start on that, I was not in the courtroom. I was informed that there was some conversations that were going on with members of the media about the stipulation issue.

THE COURT: They asked me, to begin with, whether or not I was going to schedule any of this hearing during the election week, and I told them no. I told them that the reason I was thinking that this case would go shorter was because the joint stipulation led me to believe that y'all had jointly stipulated to those facts and that you hadn't. The press asked me, well, what's on there? And I said, "I think it's on PACER. If you would like to look there, you may." Then we went into the fact my Mack truck case that's set for two weeks has a

similar problem with Veteran's Day. And it was really more of a situation where I was telling them that we set six or seven criminal cases on any given Monday hoping that some will settle and not.

With regard to the stipulations, that was just that. We didn't discuss any particular stipulation, only that that was what led me into the Blue Angel issue where I'm headed into the ground thinking we're going to get things done sooner than possible. But we didn't discuss any facts of the case or any particular stipulation, only that that's what led me to believe we could be shorter than we were.

MR. JACOBS: I think I understand. Assuming that issue is resolved for our purposes, I think that's all I was inquiring about.

THE COURT: That's fair enough. We got to talking about generally how many cases in the world, what percentage of civil cases settle and what percentage of criminal cases ultimately plead and what happens when I have six cases set and four of them don't.

MR. JACOBS: I appreciate the clarification, Your Honor.

THE COURT: Sure.

CROSS-EXAMINATION

BY MS. TEMPLIN:

Q. Dr. Hutchison, my name is Hannah Templin. I work for the

Arkansas Attorney General's Office and will be asking you some questions today. I will try not to retread everything you've already been through, but we'll see. So you testified that you worked at the gender spectrum clinic here in Little Rock for some time. How many years was that?

A. Let's see. We started the clinic in February of 2018, and I left in July of this year.

Q. About four years. What was the demographic ratio of natal males to natal females presenting at the clinic during your time there?

A. It changed subtly a little over time, not dramatically. But I want to say roughly -- these are rough numbers. I don't have anything in front of me -- roughly 60 percent were natal female, and the remainder of that was primarily natal male.

Q. And you testified that you had four patients on puberty blockers during your time. Right?

A. There were four patients in the clinic on puberty blockers. I only initiated two of those.

Q. Did all four of those patients transition to hormone therapy?

A. I know of at least one for sure that I can think of who did. I'm not certain of the other three. They may still be on hormone blockers for all I know.

Q. And you said -- I believe you testified you had approximately 300 patients on hormone therapy at some point

during your time there. Right?
A. I don't think that's accurate.
Q. Okay.
A. I think I testified that I had seen about 300 to 320, but not all of those kids were on -- sorry. Did you say hormone blockers?
Q. Hormone therapy.
A. No. Not all of them were on hormone therapy.
Q. Thank you for that clarification then. About how many would have been on hormone therapy?
A. By hormone therapy, you mean cross-sex hormones like estrogen or testosterone?
Q. Yes.
A. Probably -- it's hard to say for sure without having it in front of me -- more than half, but I'm not entirely sure about that number. Maybe 160 or so.
Q. Do you know approximately the number of your patients who received feminizing hormone therapy?
A. So of the number that we're -- now you're making me do math. So if we had, say, about 160 on hormone therapy, and the predominance of those would be on testosterone, so somewhere below probably more like 60, but these are rough numbers.
Q. Of course. And about the number who would have been on masculinizing hormone therapy then?
A. So the remainder would be on testosterone.

Q. You also testified, I believe, that the clinic is no longer prescribing puberty blockers to new patients. Is that right?
A. That is correct.
Q. Do you know if the clinic would restart prescribing puberty blockers if the Act were enjoined?
A. I do not know that.
Q. You also testified that the clinic is no longer prescribing hormone therapy to new patients under 18, right?
A. That is correct.
Q. Is it still offering hormone therapy to patients above age 18?
A. Keeping in mind that I no longer work in that clinic --
Q. Right.
A. -- to my knowledge, that would be accurate.
Q. And same question. Do you know if that policy would change if the Act were permanently enjoined?
A. Since I don't work there anymore, I can't speak to what their intentions are.
Q. Of course. Do you know what the gender clinic's rule is now that it's not taking new patients for either puberty blockers or minors getting on hormone therapy?
A. Well, my understanding is that they are still accepting patients into the clinic, but just not providing hormone therapy or puberty blockers. So there's a lot of questions to help the families understand what their child is going through, help

support the child, provide resources and help link them up with a counselor, so there's still a lot of resources to be provided and a lot of just affirming support to be provided.

Q. Are there similar clinics offering those same sorts of resources in Arkansas that you are aware of?

A. I can't speak to specifically what other clinics offer, but I would assume that they do.

Q. Before the gender clinic started operating, were there other clinics that were offering hormone therapy to minors in the state of Arkansas?

A. I'm not entirely sure. There might have been some providers doing so, but I couldn't say for sure.

Q. I believe you testified also that you practiced as part of an endocrine clinic?

A. Uh-huh.

Q. Do you treat any of your gender clinic patients at your endocrine clinic?

A. There was actually a little bit of an overlap. For example, I had a number of kids who had both type 1 diabetes and transgender. Those were very long clinic visits, and I would split it. I would say, okay, for the first half-hour we're going to talk about diabetes. Now we're going to talk about gender. And it was a lot of work, but we did it.

THE COURT: Doctor, can you slow down?

THE WITNESS: I'm so sorry. Yeah. I get excited. So

those kids who, for example, had both diabetes and gender dysphoria, those were long visits. I would treat their diabetes, adjust their insulin doses, go through all their data. Then I would take off the diabetes hat, put on the gender hat, and talk about gender. I had to, in my mind, kind of split those. Then I also had some kids who I think had some thyroid disorders. And, in general, anytime I saw a child in the gender clinic, if I identified a medical need, such as hypertension, obesity, high cholesterol, we address those things as well.

BY MS. TEMPLIN:

Q. Just to clarify, you said when you would talk to them about gender dysphoria, gender issues, you would be putting on your gender clinic hat, not your endocrine clinic hat. Right?

A. There's a lot of overlap. But it was helpful to the patients to separate them a little.

Q. So you also testified, I believe, that you require a psychological evaluation for anyone who is going to pursue hormone therapy at the gender clinic. Right?

A. Yes.

Q. Do you require a gender dysphoria diagnosis specifically?

A. Yes.

Q. Were there any other gender identity related conditions that you would treat at the gender spectrum clinic?

A. I'm not sure exactly how to answer that question. We were diagnosing gender dysphoria using the DSM-5 criteria and really

focused on that.
Q. Would you treat any individuals who were not diagnosed with gender dysphoria, perhaps a non-binary individual?
A. By treat, I use that word to mean give them counseling, recommend them to a therapist, yes. That patient may or may not require medical treatment with medication.
Q. Would you prescribe puberty blockers or hormone therapy to that individual if they requested it?
A. Well, again, it would be on a case-by-case basis. We had, not to my recollection, been faced with that specific possibility, but I think we would have to take that on a case-by-case basis.
Q. So you also talked about, in your testimony, about puberty blockers and said you prescribe them both for your patients with endocrine issues and with gender dysphoria. Right?
A. Correct.
Q. What are the reasons why you would prescribe those to a non-transgender patient?
A. The FDA-approved indication and how we used it was for, in my clinic, was to use it for children who started puberty early. These medications are used sometimes in cancer treatment, but I'm not part of that. So we used it in the general endocrine clinic for kids who are starting puberty too early.
Q. About what age counts for starting puberty too early?
A. So there are agreed-upon definitions for what's called

precocious puberty. So that would be, for example, a girl starting puberty before age 8 or a boy starting puberty before age 9. The cutoffs are different for boys and girls.

Q. How would you diagnose that?

A. So both with a physical exam, so, in other words, if it's a natal female, developing breast tissue or, if it's a natal male, it would be increased size of the testicles. And then we would confirm that with blood work to look for increased serum levels, blood levels of either the sex steroids or certain hormones called a gonadotropin. These are the hormones that come from the pituitary to regulate the production of sex steroids.

Q. Generally when would you stop the treatment for precocious puberty?

A. Usually around the time that you would expect the child to go into puberty naturally, which coincides with when insurance doesn't want to pay for it anymore, which is around 11 to 12.

Q. Are there any particular criteria that you use to determine whether a particular child is ready to get off the blocker?

A. It really has to do with family preference and that age. So occasionally we may have a child who says they just don't want to take the shots anymore, and they may stop at 10. But most patients and families are interested in continuing it until that cutoff is about 11 to 12.

Q. Generally not beyond 11 or 12. Right?

A. We would not generally do that.

Q. What about your transgender patients? At what age do you prescribe puberty blockers to them?
A. So that is age dependent, and it would depend on when they start puberty. So if they are, for example, a little delayed and don't start puberty until 12, we would start them at 12.
Q. So does that mean that you would end up prescribing it to them for beyond 11 or 12 in some circumstances?
A. Yeah. In that case they might be on it for the two years between, say, 12 to 14.
Q. When do they generally stop?
A. Generally at age 14 because that's the youngest age at which we would prescribe cross-sex hormones.
Q. Is there a particular criteria for stopping?
A. So criteria for stopping puberty blockers?
Q. Yes.
A. It would be at the time that the patient requests stopping them or at the time that they choose to transition over to cross-sex hormones. My personal preference would not be to continue them on the puberty blockers indefinitely. I just don't think that that's probably beneficial for the patient.
Q. I know you've had a limited subset of patients on puberty blockers. But what is the latest that you've had someone stay on them in the gender clinic?
A. At my time that I was there, we did not have anybody approaching -- well, no. We did have somebody who was 13, like

13 1/2 I think was the latest that I personally had anybody on puberty blockers.
Q. Again, just to reiterate, it's an individualized criteria when they decide to move on?
A. That is correct.
Q. Are there any risks to stopping at 14, 15, that age, as opposed to 11 or 12 with precocious puberty?
A. So help me understand.
Q. Apologies. Let me rephrase. Are there any risks to stopping puberty blockers at 14 or 15 as opposed to 11 or 12, which is, as you testified, the average age when people stop if they have precocious puberty?
A. I see. So we're speaking about precocious puberty patients. So if I had started a patient at, say, age 6 and continue them on until 14, by my math that's eight years on therapy, which seems like a long time. And I personally would not want a child to have to wait that long to start puberty.
Q. Are there any risks to your transgender patients for waiting that long?
A. Generally I would say no because they are starting the puberty blocker at a later age than the precocious puberty kids are, so they actually, in general, are on that medication for a shorter duration of time.
Q. Are there any studies confirming that there is no risk to stopping at 14 or 15?

MR. BODAPATI: Objection, Your Honor. Dr. Hutchison is not an expert witness. So rather than getting to the studies, we would ask the defendants focus questions on clinical experience of the patients she has treated.

THE COURT: Rephrase your question.

BY MS. TEMPLIN:

Q. Do you have any indication other than your experience that there is no increased risk, or are you basing this off of your experience as a clinician?

A. I am not aware of any increased risk.

Q. Just to also confirm, do you obtain a signed consent form for patients in the gender clinic who you prescribe puberty blockers to?

A. We do not.

Q. But you did testify that you obtain a consent form to patients who are going on hormone therapy?

A. That's correct.

MS. TEMPLIN: Your Honor, may I approach?

THE COURT: Sure.

BY MS. TEMPLIN:

Q. Do you recognize this form?

A. Yes. I think it's a little darker from being copied. Yeah. It's mine.

Q. What is it?

A. This appears to be a copy of the consent form, the written

consent form specifically for masculinizing therapy, i.e., testosterone.
Q. Does it accurately reflect what you tell your gender clinic patients when they start masculinizing hormone therapy?
A. Sure. There's a couple of little things in here that I would edit now at this point if I could. But, yeah, it's generally the same.
Q. This is what you told them?
A. Uh-huh.
MR. BODAPATI: Your Honor, objection. Before we go any further, I would just note this document is hearsay.
MS. TEMPLIN: Your Honor, this is where we would invoke the opposing party statement because, as Dr. Hutchison has testified, these are the things she was telling her patients when she was treating them. We have other potential bases for entering, but that was the primary place we wanted to raise that.
THE COURT: First of all, I did some research, and she's not considered an opposing party. There's a Northern District of Iowa case, a Georgia case, a Fifth Circuit case and everything that talks about basically 30(b)(6) witnesses who have later testified on behalf of parties that have been dismissed and their depositions or testimony is no longer admissible. This is not her testimony. So you are not offering her testimony against her, so I'm not sure what basis she would

have to admit Defendants' Exhibit 49 based on the fact this isn't her statement.

MS. TEMPLIN: As she's testified, these are the things that she has told people coming into her clinic. This represents her statements, and so these are things she would have adopted, which, under Rule 801(d), are party-adopted statements.

THE COURT: Well, first of all, you are going to have to find another way because I said she's not a party-opponent anymore. Second of all, she said this is what I use with edits.

MS. TEMPLIN: We would argue to the first point, Your Honor, that dismissing her from this case at this stage, right before testimony, is prejudicial to our case since she had not moved to dismiss until this morning. So we would ask that this Court dismiss her after her testimony. But if this Court does not -- decline to do that, I'm happy to offer alternative bases for admission.

THE COURT: Let's move to alternative bases.

MS. TEMPLIN: So we would also offer this as a business record. These are the types of things, that this is the type of form that she regularly keeps and uses to treat her patients.

THE COURT: How do you glean that?

MS. TEMPLIN: As she's testified, these are the forms that she uses with her patients. She testified that it's

accurate.

THE COURT: No. She said these are the things she usually discusses with her patients with certain edits. She didn't -- first of all, she didn't author this. It has to be made by the business in its regular course of business and kept there. The fact that she keeps stuff doesn't make it a business record. It has to be something that she prepared or the business prepares in its regular course of business, so I'm not going to allow it under the business records exception at least on the foundation that you've provided so far.

MS. TEMPLIN: Your Honor, we would also note that this is a consent form where there are initials, places for the parents and the children to initial. So this is the type of record that she would be keeping under the circumstances. In fact, if you turn to page 8 or 9 of the exhibit, this is the type of form that the parents would be signing. It's not simply -- it is something that she would talk about with them, but it's also the type of record that they would be keeping to record consent.

THE COURT: What other option do you have?

MS. TEMPLIN: We would offer this as not hearsay, something not for the truth of the matters asserted in it, but merely just as evidence of what she tells patients, the fact of whether there would be these sorts of risks or benefits.

THE COURT: You are getting some guidance from Mr.

Jacobs.

MS. TEMPLIN: Or, if you are inclined, I could ask her more questions to establish a foundation for the business record exception.

THE COURT: I'm not going to receive it based on what I've heard so far, so it's up to you if you would like to ask more questions.

MS. TEMPLIN: Sure. I will.

BY MS. TEMPLIN:

Q. Dr. Hutchison, you've testified that this is a form that you use to speak with families. Correct?

A. Yes.

Q. And ordinarily you would give this form to the parents to sign and agree to. Right?

A. I'm not sure if it was this exact form. But, yes, they would get a copy of the form.

Q. They would get this form. Would you keep this copy signed by the parents or the children as part of your clinical practice?

A. Yes.

Q. Is there any reason to doubt that this form is accurate or trustworthy?

A. I don't have any reason to.

MS. TEMPLIN: Your Honor, based on her testimony that they keep this as part of their practice, we would offer it

again as part of the business record exception.

THE COURT: She hasn't identified that this was her form, so no.

BY MS. TEMPLIN:

Q. Is this the form that you personally used?

A. I believe so.

THE COURT: That's different than what she said the first time.

MS. TEMPLIN: We would offer it then, Your Honor.

THE COURT: Defendants' 49 will be received.

(Defendants' Exhibit 49 received in evidence.)

MS. TEMPLIN: Your Honor, may I approach again?

THE COURT: You may.

BY MS. TEMPLIN:

Q. Dr. Hutchison, do you recognize this form?

A. Yes. It's the companion for feminizing therapy.

Q. As with the masculinizing therapy form, would you discuss this form with parents and families?

A. If they were starting estrogen, yes.

Q. Would you keep it as part of your records for parental consent?

A. Yes.

Q. And this is your form?

A. I believe so, yes. It looks like it.

MS. TEMPLIN: Your Honor, we would like to offer this

form also under the same business record exception.

THE COURT: Any objection to 54?

MR. BODAPATI: Not at this time, Your Honor.

THE COURT: It will be received.

(Defendants' Exhibit 54 received in evidence.)

BY MS. TEMPLIN:

Q. I don't want to be duplicative and go through both forms, so we will focus on form 54, Exhibit 54. Could you look at page 2 with me, the last paragraph. And that says: "Before beginning hormone therapy or hormone replacement therapy, your child will undergo a thorough psychological" --

THE COURT: Ma'am, you are reading way too fast for my court reporter. Can you start over, please.

MS. TEMPLIN: I can, Your Honor. Apologies.

BY MS. TEMPLIN:

Q. "Before beginning hormone replacement therapy, your child will undergo a thorough psychological and social evaluation performed by our team. We also require that your child is participating in ongoing psychological therapy. We will need a letter from your child's therapist confirming this." Did I read that correctly?

A. Yes.

Q. And just to confirm, this is the psychological evaluation that you testified about earlier?

A. Yes.

Q. Why do you require a psychological evaluation for your gender clinic patients?
A. Everything we require is really to benefit the patient. So it's my belief that any problems that they may be struggling with, such as depression or anxiety, PTSD, whatever it may be, should be addressed and under control before we start medication.
Q. And why do you require ongoing therapy?
A. Like I mentioned before, probably every teenager should be under therapy. But being a teenager is hard, and being transgender and transitioning is hard. And doing all of that at the same same is just exceptionally difficult. So I felt very strongly that the kids would benefit from being in regular therapy as they make this transition.
Q. Do you have a requirement for how long that therapy must continue?
A. My recommendation to the parents, as I verbalized it, was always during the period of transition.
Q. I believe you testified earlier that many gender spectrum clinic patients have had comorbid conditions. Is that correct?
A. That is true.
Q. What are the most common ones, mental health conditions, they might also have?
A. Sure. The most common ones are depression, general ized anxiety, PTSD. And a few of the kids have ADHD, but I think

those rates are equivalent to the general population.
Q. What percentage of gender clinic patients present with depression?
A. I want to say it's roughly 60 percent.
Q. Is that higher than the average population?
A. For American teenagers, it is higher.
Q. Is depression a bar to treatment?
A. I'm sorry. Say that again.
Q. Is depression a bar to treatment?
A. Not in and of itself. But untreated depression would be.
Q. What percentage present with anxiety?
A. Are you talking about before or after the bill was presented?
Q. Before.
A. Before, it was roughly around 40 percent.
Q. And after?
A. It was above 60 percent.
Q. Are either of those numbers higher than the actual population?
A. Yeah. I believe so.
Q. Both of them?
A. Yes. I think so.
Q. Is anxiety a bar to treatment?
A. Untreated anxiety would be.
Q. What percentage present with PTSD?

A. It's 10, 9 or 10 percent, something like that.
Q. Is that higher than the general population?
A. I honestly don't know the answer to that question, but it may be.
Q. And is PTSD a bar to treatment?
A. Untreated PTSD would be.
Q. Do you know what percentage present with autism spectrum disorder?
A. We, in our clinic, it was somewhere around 8 or 9 percent had a diagnosis, established diagnosis, of autism.
Q. Do you know if that's higher than the general population?
A. That has been reported in many transgender clinics, yes.
Q. And is autism a bar to treatment?
A. If we felt the patient was not cognitively able to assent to treatment and if the autism was contributing to that, then the answer might be yes. But, again, that's dependent on the patient.
Q. Generally no?
A. Generally no.
Q. What percentage of gender clinic patients presented with a history of self-harm?
A. I don't remember the exact number, but it's somewhere in the range of 45 to 50 percent.
Q. Is that higher than the general population?
A. Yes.

Q. And is self-harm at all a bar to treatment?
A. If it's happening currently and it is not under control, we would delay treatment.
Q. Could we look at page 3 now of Exhibit 54. There is a bullet point "and either" and number -- well, I should start at the top. It says: "Once the above criteria are met, hormone replacement therapy may be initiated if your child meets the criteria established by the Endocrine Society, which includes all of the following." Then jump down "and either," bullet point 7: "Your child is greater than or at least 16 years old and has experienced a full social transition to the desired gender for greater than or equal to a year or, No. 8, your child is 14 to 15 years of age and has experienced a full social transition to the desired gender for greater than or equal two years." Did I read that correctly?
A. Yes.
Q. Under these guidelines, could a child begin to experience gender dysphoria for the first time at 15 and receive hormone therapy a year later?
A. Technically, as this is written, it suggests that. But in our practice we would probably take more time.
Q. Do you have any patients who have experienced gender dysphoria for the first time after puberty starts?
A. That's very rare. Can I clarify something?
Q. Sure.

A. So the way this is written -- this is, when I said edits, this is one of the things I would edit a bit if I could go back in time and change it. Full social transition actually refers to living in your affirmed gender. It doesn't mark the beginning of that identification. So that 15 year old that you proposed may have identified in their gender at 8 or 9 but just chose to start living in that gender at 15, so social transition means something different.

Q. But assuming that social transition happened around the same time as gender dysphoria, someone could then still get on treatment for a year later?

A. We would probably take more time with that patient because that would be an unusual case.

Q. If a patient presents with gender dysphoria that develops after puberty, is that a bar to treatment?

A. Not in and of itself, but it is highly unusual, so we tend to address those patients a little differently.

Q. Still on this page, the last bolded sentence reads: "After hormone replacement therapy has been initiated, the following will be required." Jumping to No. 3: "X-ray of the hand, bone age, once a year if your child is still growing if needed."

A. Uh-huh.

Q. And No. 4: "Bone DXA scan once a year if needed. This will allow us to monitor your child's bone density, bone strength during treatment, which can be altered by hormone

replacement therapy." Did I read that correctly?
A. Yes.
Q. Why is this a requirement?
A. So, again, this is one of the edits that I would like to make if I could rewrite this form. When we wrote the form, when we developed it, those were our intentions. And then, over time, we realized that, A, it was an added expense to the families that I felt was not beneficial, that the risk-benefit analysis just didn't pay out. Many of the patients who come to us are self-pay, and these are expensive modalities. So, as we talked about it and decided that these actually weren't really all that important, we did not make those a requirement.
Q. So, to clarify, gender clinic patients did not have to monitor their bone density.
A. That's correct.
Q. Why were those requirements in the form in the first place?
A. So this form is now pretty old. It's a little outdated. I think at the time we were just trying to be very conservative. And there were theoretical concerns for, as we discussed earlier, bone density accrual during the time of puberty being delayed by using, for instance, a puberty blocker. And, as time went by and working with patients and reading the literature, I just made the decision that this was not a significant risk to patients and therefore it did not need to be a requirement any longer. And then, of course, there was the cost issue. So,

again, if I could go back and edit this form, I would remove those.

Q. You mentioned just now reading the literature. Are you aware of literature conclusively establishing that there is no risk for bone density?

A. I don't believe there's any literature that conclusively states either way.

Q. Let's then flip to one more page. For some reason the page numbers all show up as the same on my copy.

A. Yes. That's another edit that I would like to make. After page 4, they all say page 10. That was a mistake.

Q. Let me try to make sure I find the right one.

A. Sure.

THE COURT: Are we still working in Exhibit 54?

MS. TEMPLIN: Yes, Your Honor, we are.

THE WITNESS: If you just tell me what it says at the beginning of the page, I'll find it.

BY MS. TEMPLIN:

Q. At the beginning of the page, it says: "Please initial each statement," and the first bolded thing is effects of feminizing medication.

A. That's the fifth page.

Q. It is, yes. The bottom indent, where patients could consent, reads: "I understand that my adolescent's body will make less testosterone. This may affect sex life in different

ways and the future ability to cause a pregnancy." Did I read that correctly?
A. Yes.
Q. Is that something -- I believe you testified you tell your patients that?
A. We go through everything that's on this form, yes.
Q. Is this a consequence of testosterone treatment for your non-transgender patients?
A. So this is the feminizing form, so this would be a consequence of estrogen.
Q. I apologize. Sorry. Is this a consequence of estrogen for your non-transgender patients?
A. No. Because in my non-transgender patients, I'm using estrogen in a natal female, so it wouldn't affect their ability to get someone pregnant.
Q. Is there a similar consequence, say, for masculinizing hormone therapy in transgender natal females who are transitioning to male for risk of infertility?
A. Using testosterone in a transgender male, for example?
Q. Yes.
A. Yes. So we discussed the potential that it might not be possible for them to become pregnant or carry a pregnancy later.
Q. Is that a consequence of testosterone treatment for your non-transgender patients on testosterone?
A. Well, boys can't get pregnant, so no.

Q. What about would it risk their ability to get someone pregnant?
A. In a cisgendered male?
Q. Yes. Testosterone.
A. Well, that's a tricky question because many of the boys that we use testosterone in already have some underlying infertility problems, they are hypogonadal or have Klinefelter's. They have baseline inability to be fertile, so that's a difficult question to answer.
Q. But the testosterone prescription that you are giving them is not the cause of the infertility in that case.
A. Yes. I see what you are saying. That would be an accurate statement.
Q. How long would a transgender female have to be on estrogen treatment to become infertile?
A. I don't believe we have that data.
Q. Do you have data for a transgender male on testosterone?
A. I do not.
Q. One last question about this. Are the teenagers at your clinic usually sexually active?
A. Interestingly, most of them are not. I think that what they have related to me is they feel uncomfortable in their bodies, and so many of them are not.
MS. TEMPLIN: Your Honor, can I have a minute?
THE COURT: Sure.

MS. TEMPLIN: Your Honor, I believe we're ready to move on to the confidential portion of this examination, however the Court would like to proceed with that.

THE COURT: All right. Well, who are we going to be talking about? All of the named plaintiffs?

MS. TEMPLIN: The minor plaintiffs treated by Dr. Hutchison.

THE COURT: As a group or individually? What I'm trying to figure out is --

MS. TEMPLIN: Individually, Your Honor. We're happy to start with -- we can tell you the order.

THE COURT: I can ask the audience generally to leave. What I'm trying to figure out is, as between the plaintiffs, who are entitled to be here throughout the testimony, how the plaintiffs' particular medical information as between them is to be handled.

Ms. Cooper, you are looking around the corner. Is that because you are going to talk, or is somebody else going to try to thread that needle for me? Do you understand the question?

MS. COOPER: We are just conferring. One moment, Your Honor.

Your Honor, all of the plaintiffs can remain in the room for all of the discussion.

THE COURT: Can each of them confirm that they are okay for other plaintiffs to be hearing their medical testimony?

MS. COOPER: Yes, Your Honor.

THE COURT: I'm going to ask them to do that once we clear the courtroom. I'm going to ask everybody that's not a party or a lawyer to this action to please step out in the hall likely through lunch because we're breaking at 12:15 to handle my criminal docket. If they finish before that, I'm going to break for lunch in any event until 1:30.

[Sealed proceedings under separate cover.]

REPORTER'S CERTIFICATE

I certify that the foregoing is a correct transcript from the record of proceedings in the above-entitled matter.

/s/Elaine Hinson, RMR, CRR, CCR Date: October 26, 2022.
United States Court Reporter

(Proceedings resumed at 1:29 p.m.)

THE COURT: We're back on the record. I'm going to ask everybody to look around the room and confirm after the lunch break only those so-called authorized individuals are in the room and everybody is satisfied that we may proceed on the sealed portion.

Is everybody -- does anybody have a complaint about who we have in the room?

MR. JACOBS: Your Honor, Dylan Jacobs. We got one change. So Shannon is no longer here, but in the courtroom now who was not in before lunch is Julie Benefield, the chief deputy AG. So I don't know if the Court would like to --

THE COURT: What's her involvement in this case other than being a spectator?

MR. JACOBS: Would the Court like to --

THE COURT: Or you can speak to her. I'll speak to her.

MR. JACOBS: If the Court wanted to engage in sort of what happened before --

THE COURT: Ma'am, what involvement do you have in the case?

MS. BENEFIELD: Your Honor, I'm Chief Deputy Attorney General. I am helping oversee this case. The --

THE COURT: What particular involvement do you

have with the medical records that are going on in this sealed portion?

MS. BENEFIELD: Your Honor, I have been involved in the discussion of the medical records that as well as every other portion of the case.

THE COURT: Tell me about that.

MS. BENEFIELD: Well, as far as discussions go in the case and how to proceed with the case, the strategy of the case, what all is involved, what should be introduced into evidence, and that's -- anything that involves trying a case.

THE COURT: Do you agree that whatever you hear during this sealed portion of this proceedings that you'll keep confidential to yourself?

MS. BENEFIELD: Absolutely.

THE COURT: Anything else we need to address?

MR. BODAPATI: No, Your Honor.

THE COURT: Okay. I mentioned to Mr. Cantrell as he was leaving the court, that upon further reflection and weighing everything that I have before me, I think it's in the best interest of all of the parties that we're going to proceed with the three witnesses on Friday. And I ask that the defense counsel provide me a time where we can have all the witnesses here live because judging credibility is a big part of this case, and I think it

would be in the best interest of the case that I have as many witnesses live as I can.

MR. JACOBS: Understanding that that's the ruling now, Your Honor, I would just state for the record that we did track down the three witnesses that were going to go on Friday that would have been -- availability at points during the week of November 28 that they could have testified. So just -- so I'm -- so I've got my instructions when I go back and talk to our experts in particular, the -- am I understanding it correctly that the Court is not going to allow any remote testimony for any witnesses going forward and I should engage in scheduling discussions on that understanding?

THE COURT: Mr. Jacobs, I'll say that's my preference. If that can't happen, I'm willing to hear what you got to say, but that would be my preference. I'm not telling you no. I'm just telling that you that I would prefer that these individuals be here live as it was anticipated in the first instance.

So it's my understanding that these individuals were going to be here live next week, but because of our situation, they are not. And it would be my preference that, when we reschedule, that they would be live. But we don't know that that can happen or not. So it would be better for the case and better for me if they were. So

I'm not saying no, I'm saying I prefer not.

MR. JACOBS: I understand Your Honor. So I can represent that, if November 28, that week is the week that this is going to happen, all of our witnesses other than Dr. Regnerus are available to testify here live.

Dr. Regnerus is out of the country that week, and he's willing on a seven-hour time differential to testify remotely starting at 8 a.m. Central until we're done with him. But if that's the week, Dr. Regnerus does not have an in-person availability to testify.

THE COURT: Understood that.

MR. JACOBS: -- confer about that and get the parties' position or if I should go back on tell everybody else the week of the 28th is out because we don't availability for all of our witnesses in person.

THE COURT: I had understood that the other witness wasn't available until Thursday.

MR. JACOBS: So that is correct, Your Honor. Dr. Hruz, his sole availability is Thursday. He's available in person, but for scheduling conflicts he can come Thursday, and he is otherwise not available between November 28 through December 9. But he is able to travel in person Thursday, November 1. And that's what -- that's my current understanding.

THE COURT: I'll think it through.

MR. JACOBS: Understood, Your Honor.

THE COURT: We're going to go ahead and proceed with the three witnesses on Friday because there's too much that can happen and I need to take advantage of a day we have with witnesses that are currently available.

MS. GOLDSMITH: Your Honor, for the record plaintiffs are fine with proceeding on November 28 and have no objection to the remote testimony of Dr. Regnerus.

THE COURT: So the only question I've got is whether or not there is enough testimony to fill between Monday and Thursday when Dr. H-r -- I have trouble pronouncing his name. Is it Rue or?

MR. JACOBS: I say Ruse, like there's a silent H. I'm not sure if I'm pronouncing it right.

THE COURT: You know who we're talking about.

MR. JACOBS: That's right, Your Honor.

I've got it sort of mapped out for a full day on the 28th, three witnesses, including Dr. Regnerus and then two in-person witnesses on the 29th, three witnesses on the 30th, and then in addition to Dr. Hruz, if we're having testimony on Thursday, December 1, I can probably go that day depending on if we -- so we got -- we wouldn't have a day of nobody in court. I can't promise that we wouldn't be done at 2:00 depending on direct and cross length.

THE COURT: We'll plan on that tentatively

knowing that I'm going to think it over as we're going along for the day, but I'm -- in principle I'm all right with that if nothing's happened to change since.

MR. JACOBS: Understood, Your Honor.

THE COURT: Got a witness. Got a lawyer. Got a court reporter. We're ready to go.

[Sealed proceedings under separate cover.]

THE COURT: You swear to tell the truth?

THE WITNESS: I do.

THE COURT: Have a seat.

MR. ESSEKS: May I proceed, Your Honor?

THE COURT: Let's see how many people are going to shuffle in so we're not trying to --

Seem like everybody?

KATHRYN STAMBOUGH, PLAINTIFFS' WITNESS, DULY SWORN

DIRECT EXAMINATION

BY MR. ESSEKS:

Q. Good afternoon. Good afternoon, Dr. Stambough. Would you please state your full name for the record?

A. Yes. It's Kathryn Kristin Stambough.

Q. Are you a party in this proceeding?

A. I am.

Q. Are you a plaintiff?

A. I am.

Q. Can you tell us briefly about your educational

background?
A. I can. I was born and raised in Little Rock, Arkansas. So I did high school here. I went on to college at St. Louis University in St. Louis with degrees in biological and psychology. I stayed in St. Louis at Washington University School of Medicine in St. Louis for my medical doctorate and then I completed a fellowship in pediatric and adolescent gynecology at Baylor College of Medicine Texas Children's in Houston.
Q. Dr. Stambough, when did you get out of medical school?
A. 2011.
Q. And when did you finish your residency?
A. 2015.
Q. And you mentioned a fellowship at Baylor. When did you finish that?
A. 2019.
Q. Are you board certified in any medical specialty?
A. I am in obstetrics and gynecologist.
Q. When you finished your fellowship in 2019, did you start working someplace else?
A. I did.
Q. Where was that?
A. I took a position as an assistant professor at the University of Arkansas for Medical Sciences in the

department of obstetrics and gynecology and a member of the division of pediatric and adolescent gynecology with a position at Arkansas Children's.

THE COURT: Ma'am, can you slow down?

THE WITNESS: Yes. I'm sorry.

BY MR. ESSEKS:

Q. Dr. Stambough, do your current job duties involve teaching?

A. They do.

Q. Who do you teach?

A. I teach medical students, I teach residents, I teach fellows, as well as other allied health professional trainees.

Q. You mentioned Arkansas Children's Hospital. Do you have a clinical appointment there?

A. I do.

Q. In what -- what areas -- what practice areas?

A. So I practice in several clinics. I provide care in the general gynecology clinic at Arkansas Children's. I also provide care in the In-Step Clinic which cares for patients with differences of sex development, as well as the Spinal Cord Disorder Clinic. And then I am the medical director of the gender clinic at Arkansas Children's. I also have a clinical appointment and serve as a member of the team at UAMS in the adult gender

clinic.
Q. If we could focus on the gynecology clinic briefly. What's your role there?
A. So I am one of two physician providers in that clinic.
Q. Can you describe the kind of care that you provide to patients in the gynecology clinic?
A. I can. I provide care for a number of gynecologic conditions, pubertal disorders, menstrual disorders, abnormalities of the reproductive tract, ovarian masses, fertility preservation, and then a number of other kind of potpourri of diagnosis that may get referred to that clinic.
Q. Dr. Stambough, you mentioned what you called the In Step Clinic, which I think you said involved differences of sexual development, or DSDs. Can you explain what kind of patients goes to the DSD clinic?
A. Yes. That would be a clinic that sees a patient either with a known diagnosis of a difference of sex development or who was undergoing an evaluation for that diagnosis, such as a child presenting with ambiguous genitalia.
Q. How old are the patients that you see in the DSD clinic?
A. They are newborn to 21 years of age.

Q. What kind of care does the DSD clinic provide?
A. So that's a multidisciplinary clinic where they are provided with a thorough evaluation that includes a social worker, a clinical psychologist. And then there is a number of members of the team who help provide both medical and surgical care as appropriate.
Q. What is your role in that clinic?
A. I'm one of the physician providers and provide a gynecologic perspective to care.
Q. So Dr. Stambough, I'd like to turn to the gender clinic. When did you start working in the gender clinic?
A. August of 2020.
Q. When you first joined the gender clinic in 2020, what was your role?
A. I was a physician provider in the clinic.
Q. Has your role in the gender clinic changed over time?
A. It has.
Q. What is it now?
A. So I'm the medical director of the clinic.
Q. When did your role change?
A. In July of this past year.
Q. What prompted your change in role at the clinic?
A. Dr. Michele Hutchison had a great opportunity to go to New Mexico and left the university and the hospital.
Q. Dr. Stambough, how many patients are in the gender

clinic now?
A. Currently there are 248 patients actively seen in the clinic.
Q. Has the size of the patient population in the gender clinic changed during your tenure there?
A. No.
Q. Dr. Stambough, were you in the courtroom when Dr. Hutchison testified?
A. I was.
Q. Did you hear her testify about the gender clinic's treatment protocols and the fact that there was a change in those protocols in early 2022?
A. I did.
Q. Did you hear Dr. Hutchison's testimony about what the hospital told patients and their families about the reason for the change in protocol?
A. I did.
Q. Do you agree or disagree with her testimony on that point?
A. I agree with her testimony.
Q. Does the clinic continue -- under your supervision continue to provide gender-affirming hormone therapy to patients who had already been receiving such treatments at the clinic?
A. It does.

Q. How many patients are still receiving such treatments at the clinic?
A. There are 81 patients still receiving such treatment at the clinic.
Q. Dr. Stambough, if Act 626 is permanently enjoined, do you expect the current protocol to continue?
A. No.
Q. What do you expect to happen?
A. I would expect us to be able to return to the previous protocol.
Q. Dr. Stambough, did you hear Dr. Hutchison testify about how the clinic evaluates new patients?
A. I did.
Q. So I want to ask you whether the gender clinic under your supervision continues to evaluate patients, including assessing them for gender dysphoria and for any other mental health issues in the manner that Dr. Hutchison described in her testimony here at trial.
A. It does, although the members of the team that provide some of that evaluation in terms of their roles may look different.
Q. Did you also hear Dr. Hutchison testify about the treatments for gender dysphoria that the clinic sometimes provides to patients based on what their individual needs are?

A. I did.
Q. Does the gender clinic under your supervision continue to determine what treatments, if any, are appropriate for patients were gender dysphoria in the manner that Dr. Hutchison described in her testimony?
A. It does.
Q. Just to make sure I'm clear about this, you testified earlier about a change in the clinic's treatment protocols in February of this year. Is that the treatment protocol that applies now?
A. Yes, it does.
Q. Dr. Stambough, did you hear Dr. Hutchison discussion potential risks that puberty blockers and gender-affirming hormone therapy can pose and about how she informed her patients and their parents about those risks?
A. I did.
Q. Do you discuss that same information about the risks of puberty blockers and gender-affirming hormone therapy with your patients and their families in the clinic?
A. I do.
Q. Dr. Stambough, did you hear Dr. Hutchison testify about the fact that, while she was running the gender clinic, there were no clinic patients who indicated that they regretted treatment or that detransitioned after starting medical intervention for gender dysphoria?

A. I did.
Q. Is that still the case since Dr. Hutchison left the gender clinic?
A. It is.
Q. Would the clinic provide support to patients who detransition?
A. Absolutely.
Q. Under your supervision, Dr. Stambough, does the gender clinic perform any kind of surgery as a treatment for gender dysphoria?
A. No, it does not.
Q. Dr. Stambough, the experts for the State have suggested that doctors who provide gender-affirming medical care are steering young people into being trans.
Is that how the gender clinic operates under your supervision?
A. No, it does not.
Q. Have you had patients in the clinic who came in thinking that they were trans and ended up coming to feel that they were not transgender?
A. Yes, I have.
Q. Can you tell us about any of those?
A. I can. I can remember one in particular who -- I know Dr. Hutchison went over our protocol, so I wouldn't belabor the point -- but in coming in had the opportunity

to get to know her, was questioning her gender identity, and really trying to feel out whether she identified as a trans male. That's how she presented.

As part of our kind of clinic protocols, we discussed, she was referred to an established care with an affirming therapist. Through that process, as well as meeting with our clinical psychologist, was able to further explore her gender identity and came to the understanding that she was a cisgender female, but leaned tomboy is the way she described herself.

THE COURT: Slow down.

THE WITNESS: That process took about a year and a half and that patient subsequently has not required the care of our gender clinic.

BY MR. ESSEKS:

Q. Dr. Stambough, have you had similar experiences to the one you just described with other patients in the gender clinic who ultimately identify as cisgender?

A. I have.

Q. Dr. Stambough, there's been expert testimony in this case about the impact of gender dysphoria on individuals and the -- also about the impact of gender-affirming hormone therapy on them.

Can you tell us how gender-affirming hormone therapy as has affected some of your patients in the gender clinic

at Arkansas Children's?

A. I can. Give you some patient examples. I think that's probably the best way to describe it. So a couple of patients come to mind. I will try to talk slow.

One of them is a patient actually had the privilege of taking care of since I've been in clinic. He was one of my first patients. He came to clinic, he and his mother, to establish care, and was really having a difficult time. When he was younger, he had really excelled at school and had a lot of interests outside of the classroom, particularly arts. But with increasing dysphoria and just felt so withdrawn and uncomfortable with who he was, was doing really poor academically because he was afraid to speak up and afraid to present himself in class as who he was. He was very withdrawn and anxious. And often mom would have to go pick him up from school.

Because of that, in working with our clinic over the course of time, he was felt to be an appropriate candidate, and both he and he mom consented for masculinizing therapy. And once starting that therapy, he became a totally different child.

Mom actually comments on how she hasn't had to pick him up from school in a long time except for the random stomach bug or something that we all have to pick our

children up for. He's done amazing. He is active in school clubs. He's exploring his love of art and is engaged in groups that get to go show their art at different place. He's always bringing me something to show me in clinic. He just became such a different kid after he had access to that care.

I can think of a trans female who similarly came to see me with her mom. And I remember as part of the protocol reaching out to her therapist to discuss readiness for therapy, any concerns as we've talked about previously with Dr. Hutchison. And her therapist said, you know, I'm just actually really surprised that she survived to get the care that she's getting now because of how significant her dysphoria was.

She got started on feminizing therapy. And I remembered even before her first visit to come back to see me for surveillance after three months to check up, she reached out to tell me that, before starting therapy, she saw the world in black and white and now she sees the world in color. And she's gone on to go to college and is doing amazing things.

I have a patient who had no less than six suicide attempts before he came to our clinic. As part of his care, he was engaged with an affirming therapist. He met with our clinical psychologist, again, started on

masculinizing therapy when appropriate, and he's had no further attempts. And I just saw him back. And his dad just could not believe how well he's done since he got started on treatment.

I mean, there is another patient who similarly was seen in clinic who had difficulty in school, and a lot of that was being very withdrawn and uncomfortable with how he presented because it wasn't aligned with his gender identity and had concerns about that. Very withdrawn. He was afraid to speak up in class actually because of how dysphoric he was from his voice, among other areas that created dysphoria for him.

And he is a totally different kid now that he's gotten started on therapy. He's active. He's engaged. He's doing well. He has flourished. Very smart, but really, really under performed academically until he felt more comfortable with himself.

Q. Dr. Stambough, the patients that you've just described to the Court, are any of them plaintiffs in this lawsuit?

A. No.

Q. You've just described the benefits of gender-affirming health care to some of your patients. Are those outcomes that you just described, are they typical or atypical among your patients in the clinic?

A. They're typical.
Q. Dr. Stambough, continuing to focus on your patients who are currently undergoing gender-affirming hormone therapy, my question is whether any of those patients have raised with you any concerns about what would happen to them if they were forced to stop the hormone therapy because of Act 626?
A. They have.
Q. What have they told you?
A. It's not only the patients, but their parents and caregivers as well. As we discussed, patients come in potentially with a significant amount of distress and they go on to do well on these treatments. So they all remember how they felt and how they were before. And so they have expressed concerns for that, increasing anxiety, kind of concerns about how they're going to access their care, concerns about what will happen to them if they don't have access to the therapy in the sense that their bodies will have changes that aren't consistent with their gender identity. There's concerns for safety surrounding that as well.
Q. Dr. Stambough, you testified earlier about how the clinic's treatment protocol changed in 2022 so that the clinic will accept new patients but will not start them on puberty blockers or hormone therapy.

Since that change, have you had any patients in the clinic for whom in your medical opinion puberty blockers were appropriate?
A. I have.
Q. How many patients are in that category at the moment?
A. Five.
Q. And in those cases, what have you done where you can't provide the puberty blockers yourself?
A. I refer them to other providers.
Q. Since that same change in protocol, have any of your patients needed gender-affirming hormone therapy in your professional opinion but not been able to get it through the clinic?
A. Yes.
Q. How many patients fall into that category?
A. 44.
Q. Have all of these patients who are ready for -- to starting puberty blockers or gender-affirming hormone therapy been able to find treatment elsewhere?
A. No.
Q. Focusing on these patients -- your patients for whom puberty blockers or hormone therapy treatments are medically indicated but who can't receive those treatments under the new Arkansas Children's protocol, what is happening to them now?

A. They're not doing well. I think a lot of them are holding out hope, obviously, but they have expressed kind of ongoing concerns and anxiety and distress surrounding an inability to get care that we have evaluated them for and felt that they're appropriate for as has their parent or caregiver.
Q. Have any of these patients previously socially transitioned to living consistently with their gender identity?
A. Yes.
Q. Have any of them done legal name changes?
A. Yes.
Q. How are these patients handling the situation?
A. Not well. Many of them are concerned because they have only been known as their gender identity, and they have concerns about an inability to access treatment to affirm that identity and they have concerns about safety as well and about changes that may happen that don't align with who they are.
Q. Have these patients talked to you about how it feels to see their bodies change in ways that conflict with their gender identity?
A. Yes.
Q. What have they told you?
A. They've told me about how distressing it is. I think

Dr. Hutchison alluded to the fact that patients put sheets over their mirrors so they don't see themselves. They withdraw. They aren't as engaged as they would be because of how distressed they are over changes that don't align with who they are.

Q. Dr. Stambough, the State has said that minors with gender dysphoria can simply wait until they're 18 and get the hormone therapy then.

How would that affect your patients?

A. I think it's -- you cannot minimize the impact on patients of waiting for therapy when there's active distress for those patients. And I am not hyperbolic when I say that I have concerns that not every patient would be able to make it to 18 in terms of patient self harm and suicidality.

Q. Dr. Stambough, has gender-affirming hormone therapy caused any harmful health consequences for your adolescent patients?

A. It has not.

Q. I want to ask you a few questions about counseling your patients about fertility. Do you counsel patients and their families in the gender clinic about possible fertility issues before they start either gender-affirming hormone therapy or puberty blockers?

A. I do.

Q. For those same patients in the gender clinic, do you discuss fertility preservation option?
A. I do.
Q. How often do your patients in the gender clinic decide to take steps to preserve fertility?
A. Not often.
Q. Are there times when you need to advise patients outside of the gender clinic about fertility preservation options?
A. Yes.
Q. How often does that group of patients decide to take steps to preserve fertility?
A. At similar rates to patients in the transgender clinic.
Q. Dr. Stambough, early in your testimony you talked about your work at the In Step Clinic that was -- dealt with differences in sexual development. In that DSD clinic, do you face situations where you administer medical treatments or perform medical procedures that affect a patient's fertility?
A. I do.
Q. Can you give us some examples of those procedures?
A. I can. The most obvious one would be removal of a patient's gonads.
Q. In what circumstances would you do that?

A. So that would be done in a patient where they had a difference of sex development and where they may retain tissue in the gonads that could either have malignant potential or cause hormone production that wouldn't align with their gender identity.
Q. Does Act 626 say anything about the legality of those procedures that you perform on patients in the DSD clinic and that affect fertility?
A. It does. It carves them out as an exception.
Q. Does the DSD clinic continue to perform those procedures today?
A. It does where appropriate.
Q. You mentioned earlier in your testimony that at times you need to refer a patient to another health care provider. When you make that referral, does it involve discussions with patients and their families?
A. It does.
Q. What do you talk to them about?
A. So we talk to them about their goals of treatment. We talk to them about their options and what we think is appropriate with counseling surrounding those options. We talk about logistics of that referral, so whether that's geographic logistics or insurance coverage, but that help guide us in making that referral, and then we give recommendations as appropriate.

Q. If Act 626 were to go into effect, would you be able to make all of the referrals you would need to make in order to care appropriately for your patients in the gender clinic?
A. No I would not.
Q. Dr. Stambough, as a plaintiff in this action, you are bringing claims both for yourself and on behalf of your patients. Can you describe for the Court the kind of relationship you have with your patients in the gender clinic?
A. I can. I think Dr. Hutchison used the word "privilege" earlier, and that's certainly what it is. I have a very close relationship with all of my patients and I think that's because we really get to be on a journey with them. So that first visit is always a long one is what I tell them. That's because we have the opportunity to not only hear what they're telling us in that moment, but to learn about them before they come to see us. Part of that visit is also understanding their social support and who they have around them.

Then over time, we get to go through the process with them. And it's an amazing privilege to be a part of and an honor. I think they're always calling or emailing or using electronic medical record to send updates as to not only how they're doing for their care, but also just

updates. It's not uncommon that they'll send us an achievement that they have or a piece of art or something that they've engaged in just to let us know. And that always happens at visits. We're always getting updates.

Q. Dr. Stambough, are all of your patients open about being transgender in all aspects of their life?

A. No.

Q. Do some choose to keep it private in certain contexts?

A. They do.

Q. What are some of those contexts?

A. So many may be out to their close family members but not out to extended family. I can think of one patient in particular who is very supported by his stepmother and his father but extended family is not somebody that he has ever felt comfortable kind of being out in terms of his gender identity, and that's incredibly distressing to him because they are people in his life who he loves. There are people who choose not to be out at school or choose not to be out in other social situations, and that's all kind of dependent on the individual.

Q. Have any of your patients told you that they have faced harassment because they're transgender?

A. Yes.

Q. Can you do you have any examples?

MS. TEMPLIN: Objection, Your Honor. This is soliciting hearsay.

MR. ESSEKS: Your Honor, this information is provided to Dr. Stambough as part of her work as a doctor to provide medical care to these people. Part of it is based on their life experiences and she's -- she is in part of a mental health counselor.

THE COURT: Overruled.

THE WITNESS: Does that mean answer?

BY MR. ESSEKS:

Q. Yes.

A. Yes. So I -- again, we screen for a history of -- of those things. And so I can remember one patient in particular sharing about how kids would sidewalk chalk hateful things that he had to read on his walk into school every day.

Q. Dr. Stambough, are some of the individual plaintiffs in this action your patients?

A. They are.

Q. Based on your knowledge of your other patients in the gender clinic, would all of those other patients be in a position to do what the adolescent plaintiffs in this case have done, that is bring a lawsuit in their own name seeking to challenge the constitutionality of Act 626?

A. No.

Q. Is that why you are bringing this action on their behalf?

MS. TEMPLIN: Your Honor, objection. This is asking for a legal conclusion.

THE COURT: Overruled.

BY MR. ESSEKS:

Q. Dr. Stambough, is Parker Saxton a patient of yours?

A. He is.

Q. We heard Dr. Hutchison testify about her experience with Parker until she left the clinic. What treatment is Parker on currently?

A. He's currently on testosterone therapy.

Q. And how has that therapy affected Parker's gender dysphoria?

A. It has decreased his gender dysphoria.

Q. Have you met with Parker and his family recently?

A. I have.

Q. What did you learn in that visit?

A. That Parker is doing really well at the moment.

Q. Did you discuss Parker's future?

A. I did. I did. It is my first time meeting Parker, and so -- and he's in 12th grade. So in talking like any kind of followup adult question, I want to know what are you going to do next. That's always the dreaded question that my high schoolers get. And he shared a number of

things that he has that he wants to do after high school.

His dad looked at me and he said that's different. I'm like, what do you mean that's different? He said, before there was no future. There was no goal planning. There was no next. And now Parker has all these goals and these things that he wants to do and what he's thinking about, and that is a world away from where we started.

Q. Dr. Stambough, as Parker's doctor, what do you think the impact would be on him if Act 626 were to go into effect and he had to stop the testosterone therapy?

A. I think that impact would be significant on Parker.

Q. Dr. Stambough, is Dylan Brandt a patient of yours?

A. He is, but I've not yet seen him in clinic.

Q. Is Brooke Dennis a patient of yours?

A. She is.

Q. How old is Brooke, ma'am?

A. Ten.

Q. Is Brooke on any medical treatment for gender dysphoria at this point?

A. She is not.

Q. Have you seen her?

A. I have.

Q. How is she doing?

A. She is doing well. Brooke is a little ray of sunshine. She's an amazing patient. I would say she's

having some increasing worry and concern surrounding the knowledge that puberty will start for her sooner rather than later, and is starting to have some concern about kind of what will happen to her when that begins.

Q. Do you believe she is close to puberty?

A. I do.

MR. ESSEKS: No further questions.

CROSS-EXAMINATION

BY MS. TEMPLIN:

Q. Good afternoon, Dr. Stambough. Thank you for being here today. My name is Hannah Templin. I'm one of the lawyers for the Attorney General's office. We haven't met before, but nice to meet you now.

I'm going try to not rehash everything that they've already questioned you about, but just to confirm, you work both in the gender clinic and a gynecology clinic here, correct?

A. At Arkansas Children's Hospital, I do.

Q. Perfect.

Do you see transgender patients at your gynecology clinic?

A. I do.

Q. If someone presents at your gynecology clinic with signs of gender dysphoria, what do you do?

A. I refer them to the gender clinic.

Q. What are the signs of gender dysphoria that you look for?
A. So the signs of gender dysphoria I look for are if the patient expresses distress for things that don't align with their gender identity.
Q. What criteria do you use to evaluate gender dysphoria?
A. Can I clarify what you mean?
Q. Yes, of course. Do you use the DSM guidelines or any other standards for diagnosing gender dysphoria?
A. So the DSM-5 criteria?
Q. Yes, ma'am.
A. Yes.
Q. Does that criteria indicate whether the patient will persist in a transgender identity into adulthood?
A. I'm thinking about your question. So that criteria indicates that the patient is experiencing gender dysphoria.
Q. But does it tell you that they will continue to experience gender dysphoria through adulthood?
A. So it does not.
Q. Were you deposed in this case?
A. I was.
Q. Let me pull up deposition.
A. Okay.

Q. Does this appear to be the document from the deposition in your case? I can flip a page.
A. That does, yes.
Q. I'm going read lines 3 through 10 of the deposition and --
THE COURT: What page and line?
MS. TEMPLIN: Apologize, your Honor. Page 27.
THE COURT: Thank you.
MS. TEMPLIN: Let me know when you're there.
THE COURT: I don't have her deposition. I was just -- for the record, I wanted to be able to trace back to where you were. I don't have the benefit of the -- you're good. Go ahead.
BY MS. TEMPLIN:
Q. Starting on Line 3 for -- starting on the first line, in a directive way.
The lawyer asked in Line 1: Can you explain what you mean by a directive way?
So quoting on Line 3: Yes. So if a patient came to me in gynecology clinic with a problem, because of my training, I would tell them that I had a solution. So you come to me with an annexal [sic] mass. You need surgery and these are the reasons why.
A gender-affirmative model is a way in which we work with a patient in a nondirective way to allow them to

explore their gender identity and best support them.

Is that a correct reading?

A. It is. It should be adnexal instead of annexal.

Q. Apologies. Thank you for correcting me on the medical pronunciation.

Can you explaining what you mean by a "gender-affirmative model of care"?

A. Gender-affirming model of care?

Q. Yes.

A. So a gender-affirming model of care is one in which patients can seek care from providers who are respectful of their exploration of their gender identity, who allow space for that, and who support that. That generally is done in a nondirective way where a patient can come in and is supported both with, as we spoken about before, mental health, therapy with counselors who are adept as exploring gender identity with a psychological evaluation, and then the care would be kind of directed by patient goals as well as, again, when addressing areas of dysphoria and how to best to treat the patient for those.

Q. So to confirm, when you just used the phrase "nondirective," do you mean that the patient guides their care as opposed to doctor prescribing something?

A. I mean that we don't tell the patient what they have to do.

Q. Okay. Just to confirm, the gender clinic does follow the affirmative gender-affirmation model of care?
A. Can you rephrase that question?
Q. Sure. In your deposition, you reference the affirmative model -- gender-affirmative model. That is the approach you take in the gender clinic?
A. So we aim to provide care with an affirming model.
Q. Can you explain what -- you use the phrase "nondirective." Would the opposite of that be a directive model?
A. Yes.
Q. Can you explain what a directive model is?
A. A directive model of care would be one in which a patient comes in with an issue and we tell them what they need to do.
Q. Which model would you use for your gynecology clinic patients?
A. So it depends on the issue with which they're presenting.
Q. But in some cases you would use a more directive approach than you do for the gender clinic?
A. Yes. And in some case I wouldn't.
Q. Okay. So I believe you've testified that you provide many of the same treatments to your transgender patients as to your nontransgender patients. Is that correct?

A. Yes.
Q. Which treatments?
A. So pubertal blockers or -- as they're colloquial known, otherwise they're GrNH analogs are provided for number of conditions that I care for. Estrogen therapy, I also provide as well as androgen blockers.
Q. So let's talk about puberty blockers. Why would you prescribe it to a nontransgender patient in your gynecology cling?
A. So I would prescribe it for central precocious puberty. I would provide it for menstrual suppression in patients who would require that therapy. It can be used experimentally for fertility preservation in patients undergoing gonadotoxic treatment like chemotherapy. I use it in patients who have Mullerian, M-u-l-l-e-r-i-a-n, anomalies and would require suppression of menses until they could have definitive surgical repair.
Q. How would you diagnosis precocious puberty?
A. Precocious puberty would be diagnosed based on a physical examine as well as laboratory assessment or potentially radiologic evaluation.
Q. Are there objective criteria you would be looking for?
A. Yes.
Q. What about the other disorders that you mentioned,

how would you diagnosis those?
A. All of them?
Q. Yes. Well, what was -- I'm forgetting what one of them -- you said Mullerian --
A. Sure. Mullerian anomalies are diagnosed based on an ultrasound. Endometriosis can be treated empirically and may not be diagnosed with surgery, but there are surgeries that can be done to diagnosis endometriosis. Again, a patient would come to me with a diagnosis of cancer prior to receiving a treatment.
Q. So let's take endometriosis for an example. What are the goals treating endometriosis?
A. To relieve the patient's pain.
Q. What are the different treatment options?
A. Hormonal therapy or surgery.
Q. How would you suggest -- how would you select the appropriate treatment?
A. You would counsel the patient with regard to the risks, benefits, and alternatives to the treatment and then help the patient make the best decision for them based on those options.
Q. Would puberty blockers be an appropriate starting treatment for a teenager with endometriosis?
A. When you say "puberty blockers," you mean GrNH agonist?

Q. Yes.
A. Can you ask that question again?
Q. Yes. Would GrNH agonists be an appropriate starting treatment for a teenager with endometriosis?
A. So it would not.
Q. Why not?
A. So in that patient, we would discuss the risks, benefits, and alternatives of every medication. Generally, there are medication options that have less risk for the patient than a GrNH agonist.
Q. What is the risk of that medication?
A. Decreased bone accrual.
MS. TEMPLIN: Your Honor, may I approach?
THE COURT: You may.
MS. TEMPLIN: This is Exhibit 15. We're not going to talk about this entire exhibit, but turn to page --
THE WITNESS: I'm sorry. Can you say the page number?
MS. TEMPLIN: 32.
BY MS. TEMPLIN:
Q. What is this?
A. This is a chapter out of a textbook that I contributed to.
Q. This chapter is on osteoporosis, correct?

A. It is.
Q. Could you read the final bullet point under, key points?
A. Yes.
Q. Would you read it, please?
A. Yes. Osteoporosis and low bone mineral density are associated with poor nutrition, chronic disease states, genetic disorders, prolonged corticosteroid use, primary ovarian insufficient, POI, cancer, renal disease, and certain other medication use.
Q. Might GrNH analogs be one of those medications?
A. They would.
Q. Why does it risk bone density issues?
A. It can decrease bone accrual.
Q. The first bullet point under key points if I'm going read it. Adolescence is a critical time for peak bone accrual during which is approximately 40 percent of the adult bone mass is established. Is that accurate?
A. That is accurate.
Q. Might interrupting puberty harm bone density?
A. Can you rephrase that question? I'm sorry.
Q. Is there a risk that, if someone interrupts pubertal development, that it might harm their bone density accrual since adolescence is a critical time for accruing?
A. Can you clarify what you mean by "interrupt pubertal

development"?
Q. If puberty was paused for a couple of years, for instance.
A. Can you clarify how you would do that?
Q. Sure. Let's stipulate puberty blockers. If you were to block puberty for a couple of years, is there a risk that the bone density accrual would be damaged?
A. That is a reversible risk of interrupting puberty.
Q. On the third bullet point it says, every ten percent increase in bone mass acquired during adolescence translates to a potential 50 percent reduction in future fracture risk. Is that also accurate?
A. That is accurate.
Q. Does this mean that, if someone were to miss out on developing some of the bone mass they ordinarily would, that they would run a greater risk of osteoporosis when they get older, 50 say?
A. Can I clarify? Am I allowed to clarify?
Q. Yes.
A. Are you referring to the use of these medications for pubertal blockade in transgender patients or are you referring them for the other indications that we discussed?
Q. Generally.
A. So the risks are different though.

Q. You can explain.
A. When we talk about the risk of using pubertal blockade in patients who say may have endometriosis, that is where we do not then follow that, right, in terms of supplementing with hormone therapy to help them gain the bone that they lost as opposed to our transgender patients who would use pubertal blockade. Instead, that's a reversible side effect because we're delaying puberty but then following up either with their own endogenous puberty where they gain that bone back or with cross-sex or affirming hormones that allow them to build back bone. So they're two separate patient populations.
Q. Are you aware of any conclusive information establishing that the cross-sex hormones bone accrual work the same way as it does with the endogenous hormones?
A. I am not.
Q. Let me go back actually and talk to you briefly about precocious puberty. Is there a treatment cutoff date generally for someone with precocious puberty?
A. That's going to be individualized. A lot of that takes in the patient's linear height velocity as well as a number of the other factors. But, generally, that is going to be around 11 or 12 years of age.
Q. Is there a treatment cutoff date for transgender individuals on puberty blockers?

A. Typically, again, would be individualized for the patients. Typically, that would be around the age of 14 and that would be when the patient has either, again, elected to come off of those therapies or when there's been persistence and consistency in their gender identity.
Q. So you also I believe testified that you would prescribe estrogen to both transgender and nontransgender patients. Is that correct?
A. That is correct.
Q. Why might you prescribe it to a nontransgender patient?
A. There are a number of reasons. Primarily that will be ovarian failure.
Q. What -- how would you diagnosis ovarian failure?
A. That's done with a clinical exam as well as lab work.
Q. Is there objective criteria that you're looking for?
A. There are.
Q. So would it be reasonable for a physician who wanted to treat gender dysphoria to use the same criteria as they would to diagnosis ovarian failure?
A. No.
Q. What about for the same criteria as for endometriosis?
A. In general, we don't allow criteria for any medical condition to be used to diagnosis any other medical

condition because it's specific to that condition.
Q. What guidelines would you consult instead to diagnose gender dysphoria?
A. For gender dysphoria, the DSM-5 criteria.
Q. Would it be reasonable to use the DSM-5 criteria to diagnosis endometriosis or any of these other disorders that you mentioned?
A. No, because it does not address gynecologic conditions.
Q. Let's talk just a little bit more specifically about diagnosis and treating your transgender patients. How would you diagnosis someone who has gender dysphoria?
A. Can you clarify?
Q. Let me ask more specific question. Can you -- do you primarily diagnosis gender dysphoria through information received from the patient?
A. So I would say the diagnosis of gender dysphoria is done kind of in a multidisciplinary level, as Dr. Hutchison discussed. So it's what the patient tells you in terms of their gender identity and the distress that that may bring in terms of meeting the criteria for dysphoria. It's done with a formal psychological evaluation, as well as with their mental health provider.
Q. You wouldn't use imaging or a blood test or the type of things you would to use to diagnose endometriosis, for

example, to diagnose -- you can't use that for gender dysphoria?
A. As we discussed, endometriosis can be treated empirically and doesn't require surgery and there's no imaging study to diagnosis it. So there's lots of actual conditions where I don't have objective criteria like a blood test or imaging to diagnosis as well.
Q. Are there any -- how would you recommend one treatment option to a transgender patient? Is there a reason why you would recommend one treatment over another?
A. So the counseling and the treatment offered is to meet the patient's goals in the areas that create dysphoria or distress for the patient. So that's going to be individualized based on their needs.
Q. For the hormone replacement therapy that you prescribed to nontransgender patients, is fertility loss generally a potential side-effect?
A. Generally, estrogen therapy is provided to cisgender females who already potentially have an impact on their fertility because of the condition for which they're being supplied the medication.
Q. But it's not a result of prescribing estrogen?
A. I would argue that we don't know any impact that estrogen may have because those patients already have subfertility.

THE COURT: Did you say sub?
THE WITNESS: Subfertility. Usually they have --
THE COURT: Some or sub?
THE WITNESS: Sub, s-u-b. Usually they have decreased fertility potential based on the diagnosis for which they're receiving the treatment.
BY MS. TEMPLIN:
Q. Would you agree that fertility loss is a potential side-effect of prescribing estrogen to your transgender patients?
A. I would agree that an impact on fertility is a potential side effect of estrogen treatment in our trans females.
Q. What are the different forms of fertility preservation available to gender clinic patients?
A. They have the opportunity for sperm cryopreservation, oocyte cryopreservation. Very rarely would they have the ability for embryo cryopreservation -- sperm cryopreservation. Oocyte is a very odd word. O-o-c-y-t-e, same thing, cryopreservation. And very rarely embryo, e-m-b-r-y-o, cryopreservation because that not only would include the oocyte but also would require sperm.
Q. What is sperm cryopreservation? How does that work?

A. A patient would provide a sample of sperm to be frozen.
Q. Is it an option for a natal male who started puberty blockers and then transitioned straight into feminizing hormone therapy without going puberty as male puberty?
A. So that would have to be approached on an individualized basis to understand how these pubertal blockade affected that individuals's spermatogenesis.
Q. What about -- how do you pronounce it, ooctye?
A. Yeah. You can use say --
Q. -- cryopreservation. What -- how does that work?
A. Could that is where a patient would undergo hormonal preparation and then ovarian stimulation to allow for oocytes to be retrieved and then frozen.
Q. Is that an option for natal females who start puberty blockers and then transition into masculinizing hormone therapy straight through without going through female puberty?
A. That would require an individualized assessment to understand how pubertal blockade has affected their ovarian development.
Q. What is the success rate for -- if someone uses these option -- utilizes these options and then tries to get pregnant or contributes sperm in the future, what is the success rate for fertility?

A. I'm sorry. To clarify, do you mean what is a success rate of oocyte, embryo cryopreservation and then sperm cryopreservation?
Q. Yes.
A. That is going to be dependent on many things. It's going to depend on -- most centers have their own kind of number for success rate, and it's not uniform. So I can't give you an exact number as to the success rate, but it would be comparable to their cisgender peers.
Q. Generally, what is that? Is it a high number, is it a low number in the ballpark? Do you know?
A. It would depend on many factors. I cannot give you a ballpark number.
MS. TEMPLIN: No further questions, Your Honor. Pass the witness.
MR. ESSEKS: Nothing further, Your Honor.
THE COURT: You can step down, Doctor.
MS. GOLDSMITH: Plaintiffs next witness is Amanda Dennis.
THE COURT: Do you swear to tell the truth?
THE WITNESS: I do.
THE COURT: Have a seat, please.

AMANDA DENNIS, PLAINTIFFS' WITNESS, DULY SWORN

DIRECT EXAMINATION

BY MS. GOLDSMITH:

Q. Good afternoon, Ms. Dennis. Would you please state and spell your full name for the Court?
A. Amanda, A-m-a-n-d-a, Brooke, B-r-o-o-k-e, Dennis, D-e-n-n-i-s.
Q. Are you married?
A. I am.
Q. What's your spouse's name?
A. Shayne, S-h-a-y-n-e.
Q. And about how long have you and Shayne been married?
A. 15 years.
Q. Do you and Shayne have any children?
A. We do. We have three children.
Q. What are your children's names?
A. My oldest his name is Myles, M-y-l-e-s. My middle child is Brooke, B-r-o-o-k-e. And my youngest is Hatti, H-a-t-t-i.
Q. What are your children's ages?
A. Myles is 14, Brooke is ten, and Hatti is seven.
Q. You mentioned you have a daughter Brooke. What grade is Brooke in?
A. Brooke is in fifth grade.
Q. Can you tell us what is Brooke like?
A. She's like an incredible kid. She's probably one of the most incredible humans I know. She's really -- I mean, since she was a little kid, like, people gravitate

toward her, and she's kind and empathetic and funny, has a very, very, very great sense of humor. Most of all, she's really kind. She's a really, really kind person.

Q. Does Brooke have any hobbies or interests?

A. She loves to draw. She loves to make up stories and write. She loves to play with her sister most of the time. We love Roblox at our house, so she likes to build things on Roblox and play outside and play with her dog and talk to her friends.

Q. And what was Brooke's assigned sex at birth?

A. Brooke was assigned male at birth.

Q. Does Brooke still identify as male today?

A. No, she does not.

Q. What is Brooke's gender?

A. Brooke is female.

Q. When did Brooke start to identify as a girl?

A. Brooke has always kind of gravitated toward more feminine things, but it was around grade, you know, two I believe when she first started to identify as female.

Q. How did you learn that Brooke's gender identity is female?

A. We had -- we moved kind of the beginning of the pandemic. So my realtor gifted us a family portrait session, you know, the outdoor, front yard, socially distanced picture session. And, you know, after that --

after that photography session, I noticed that the photographer was referring to her with female pronouns. And we had a discussion about that afterwards. I asked her how that made her feel. And that was the first time we really had a discussion about it. And she expressed that that felt right and it made her happy.

Q. When Brooke told you that she preferred people use female pronouns, how did you and Shayne react?

A. We said, okay, great. If that's who you are and that's what you would like to be called, we will use those pronouns for you. And, you know, we were happy that, you know, we were such loving parents to all of our children that she would feel comfortable expressing that to us.

Q. When Brooke told you that she was a girl, were you and Shayne surprised?

A. No.

Q. Can you say why not?

A. No. Like, Brooke has, you know, from a young age always gravitated toward more feminine -- well, what you would consider traditionally feminine clothing and play and toys and, you know, during make believe play, it was always princesses and things that were more traditionally feminine.

Q. Do you recall any specific examples from Brooke's early childhood where she preferred to wear more typically

girl's clothes?
A. All the time. Anything that Brooke could put on her head to have, you know, long hair or long ponytail. This was, you know, when we all discovered *Frozen* the movie. And so anything to have an Elsa ponytail. And so she would often take a t-shirt or the towels that I use to wrap my hair up after I showered, you know, turbine towels, she would take that and wrap it around her head and put a ponytail holder on it to make -- it was yellow, so she made blond hair.
Q. Did Brooke ever dress up in more typical girls clothing for school?
A. She did. It was a bit, you know, later in her life, more toward like second grade when she really started asking not to shop in any of the traditional boy sections of any store and she wanted girl's clothing.
Q. Have you ever seen Brooke become upset because others don't see her the way she sees herself?
A. Yes. You know, a lot at school, you know, in that second grade kind of age. She would often become upset and distressed because, you know, she wouldn't be recognized as, you know, who she was feeling like on the inside. And, you know, when she would get questioned or when there were times in which at school if, you know -- at that grade, they very structured approaches to all of

the things that you do at school, like standing in the bathroom line and things like that. It's always divided. And, you know, that would cause her a lot of distress.

Q. Do you recall any other specific examples where Brooke was upset because others don't see the way -- her the way she sees herself?

A Yeah. There -- there were lots of times, you know, in those early years at school and other times when, you know, she knew who she was. She's known who she is from a very young age and, you know, it would -- it would make her upset when people would ask questions about who she is. And she would -- it got to the point where she was having trouble at school and acting out and at home. And, you know, it caused a lot of behavior problems and anxiety and distress.

So a lot of moments in her early life when, you know, be happy and fun times for a kid you know, she didn't get to experience that happiness and enjoyment and just the joy in her daily life, you know, that kids should be able to experience.

Q. So after Brooke asked to be called by female pronouns, did she start to go by Brooke and be addressed by female pronouns?

A. She did. After that family photography session, we came inside and I noticed that she didn't correct the

photographer on when she was using she/her pronouns and you know calling her sweetie and all of those things. She didn't correct her. So I asked her how that made her feel. And she said, well, it felt right. I liked to use she/her. I am a girl. That's how I feel and that's how I feel on the inside.

And so I said, great. And I said, what do you want to be called? And she said I want to be called Brooke, which is my middle name. And I said, great. And, you know, it was like after that -- I mean, after that my husband said, it's like she got her smile back. A lot of that kind of sadness that we saw just went away and it was finally -- you know, she was just able to have that joy and that kind of happy -- happiness that kids should be able to experience in their growing up.

Q. Does Brooke continue to go by Brooke and be addressed by female pronouns today?

A. Yes, she does.

Q. So after Brooke told you that her gender identity is female, did you seek any medical treatment or consultation for Brooke?

A. Yeah. After that, you know, I -- I approach anything in life, I want to have as much information as possible to be able to make a good decision and how to move forward. So, you know, I knew someone at work, just through

different work things and I had -- I knew that this person had a transgender child. So I reached out and just asked, hey, do you have anybody that I could talk to. And she recommended a local therapist who had experience with children who were kind of experiencing gender dysphoria or and other transgender children and minors, and so I -- that's who we spoke to first, my husband and I.

Q. Approximately when was the first discussion with a therapist?

A. April 2020 is when Brooke affirmed who she was. So it was -- you know, I don't remember the specific date, but it was some time shortly after that.

Q. And did that therapist diagnosis Brooke with gender dysphoria?

A. After we saw her for a while, Brooke did, and after that, she did. And I don't remember the exact date, but it was after seeing her for a time.

Q. After seeing that therapist, did you seek any other medical treatment or consultation for Brooke around the same time?

A. We did. We saw her pediatrician as, you know -- her pediatrician has been treating her since we moved to Bentonville. So we had -- my husband had an appointment -- and Brooke had an appointment with her and spoke to her about it as well.

Q. Did you or did Shayne discuss Brooke's transition with the pediatrician?
A. Yes.
Q. And did the pediatrician give Brooke a referral to the gender clinic?
A. She did.
Q. Let's talk now about the visits to the gender clinic. After you and Shayne obtained the referral, did you arrange for Brooke to visit the gender clinic?
A. We did. It was a little later in the year. I believe it was around October of 2020 when we had that first appointment.
Q. What was the primary purpose of that first visit?
A. We wanted to understand more about the Gender Spectrum Clinic and, you know, meet their care team, ask questions, understand what they do and what kind of care they provide, and what we should be learning more about and thinking about for Brooke's future.
Q. Do you recall who you met during the visit?
A. Yes. We met Dr. Hutchison, the social worker. I don't remember her name. And the chaplain.
Q. Did you discuss Brooke's history?
A. We did. We kind of got to know Dr. Hutchison little bit. We talked about Brooke and her, you know, childhood and her experiences. And, you know, we had just general

questions. And Brooke was -- you know, had a few and the -- you know, we discussed with her kind of, you know, what we should be learning about and thinking about. And we also spoke to the chaplain, and he offered services if we needed to talk to anyone and spoke a little further with the social workers.

Q. Did Dr. Hutchison provide general information about treatment options for gender dysphoria?

A. It was very general at that point because Brooke was, you know, not at the time of puberty yet, and so it was just general, this is kind of the general what we do and what to think about for the future.

Q. Did you discuss any specific treatment options in any detail?

A. Not in any real detail.

Q. Was Brooke prescribed any medication during your first visit to the gender clinic?

A. No, she was not.

Q. Can you say why not?

A. Because she hadn't started puberty, so there was no need for any medicine.

Q. And were you told to watch Brooke for signs of puberty?

A. Yes. Yeah, we talked about what those signs could be and that, you know, generally, when we could expect them,

and just to kind of watch and keep kind of an eye out for those signs.

Q. Did Dr. Hutchison tell you around when puberty could happen?

A. I mean, we talked about kind of that age range and that it could, you know, possibly begin around this range of age like to nine, ten, you know, and just to kind of keep an eye out for some of those early signs.

Q. Have you visited the gender clinic you since the first visit in October 2020?

A. We have once.

Q. When was that?

A. It was maybe like early September, first or second week of September, this September.

Q. What was the purpose of that visit?

A. We just wanted to do just a general check in. Brooke is ten and, you know, she is -- she's started to -- she knows -- we all know puberty is getting closer and that makes her very nervous and anxious. So we just wanted to have another conversation to give us the opportunity to ask a few more questions, learn a little bit more, and then give Brooke the opportunity to ask some questions now that she's a little older.

Q. And do you recall who you met during that visit?

A. Dr. Stambough.

Q. Did Dr. Stambough tell you about any specific treatment options for gender dysphoria?
A. We talked about what -- you know, puberty blockers and the options and kind of the option of what would be available, you know, just still kind of in the general terms of what would be available to her.
Q. Did Dr. Stambough prescribe any medication during that visit?
A. No.
Q. Since that last visit, has Brooke started to see any signs of puberty?
A. Yes.
Q. Do you have any plans to go back to the gender clinic in the near future?
A. We do. I actually requested an appointment through the app. I forget what it's called.
Q. Has Brooke ever expressed any distress about her body?
A. Yes. A lot.
Q. Can you say more about that?
A. Brooke has an older brother who is 14 now. And watching him grow and mature and start to go through puberty, one of the things that she's always expressed to us is, you know, she can see her dad, too. He's tall and thin. And she worries about getting an Adam's apple and,

you know, she has a lot of, you know -- it makes her distressed and anxious about her body developing more.

Q. How does Brooke feel about getting changed in front of other people?

A. She does not like that and won't, not even me.

Q. How does she feel about starting puberty?

A. She's worries about that. She's very anxious and continues to especially now that she is starting to see some development and changes happening. She has expressed to both of us this isn't what she wants and it makes her very anxious and scared.

Q. Is Brooke still receiving counseling related to her gender dysphoria?

A. She is.

Q. Do you and Shayne make medical decisions for your three children?

A. We do.

Q. And if puberty continues to cause Brooke the distress she's experienced in the past, have you and Shayne made the parental decision to start her on puberty blockers if they're recommended by her doctor?

A. We have made the decision that we would do whatever Brooke needs to keep her healthy and safe and affirm who she is. And we would enter into that decision informed, but I'm going to do what my kid needs to make sure that

she can grow up and in way that affirms who she tells us that she is.

Q. Let's switch gears just a little bit and talk about what would happen if gender-affirming care is banned.

Where do you live?

A. We live in Bentonville, Arkansas.

Q. How long have you lived in Arkansas?

A. My husband has lived -- was born and raised here his whole life. And I moved here when I was about Brooke's age, about nine, ten years old.

Q. And what is your current job?

A. I recently started a new role. I'm head of business operations for our digital ad platform at Sam's club within the Walmart enterprise.

Q. Other than Shayne and your three children, do you have any family here in Arkansas?

A. We do. So my parents live in south Arkansas. Shayne's parents live in Bentonville with us. They moved to Bentonville when we moved up there six years ago, and sisters, you know, nieces, nephews, friends, you know, our whole family. Everybody is here.

Q. Do your children go to school in Bentonville?

A. They do.

Q. Do they have friends there?

A. A lot. They have -- all their friends are here.

Q. Are they involved in any school activities?
A. Brooke is very excited because this is the first year in -- kind of in school where they get to be in clubs, and she's in drama club. She's really excited about that. They're in, you know, various things, music and choir and, you know, that kind of stuff, but yeah.
Q. Are you aware of Act 626?
A. I am.
Q. And what is your understanding of how Act 626 would affect Brooke if it goes into effect?
A. It would remove the ability for transgender minors to receive the gender-affirming, life-saving care that they need most, specifically my daughter.
Q. Does that concern you?
A. Yes, very.
Q. Can you say why?
A. You know, I -- I have three children, and just one of them not being able to get the health care that they need in the state in which we live is so distressing and upsetting to me that just one of my kids -- and I've always promised all of our children we will care for you and do what is necessary to allow you to grow and live a happy life. And the fact that I can't or potentially would not be able to get care for one of my children is it's -- it fills me with such sorrow almost that that

would happen here where I live.
Q. How do you imagine Brooke's life would change if she had to go through a typical male puberty?
A. It's something I -- it's hard for me to even think about the potential of that happening. I worry about her, the distress that it causes her when she tells us, this scares me and I don't want this and this is not what I want. I worry that, should she be forced to do that, you know -- it's hard to allow myself to think about what could happen for her.
Q. Has your family discussed what you would do if the law does go into effect?
A. We have.
Q. What would you do?
A. It's such a difficult conversation and decision to even contemplate and think about and it's almost a circular thing and it comes down to we have two options, neither of which are good. One option would be to travel out of state to a provider or a state where she could receive the care that she needs. The other option is to move out of state.
Q. If you were to travel where would your family go to get Brooke's medical care?
A. We've talked about this a lot. And my husband and I have decided that what makes sense for us and our family

and for Brooke is to find a provider somewhere that we feel like she can establish a relationship and with someone that could get to know us, get to know Brooke, and somewhere where that may not have the potential to be interrupted again at some point because I think it's important to have that -- that relationship and that understanding between a care team and us and Brooke. And for where we live, what makes most sense is probably Colorado.

Q. Would traveling for treatment affect your family?

A. Yes. I mean, in a lot of ways.

Q. Can you describe some of those?

A. Yeah. I mean, we have, like I said, three children. We have two other children. So the logistics of, you know, having to travel out of state at, you know, some regular cadence would be difficult because we have two other kids that we would have to make arrangements for.

Financially it would be difficult. You know, flying. Just the travel in itself would be expensive. Taking Brooke out of school. One of Shayne or I having to take off work for -- you know, there's just a lot of unknowns surrounding that that it just seems like a really big thing to have to like sort out and figure out, you know, for our family.

Q. You mentioned that you had some family in the area.

Would traveling out of Arkansas affect your ability to -- your relationship with them?
A. It would. Shayne's parents, my in-laws, moved with us to Bentonville. My father-in-law has Parkinson's disease and it's advanced significantly since we moved to Bentonville six years ago. It hard to just pick up and go away for, you know, extended periods of time because Shayne's mother needs support and backup and we help out quite a lot. And it's hard because they -- you know, we need to be there for them as much as, you know, they're there for us sometimes, you know, from a support standpoint.
Q. If it weren't feasible to travel back and forth for Brooke's medical care, have you considered what you would do?
A. The other option is to move out of state.
Q. Would you also move to Colorado?
A. Most likely. That is still -- you know, the -- the state where we would feel comfortable being able to continue to receive the care for Brooke and -- but still relatively close to Arkansas.
Q. Would leaving Arkansas affect your career?
A. It would. It would be difficult. I would have to have approval for a remote exception in that particular state because I don't -- we don't have that right now.

That would require CEO approval and it would also be difficult. I am the only leader that sits -- from our team that sits in Bentonville, and it would -- it would be difficult for me to continue to advance my career.

Q. How do you think your three children would handle leaving Arkansas?

A. They don't want to leave. I mean, they have friends here. My oldest is a freshman in high school and, you know, that's tough for him to leave. And, you know, again, Shayne's parents live here and, you know, we can't ask them to pack up and move with us. That would be difficult. So it would be hard to leave our community and our people that love us.

Not only family, but, you know, the friends that we've made. And it would be hard for my children to have to be away from their grandparents. My mother also lives in Arkansas, and she's a widow and she needs support and help and she isn't in great health.

We just have so many responsibilities, but beyond that, this is the state that we love. We love it here. And, you know, Shayne has lived here his whole life and, you know, we have deep roots in this state and we don't -- it's just -- it would be sad to leave and -- but just the difficulty of this decision is -- it just -- it's almost like this kind of circular decision that we have to like

continue to think about all the time.
Q. What would happen with Shayne's father if you moved?
A. Shayne's dad, the care that -- you know, that he needs has been established with a good medical team in northwest Arkansas. It would be physically very hard on them to move again. It would also be -- you know, they have established a community of their own in northwest Arkansas. It would be unfair to ask them at this point in their lives to make another big change and move. It's not -- Shayne's dad isn't in the position where he -- a move would be good for him physically and in his kind of general well-being and care.
Q. So would you have to make alternative arrangements for their care?
A. We would. We would have to -- to determine what would be best to make sure that, you know, as a caregiver, my mother-in-law has the support that she needs, you know, because it is a -- it's hard to care for someone with an illness, you know, like that. And making sure that they have the support and just that -- it would be difficult and we would have to figure out how to make sure that they had that care and the support surrounding them, and another thing on the list of things that we have to think about that we shouldn't.
Q. How do you feel about the prospect of leaving

Arkansas if necessary to get Brooke the medical treatment that she needs?

A. It makes me sad that -- that I wouldn't be able to get -- Brooke wouldn't be able to get the care that she needs in the state in which we live. And thinking about having to, you know, travel or move, it causes all of us stress and anxiety and worry and -- when we should be just focused on like raising our kids and, you know, helping them grow into adults, you know. And it's upsetting and distressing that this is -- has to be such a -- something that we have to think about and contemplate so much.

Q. Thank you, Ms. Dennis.

MS. GOLDSMITH: Nothing further.

MR. JACOBS: Nothing from us, Your Honor.

THE COURT: You can step down, ma'am.

THE WITNESS: Thank you.

MS. WALAS: Breean Walas for the plaintiffs. Plaintiffs call Joanna Brandt.

THE COURT: Ms. Brandt, do you swear to tell the truth?

THE WITNESS: I do.

THE COURT: Have a seat, please.

JOANNA BRANDT, PLAINTIFFS' DEFENSE WITNESS, DULY SWORN

DIRECT EXAMINATION

BY MS. WALAS:

Q. Would you please state and spell your name for the court?
A. My name is Joanna Brandt, J-o-a-n-n-a B-r-a-n-d-t.
Q. Where do you live?
A. Greenwood, Arkansas.
Q. Do you have any children?
A. Yes, I do.
Q. What are your children's names?
A. Erica, Dylan, and Luke.
Q. What are their ages?
A. Erica is 28. She'll be 29 in a few days. Dylan is 17 and Luke is 14.
Q. Do you have custody of your minor children?
A. Yes, I do.
Q. With custody, do you have the responsibility of making medical decisions for your children?
A. Yes, I do.
Q. Who is normally involved in that decision making process?
A. That would be myself and typically would be their -- whatever medical provider I was seeing at the time.
Q. I'm going to show you Plaintiffs' Exhibit 7 which has already been admitted. Can you identify that?
A. That is Dylan and I in a photo that my best friend took in front of her front door.

Q. How would you describe Dylan?
A. Make me cry already.
Dylan is an exceptional human being. He is kind, he is thoughtful, he is reliable and responsible, he is wise beyond his years, and likely one of the most emotionally intelligent people I know. He is a loyal friend. He is a great brother to his siblings and an amazing son and grandson. To say that I am proud of him would be a gross understatement.
Q. What was Dylan's assigned sex at birth?
A. Female.
Q. Is Dylan transgender?
A. Yes.
Q. What is Dylan's gender identity?
A. Male.
Q. When did you first learn that his gender identity was male?
A. When he was 13, he had his brother give me a letter.
Q. What type of clothes did Dylan prefer as a child?
A. He always gravitated toward a more masculine attire. He was definitely not interested in more typically feminine clothing.
Q. Did anything happen when you would try to put Dylan into, say, a dress?
A. He refused.

Q. What type of activities did Dylan prefer as a child?
A. He enjoyed playing with Legos. He enjoyed following my dad around the yard kind of tinkering with things. He was quite likely to be found outside in a mud puddles and catching bugs. Around the fourth grade or so I think he developed a love for football which was funny because I hated sports and nobody really in the house watched sports, but he developed a love of football and would play football at recess with the boys at school when they would let him.
Q. When did Dylan first tell you he was transgender?
A. Like I said, he was 13. It was shortly after school got out beginning of June in 2019 that he let me know how he was feeling.
Q. How did Dylan let you know that he was transgender?
A. So I was sleeping on the couch one night watching TV and Dylan walked past me and said he was going outside and -- which I thought a little strange. It was evening time and I didn't know what he was doing. But anyway he went outside and then 30 seconds later his brother -- younger brother came to me and handed me a letter and immediately turned around and left the room. I read the letter and in the letter he explained to me that he was trans.
Q. How did that feel for you?
A. My very first concern was that I made sure that he

knew that he was loved and supported. So I called him in so that we could discuss it. I was a bit surprised. I hadn't really seen that coming, but I just I wanted to make sure that he knew he was loved and supported. I felt a little bad that he had been maybe struggling with this for a while and that I had missed it.

Q. What did you do after you read that letter?

A. Well, after I read the letter, I -- again, I called him in and we had a long, emotional conversation. And then once we were done doing that and he went back to his room, I pretty much immediately started Googling to start to kind of -- I was trying to wrap my brain around it and starting to kind of get some information.

Q. Did you have any concerns?

A. Yes. I mean, as much as I, you know, think as a parent we're concerned any time anything new comes up with our kids, and so I was probably mostly concerned about how this was going to go over in our small conservative town that we lived in. But then after that, it was -- I just wanted to make sure, like with every other medical decision I've ever made for my kids, that I was putting their health and well-being first and doing what was right for them.

Q. During that conversation, did Dylan express any distress about his body?

A. He did.
Q. What was that?
A. It was predominantly his chest. He also had quite a bit of distress around -- he had already started puberty so he was already having a period and he felt quite a bit of distress around that as well.
Q. Did he have any distress about any other parts of his body?
A. I think he started to notice that things were changing again with the onset of puberty that he had kind of been hiding under clothes a little bit. But it was mostly his chest and the period that bothered him the most.
Q. Was there anything else that Dylan expressed during that conversation about his gender identity?
A. He immediately asked that we stop referring to him by his birth name. In the letter he had signed it, your son, Dylan. And that was his first preference. He also requested that we begin to use he/him pronouns.
Q. What steps did you take immediately after Dylan came out to you as transgender?
A. Well, the first thing I did was respect those initial requests that he had made and I started working on changing the way I addressed him. Then again, I just really functioned best when I have lots of information.

The unknown makes me very uncomfortable. So I spent probably an enormous amount of time Googling trans youth and also I, you know, took to Facebook like we all do and found some parent support groups to start to get an idea of what other families were going through and just to get an idea of what was going on with, you know, not only my son but others other kids like him.

Q. After that conversation, how did Dylan present outside of the home?

A. Well, he had already cut his hair short, shorter than it had been, but he asked for it to go even shorter. We no longer were looking at girl's short hair cuts on Pinterest, we were looking at boy's short hair cut on Pinterest to find one that we liked. We also shopped for the first time in the boy's section when we went school clothes shopping. So he -- he had already really had a more masculine way about him for a few years prior, but he definitely leaned into that more socially outside of the house than he had before.

Q. You talked about going to the boy's section of the clothing store. What was that experience like?

A. It was very affirming for him. If I remember correctly, I'm pretty sure it was Plato's Closet and he went to the boy's section and started looking through clothing and then went and tried them on and we purchased

a few things and he was -- he was just incredibly happy. He felt supported and affirmed, and that brought him a level of comfort and enjoyment that he had not had before that.

Q. During that time period, did Dylan start to get recognized and addressed in public as a boy?

A. Yes. He sure did.

Q. Did you notice any changes in Dylan's mood or behavior when he began to be recognized and addressed as a boy in public?

A. Again, any time he had any type of social validation or affirmation of his male gender, it was always a good day for him. For instance, there would be occasions where we would be out to eat and the waitress would get my drink order and then turn to Dylan and his brother and say what would you boys like. And I would just see him light up across the table. He couldn't help but smile. He's always been -- words are hard -- opening the door for people. Very polite, I guess is the word I was looking for. And when he would get the, thank you, sir, that also -- I would always look back and it was him beaming.

So that social -- that occasional social affirmation of who he already knew he was was nice for him.

Q. With the social transitioning, did the distress that Dylan expressed to you during that first conversation go

away?
A. No.
Q. What continued?
A. He still had quite a bit of distress about his chest. He still really had issues with his period. He also expressed his desire to look more like the other boys at school. He knew the ways in which he didn't and wouldn't and that bothered him.
Q. Has Dylan been diagnosed with gender dysphoria?
A. Yes.
Q. When Dylan's pediatrician referred you to Children's Hospital or Arkansas Children's Hospital Gender Clinic, what did you do?
A. I don't recall whether I called or whether I emailed to get more information but I contacted them again either via email or a phone call.
Q. And when was your first interaction with the gender clinic?
A. Kirsten, the social worker, called me in November and we had a pretty lengthy phone conversation.
Q. What did you discuss during that call?
A. Oh, gosh, it felt like everything. I wish I would have taken notes at that point because there was so much information.
Kirsten took some time to get to know our family

dynamic, asked a lot about Dylan and what kind of kid he was. Obviously, we discussed his gender identity incongruence that was going on. And I was also able to ask questions as far as what the gender clinic offered, kind of what their protocol was. Again, I function best with lots of information. So I was really interested to know as much as she could tell me at that time about what their procedures were and how they tended to move forward up and down, what they offered to kids like Dylan.

Q. Did you have any concerns during that conversation?

A. Not necessarily. No. I wouldn't say I had any concerns. I felt like it was a real good first step in being able to again -- gather more information so that I could make sure that down the road I was making informed decisions about -- about Dylan, about his potential care. So, no, it felt like a pretty good first step.

Q. You said it was a first step. What steps did you take after that?

A. There was lots more Googling. I spoke with -- I had the opportunity to meet some other parents of trans kids. We had lots of conversations with them. They shared their experience with me. And then after that conversation with Kirsten, our next kind of official -- we had -- we ended up having a visit at the Arkansas Children's Hospital Gender Spectrum Clinic January of 2020.

Q. And at that January 2020 appointment, who spoke with you?
A. We met with Dr. Hutchison. We were able to meet Kirsten in person. The staff, whoever happened to be available for to us meet of their staff, we were able to meet that day. But the bulk of our conversation was with Dr. Hutchison that day.
Q. Were you provided information at that time?
A. Yes.
Q. Did Dr. Hutchison discuss possible treatment options for adolescents with gender dysphoria with you and Dylan?
A. Yes. We did get around to discussing options.
Q. What type of treatment did you discuss?
A. We discussed the possibility of cross-hormone therapy at some point, testosterone. We also, in discussing the things that Dylan seemed to be most distressed about, we -- that one being his period, we discussed what we might be able to do to put a stop to that.
Q. Did you discuss any sort of mental health therapy for Dylan at that time?
A. Yes, we did. So Dylan had actually been in therapy previously. We were kind of in between therapists at that doctor's visit, so I did ask if they knew of any kind of affirming therapist in our area since we are a couple of hours away because we were in the process of looking for a

new therapist. And they did in the -- in the process of explaining their protocol, they had let us know that being in therapy was one of the requirements. We were not opposed to that, we were just kind of in between due to some insurance issues.

Q. Did Dr. Hutchison discuss with you the various risks and benefits of each of those treatment options you just discussed?

A. Yes.

Q. Were you given any information in writing?

A. Yes.

Q. Did you ask any questions during that meeting?

A. Oh, lots.

Q. Did you feel that all your questions were answered?

A. Yes.

Q. Was Dylan prescribed any medication during your first visit to the gender clinic?

A. Yes. He received an injection of Depo-Provera.

Q. What was the purpose of that Depo-Provera?

A. That was to hopefully suppress his menstruation.

Q. Why did you decide to move forward with the Depo-Provera at that time?

A. That was a pretty easy decision for me because he was experiencing such distress over his period that if that was something that was available that could help relieve

some of that distress for him, it seemed like the kindest thing to do. I was familiar with Depo. I knew people that had been on it. So I felt like that was a safe and effective first step, hopefully, to relieve some of the distress that he was feeling.

Q. Did you have any concerns about the Depo-Provera?

A. I did not.

Q. Did the Depo-Provera address Dylan's gender dysphoria?

A. It did not.

Q. After that visit, did you continue to research treatment for Dylan?

A. I did.

Q. Did you and Dylan discuss the possibility of starting on testosterone?

A. We discussed it often, yes.

Q. Was there ever a time that he came to express a desire to start testosterone?

A. Yes. He -- I mean, he expressed it a desire for testosterone pretty early on in our conversations. Again, he had a little bit of a jump on me when he came to me as far as what his desires were. So, yeah, we had lots of conversations. And he expressed to a desire for that. But, again, I wanted to make sure I did my due diligence to make sure that I was making good decisions for him.

Q. When Dylan first expressed his desire to start testosterone, what was your initial reaction?
A. I, again, just like with every other medical decision I have ever made for any of my kids, I always want to put their health and well-being first. I questioned just about everything. So my concern was just to know that I was making the best decision for him, not only emotionally, mentally, but physically, and that the only place I was going to be able to get that information was with medical providers that were experts and had experience. So I had concerns. So I went to the place where I felt like I could get the information I needed to make an informed, intelligent decision.
Q. Did there come a time that you felt you would be open to Dylan going on testosterone if supported by his doctors?
A. Yes. I was always open to the idea. I just needed to make sure that -- that it was what was in his best interest. Just because it was something that he wanted to do, I wasn't going to jump without making sure that it was -- was best for him.
Q. When did you next visit the gender clinic?
A. August of 2002.
Q. What happened at that visit?
A. At that visit, Dylan met with the psychologist. And

then after Dylan met with the psychologist, I met with the psychologist. We also met with Dr. Hutchison and had a long conversation with her. I believe we also spoke to Kirsten, the social worker, that day as well. And then Dylan did end up getting his first injection of testosterone at that visit.

Q. Did Dr. Hutchison talk with you and Dylan about the benefits and risks of taking testosterone?

A. Yes, she did.

Q. Did Dr. Hutchison talk with you and Dylan about the possible or likely effects of hormone therapy?

A. Yes.

Q. Did Dr. Hutchison go over the informed consent process with you?

A. Yes.

Q. Did you consent to Dylan receiving testosterone?

A. Yes, I did.

Q. Did Dylan assent -- assent to receiving testosterone?

A. Yes, he did.

Q. Why did you and Dylan decide to move forward with testosterone?

A. By that point, with the approval of the psychologist who, after speaking with Dylan and myself, felt like that was an appropriate course of treatment for him, also with Dr. Hutchison expressing that in her medical opinion it

was an appropriate course of treatment for Dylan, Dylan's regular therapist that he had started seeing after that first January visit, she also agreed that at this point that would be or could be an appropriate course of treatment for him and Dylan and I talking about it, we, he and I, felt very comfortable. I felt very comfortable at that point that that was also the appropriate course of treatment for Dylan and we were excited about it.

Q. How long has Dylan been on testosterone now?

A. Little over two years.

Q. Has he experienced any negative side effects?

A. No, he has not.

Q. How has Dylan changed physically since he started on testosterone?

A. His voice as gotten very deep. I remember some of the first times that -- when I first started noticing that that was probably really one of the first things that happened. I -- we share a wall between our bedrooms and I could hear this voice reverberating. And I was like, who is that?

But, yeah, so his voice became deeper, more body hair, facial hair. I feel like his kind of body fat makeup kind of changed a little bit, kind of shifted. And a little bit of his face shape changed just a tiny bit. He looks a lot like my dad did now, which is nice. But,

yeah, those are probably -- he wishes he had gotten taller.

Q. What else have you noticed about your son since beginning hormone therapies for his gender dysphoria?

A. I compare it to a feeling that he had been holding his breath for years and he was finally able to exhale and relax. The changes that I have seen in him have been quite remarkable. The deeper the voice got, the thicker the beard got, the more his external appearance came into alignment with who he knows himself to be, he just lit up. I noticed it. Everybody else around him noticed it. His capacity for empathy for others. But in my opinion, more importantly for himself has, again, been remarkable.

I mentioned that he's one of the most emotionally intelligent people I know. And in part that happened after he started his life-affirming, gender-affirming care. The kid that Dylan was prior to his care would not be here in this courtroom today. It is only because of his gender-affirming care that he has been able to advocate for and fight for himself. The confidence in who he knows that he is has allowed him to put himself in a position to do not only for himself but for others what, quite honestly, I don't think most adults could. That is all because he was allowed the space and time to affirm who he is.

Q. How long have you been living in Arkansas?
A. I moved to Arkansas in 2004.
Q. You mentioned earlier that you live in Greenwood. How long have you lived in Greenwood?
A. Since 2009.
Q. What do you do there?
A. I'm a small business owner.
Q. How long have you owned your shop?
A. Three and a half years.
Q. Are you your family involved in any community organizations?
A. I'm on the Greenwood Economic Development Committee.
Q. And then other than your two boys, do you have any other family in Arkansas?
A. My mother's there and my sister lives across the street.
Q. Do your sons go to school in Greenwood?
A. Yes, they do.
Q. Do they have friend there?
A. Yes, they do.
Q. Do you have friends in Greenwood?
A. Yes, I do.
Q. Are you aware of Act 626?
A. Yes, I am.
Q. What is your understanding of what Act 626 would mean

for Dylan if it goes into effect?
A. It would mean he would lose the care he's been receiving.
Q. Are you concerned about what would happen to Dylan if he lost that care?
A. I'm very concerned about Dylan if he were to lose that care.
Q. Can you explain that concern to the Court?
A. All of the things that I just said about who he is and who he has become since then, my concern would be that he would lose all of it, but not only would he lose it, he would know that it was taken from him. And I would be very concerned about how that would affect his mental and emotional health.
Q. Have you and your family discussed what you would do if Act 626 went into effect?
A. We have.
Q. What have you discussed?
A. We've discussed a couple of different options. We've discussed a little bit the idea of traveling outside of the state to get his care. That would be very difficult. We don't really discuss that one very much. It would just be really hard. And we've discussed the idea of moving out of the state, and not that that wouldn't also be very hard, but that's just probably the one we have talked

about more.
Q. Have you made any plans to move if the law goes into effect?
A. No concrete plans, but because it would be hard. I don't really know how I would do it. I'm a pretty resourceful person and I would figure it out, but we have not -- we've not picked a place or necessarily made a plan, but we know that that is what would happen one way or another.
Q. Would it have a financial impact on your family to have to move out of the state for Dylan to get his care?
A. It would have a huge impact. We are a one-income household and with owning my business, which I love, I would have to give up that, and then I would have to figure out how I was going to provide for us once we went somewhere else. I don't have a college education, so that's a little scary for me that I don't have something to fall back on.
And then we own -- I own a home. And so it would -- yeah, it would just be really -- it would be really difficult. Again, I don't know how I would do it and it would -- it would put a great strain on my entire family.
Q. How do you feel about the prospect of having to move your family from Arkansas?
A. I don't like it. Especially, not if -- when I feel

like I potentially be forced out. We're not ready. We're not ready to go anywhere. Again, we've got family, we've got friends, we've got roots, we've got -- we're established where we are. So the idea of having to uproot all of that is scary.

MS. WALAS: Pass the witness.

MR. JACOBS: Nothing from us, Your Honor.

THE COURT: You can step down.

We're going to take a short break. So I'm looking at document 158 that objects to the deposition testimony of Amy Embry in its entirety because she cannot be proven to be unavailable.

Is the government still standing on that particular objection and do we need to bring Ms. Embry in to testify to what's contained in her deposition and her counter-designations, or is the government going to waive that particular objection but not the objection to the particular designation?

MS. LAND: That's correct, Your Honor. The defendants would not object to the unavailability portion of that objection.

THE COURT: Put more --

MS. LAND: -- or they would withdraw that --

THE COURT: -- use of her deposition to the extent it's admissible otherwise. Is that fair?

MS. LAND: Correct.

THE COURT: Is that the same for the other two in this notebook dealing with Ms. Lundstrum and Dr. Branman, if that's how you say that. I thought it was -- R-h-y-s Branman.

MS. LAND: Your Honor. Dr. Rhys Branman is a defendant in this case, so it would be the same analysis as with Amy Embry, who is also a named defendant in this case.

However, Representative Lundstrum is not a named defendant, so there would be some potential hearsay concerns. But as I understand it, the Court is allowing the plaintiffs to proffer that deposition to all three deposition testimonies and is noting the defendants' objections for the record.

THE COURT: I guess what I need to do is, I thought I was just ruling on the designations, not the fact that we needed to bring them in here live. So what I'm trying do is determine that if, you're saying that it's improper for me to use the depositions regardless of what it says, the plaintiffs need the opportunity to bring in in this case Representative Lundstrum live to testify, or can I use her deposition to determine whether or not what she said in her deposition is admissible or not?

MS. LAND: I'm a little confused because I

thought we addressed all of this on a previous day. I'm not clear on what -- I'm not clear if the plaintiffs have raised an additional issue on what was discussed.

THE COURT: No. I'm just reading your objections to various designations. And they, as a matter of course -- I thought it was unnecessary because it had already been sent to me -- submitted those for the benefit of this proceeding said these, three depositions and they're -- and I said, okay, they're already in the record.

What I'm asking is, am I able to rely on the fact that we're going to use these depositions to whatever extent I think they're appropriate. You don't waive your objection to any particular question or answer within these depositions, but I need to know, are you standing on any objection that the mere presence of this witness live is inappropriate?

MS. LAND: Can I have one moment, Your Honor?

THE COURT: Sure.

MS. LAND: Your Honor, we would maintain the hearsay objection as to Representative Lundstrum. As I understand it, there's been no showing by the plaintiffs that she is in fact unavailable to testify. However, I will add that --

THE COURT: Does that mean they need to subpoena

her this afternoon, I guess is what I'm saying. We're trying to set up things for Friday. And I guess my question is, do you prefer for me to rely on her deposition or does she prefer to appear live? But I need to know that before we move forward because we're scheduling witnesses for Friday.

And I was reading back over your objections and I thought it was really just objections to designations until I read a paragraph in there where you say, we don't think it's appropriate to use depositions, period.

So you can either stand on that and I'll rule on it now. And if that's the case, they can subpoena Representative Lundstrum for Friday or whenever and she can come in, or if she prefers, I can use her deposition.

That's my question to you: Would you prefer she be subpoenaed live or do you prefer that I use her deposition or do you need to talk to her about that?

MS. LAND: We'll say -- we would like to just say it's okay to use the deposition but we would like to, for the record, maintain those objections.

THE COURT: You don't get both. I'm going to rule right now that she can either be made available and I'll have her live or you can declare her unavailable and I'll use her deposition, but you can't straddle the fence on that.

MS. LAND: We'll waive availability.

THE COURT: That's all I needed to know.

MS. LAND: Thank you, Your Honor.

THE COURT: So I can read these three depositions as if we're going to read them to the extent I find them admissible either -- for whatever objection that you've announced in what I'll call your -- it's not really an Excel spreadsheet, but there's a spreadsheet embedded in these documents that has page, line, and objection.

So I will give you some kind of indication if I'm going to use this, what objection I've either overruled or sustained.

MS. LAND: Understood.

THE COURT: For these three depositions. Is that the same with any other -- do I have any other -- one other question. I'm assuming that the counter-designations are in orange or peach?

MS. LAND: I believe the plaintiffs made the initial designations. Ours would be the counter-designation. Correct me if I'm wrong, I believe the plaintiffs were in yellow and ours were in orange.

THE COURT: That's what I assume, but I just wanted to make sure that --

MS. LAND: Or peach or whatever color it showed up.

MS. WALAS: Your Honor, Breean Walas. Since we're on this matter and you just asked if there was anything else for you to review with respect to deposition testimony, as we mentioned yesterday, we were going to bring up the legislative history and the transcripts of those hearings today that the Court could take judicial notice of. And we would move to admit/proffer for the Court's review Plaintiffs' Exhibit 22, which is the transcript of the March 10, 2021, House hearing. That -- Plaintiffs' Exhibit 23, the transcript of the March 22, 2021, Senate hearing; Plaintiffs' Exhibit 24, transcript of the March 29, 2019, Senate hearing; Plaintiffs' Exhibit 25, the transcript of the March 9, 2021, House hearing; Plaintiffs' Exhibit 26, transcript of the April 6, 2021, House vote; Plaintiffs' Exhibit 27, the transcript of the April 6, 2021 Senate vote.

And we would submit, as we noted yesterday, that the Court can take judicial notice of the legislative history, obviously, subject to defendants' relevance objection that they have made with respect to when we put these on the exhibit list and the objections that they have noted there in.

May I approach, Your Honor?

THE COURT: Is all of that in one notebook?

MS. WALAS: I have it in one notebook. Your

Honor, we also have as an exhibit, Plaintiffs' Exhibit 21 the videos, but that you will ask if you would like the videos of what -- as well or if you would just prefer to just have the transcripts.

THE COURT: Those are the videotapes of the deposition transcripts?

MS. WALAS: No, Your Honor. Those are the videos of the actual hearings. These -- the transcripts that we have, those are the videos of the hearing.

THE COURT: You can make them part of the record and I'll either rule on them with the rest of it or not, but I can give you a high level of confidence that I'm not going to watch video if I've got a transcript of the floor, like C-SPAN or whatever.

So if you want to hand me that. I'm not going to rule on that right now, but I need to know --

MS. WALAS: Thank you, Your Honor.

THE COURT: I thought y'all were conferring. I was waiting for you to finish conferring. If you'll let me know when --

MR. JACOBS: That's all right. So I guess as I see, there's the issue of admitting it quote/unquote into evidence versus judicial notice. If the --

THE COURT: In a bench trial, it may not make much difference.

MR. JACOBS: That may be true. I think we'll maintain our relevance objection, but to the extent the Court thinks any of this judicially noticeable, I suppose the other objection won't apply anyway.

THE COURT: You have an argument that it is or isn't judicially noticeable?

MR. JACOBS: I think we'll maintain our relevance objection and let the other ones lie.

THE COURT: So you're not making any objection that it is not judicially noticeable?

MR. JACOBS: I'd have to pull up the judicial notice rule again. I think the entire statements people are making during committee hearings is sort of a stretch in terms of a judicially noticeable fact, like what the weather service says is the weather on a certain day. I recognize I think they have some cases where that's happened.

THE COURT: Weather is nice today, I noticed. I've got a hodgepodge of things here and so --

MR. JACOBS: I think in terms of the transcripts of the testimony, in terms of a judicially noticeable fact, the rules say something that's generally known within the Court's territorial jurisdiction. While what was said in a transcript of a hearing may be knowable, I don't know that I would say it's generally known that

people are --

THE COURT: Neither is the weather on the 15th of three months ago. It can be generally known by looking it up, but I can promise you most judges don't judicially note things just because they actually have a memory of them.

MR. JACOBS: I think I'll maintain that the -- that the contents of a legislative hearing are not the kind of adjudicative facts that are subject to judicial notice as a generally known act people in general would know.

THE COURT: So you do object? Do you want to provide me some law on your objection? Not this moment.

MR. JACOBS: So for -- in terms of the half of the question whether it gets admitted into evidence, I'll reiterate that we'll maintain relevance and rest on everything else.

In terms of whether these are judicially noticeable, as far as providing case law on that, would Your Honor prefer we do that during the course of -- now or address that in some post trial briefing?

THE COURT: Well, probably Friday morning before the defendants rest because it's going to be before they rest. I'm going to rule on whether or not their evidence is in as well as these deposition designations before they

rest, which I would have anticipated was Friday morning before you call your witnesses.

MR. JACOBS: Understood, Your Honor. If we're going to maintain our objection to the judicial notice, then we'll bring that up Friday and --

THE COURT: I need to know before then because I need to be prepared to rule Friday morning. Telling me, yeah, here's my brief, read it, digest it, and let me know is going to be too late Friday morning. You can think about it and we'll get back with it after this last witness.

I'm going to change out our court reporter. I'm going to take a short break and I'm going to ask you how many more witnesses you've got today and how long you think they'll last. Anybody at your table may respond.

MR. STRANGIO: Thank you, Your Honor. We have one more witness who will last 20 to 30 minutes, and that is our last witness in the case.

THE COURT: Thank you. Court will be in recess.

(A recess was taken at 4:08 p.m.)

* * * * *

REPORTER'S CERTIFICATE

I, Valarie D. Flora, FCRR, TX-CSR, AR-CCR, certify that the foregoing is a correct transcript of proceedings in the above-entitled matter.

Dated this the 26th day of October, 2022.

/s/ Valarie D. Flora, FCRR

United States Court Reporter

(Proceedings continuing in open court at 4:27 PM.)

THE COURT: Mr. Jacobs, I had a little research done while we were on the break, and the law of judicial notice says where there is no dispute as to the authenticity of such material and judicial notice is limited to law, legal facts or factual matters that are incontrovertible, such notice is admissible under the judicial notice. Is there any dispute as to the authenticity of these documents? Because if it's beyond dispute what they say, then I can judicially notice them.

MS. WALAS: Your Honor, they stipulated to the authenticity --

THE COURT: Go ahead, Mr. Jacobs, if you want to respond.

MR. JACOBS: I think it's noted on the exhibit list that we've stipulated to the authenticity of these exhibits. If the Court's ruling is that the incontrovertible factual nature means it was judicially noticeable, then I accept the ruling and stand on the relevance objection for when the Court considers it.

THE COURT: Understood. Thank you. Are y'all satisfied that they can keep that exhibit book for the moment?

MR. STRANGIO: We are, Your Honor.

THE COURT: Thank you for bringing your concern to my attention. That would have been unfortunate. But it's not. So call your next witness.

MR. STRANGIO: Plaintiffs call Dylan Brandt.

DYLAN BRANDT, PLAINTIFFS' WITNESS, DULY SWORN

DIRECT EXAMINATION

BY MR. STRANGIO:

Q Hi, Dylan. How are you doing today?

A Pretty good. How are you?

Q Good. Thank you. Could you please state and spell your name for the court reporter?

A Dylan Brandt. D-y-l-a-n B-r-a-n-d-t.

Q Where do you live?

A Greenwood, Arkansas.

Q Who do you live with?

A My mom and my brother.

Q How old are you?

A 17.

Q How would you describe your gender identity?

A Male.

Q When you were born, what gender were you designated at birth?

A Female.

Q Growing up, how did it feel for you when people saw you as a girl?

A It was pretty hard. It wasn't something -- it didn't feel right, but I didn't quite understand why it didn't feel right. So it was pretty hard. People acknowledging me in a

more feminine way, when inside, it just didn't match, it didn't feel right. So it caused a lot of stress and anxiety about going out.

Q How did that stress and anxiety sort of manifest for you?

A The process of going out was hard. I didn't want to, I didn't feel like I could. I kind of just wanted to stay in the comfort of my home where I didn't really have to worry about any of that. The feeling in my chest I got when somebody would acknowledge me in a more feminine way was something that was really hard to deal with because I didn't quite understand why it was happening, just all I knew was that it was, so it was hard because I didn't know why it was happening.

Q When you started puberty, how did it feel to have your body change?

A It was really hard. Something that I had to kind of learn how to deal with just because I knew that there was nothing I could do about it, but it was hard. It was hard to look at myself in the mirror and see my body changing and knowing that that was not what I wanted to happen, see things change, and it just made me really uncomfortable, it made me really unhappy. There was a big weight on my chest I felt like knowing that things were changing in a way that I really didn't want them to, did not make me feel comfortable. So it was hard.

Q What did it feel like to see photographs of yourself

growing up?
A It's hard to find a lot of them. I didn't take a lot of pictures. I wasn't comfortable with people taking pictures of me when I was younger. If there are, there's not a whole lot of me smiling. It was not an enjoyable experience for me because looking at them, it wasn't how I thought that I should look and how I wanted to look, so having those was hard, so taking them was just not going to happen.
Q When did you come out as transgender?
A I came out to my mom and my family in June of 2019.
Q What did you tell your mom?
A I told her that I was not her daughter and that I was her son and I told her how I was feeling, but ultimately that I was not her daughter and that I was her son.
Q What was her reaction?
A She was very supportive right off the bat. Right away we had a pretty in-depth conversation about how I was feeling, how I had been feeling, but she was really supportive right off the bat. And we talked a lot about it, made sure that I was comfortable and she was doing whatever I needed to be done.
Q What did it feel like to have your mother's support?
A That weight that I talked about kind of lifted a little bit. Although I knew that from the beginning before I told her that she was going to be supportive, knowing for a fact that she was just made all the difference, that weight was lifted

off my shoulders a little bit, and I felt like it was a step in the right direction that I could finally take steps to become who I knew that I was.

Q Did you take any steps as a family related to your gender at that time?

A Right away, I talked about how I wanted to go by a different name and be referred to as different pronouns so I voiced that and right away my family took to that and stopped referring to me as my birth name and started referring to me as Dylan and "he" in pronouns.

Q When did you first go to the gender clinic at Arkansas Children's Hospital?

A My first appointment was January 31st, 2020.

Q Why did you go to the clinic?

A We were referred to them by my primary doctor. And after that, my mom had done some research, had a few phone calls with them, and we went to check it out to decide if it was the right place for us.

Q Who did you meet with when you went to the gender clinic on that first visit?

A We met with Dr. Hutchison and Kristen and all of the other staff that was there. It was very nice. They were all amazing.

Q Did you discuss medical treatment at that meeting?

A We discussed the possibility of it happening down the

line, yeah, and my mom and I voiced my discomfort with my period and so we discussed ways on how we could eliminate that.
Q Did you have dysphoria other than your period?
A My chest was a big thing. There were other small things that just the way I looked as puberty started and things started changing, wasn't really comfortable with the way I looked just because I saw myself as more feminine and I didn't really appreciate that, but my chest was a big one.
Q Were you prescribed any medication at that visit?
A I was prescribed Depo.
Q Why were you prescribed Depo?
A To help eliminate my period.
Q Did you have another appointment at the gender clinic?
A In August of 2020.
Q As best you can recall, how was your mental health between that first visit in January of 2020 and August of 2020?
A It was better in a way. I still had a lot of dysphoria and discomfort, but at the same time I had a little bit of hope. We were taking steps in a direction I wanted to go, so I had some hope, I had some pressure release. But it was still -- it was hard. I was very -- the dysphoria was still very much still there. The continuous daily discomfort was still there. I didn't -- I still didn't want to go out, I still didn't want pictures being taken of me. But the time between the first and second appointment I had a little bit of

hope.
Q When you went back to the gender clinic in August of 2020, what happened?
A I went for my psychological exam, which is something that they have for their protocol, and Dr. Hutch and the psychologist both agreed that it was in my best interest that I could start testosterone at that time if I would like to.
Q Before starting you on the testosterone, did your doctors discuss the potential side effects of treatment?
A Yes.
Q Did you have any questions about how treatment would affect you?
A Yes.
Q What was the date that you started treatment?
A August 7th, 2020.
Q Do you remember it well?
A Yes.
Q How has it felt to be on testosterone?
A It's been one of the best feelings. I have grown so much since then, a little over two years. It's been one of the most amazing times of my life. The pressure that I talked about before has pretty much gone. I'm so much happier and more confident and comfortable with myself. Pictures, I am okay with people taking pictures of me. I take pictures of myself. I'm okay with them being out there and people seeing them.

Yearbook pictures are one of the craziest things that you don't really think about until it's something that you look at and you're proud of when, before, you weren't. Been one of the most amazing two years. I've learned a lot, been through a lot, but wouldn't change it.

Q How does it feel to look in the mirror and see yourself differently?

A My outside finally matches the way I feel on the inside. I have my days, but for the most part, this has changed my life for the better. I can look in the mirror and be okay with that, be okay with the way I look and it feels pretty great.

Q Do you see your grandfather when you look in the mirror?

A Yeah.

Q Have you experienced any negative side effects from taking testosterone?

A No.

Q Do you regret undergoing medical treatment for gender dysphoria?

A No.

Q Do you anticipate any other medical or surgical treatment?

A Yes.

Q What is that?

A I anticipate getting top surgery at some point down the line.

Q Why is that?
A My chest is still something that I'm very dysphoric about. It's probably my biggest thing. Always has been, but it's something that still causes me a little bit of discomfort still.
Q Are you continuing with your therapy?
A Yes.
Q Have you had further visits with the gender clinic at Arkansas Children's?
A Yes.
Q Why is that?
A Just so they can keep up, manage my health with the testosterone.
Q Do you ever fear for your safety?
A Yes.
Q Why do you?
A Being a trans kid in a small town in the South, especially with laws like this going on, people here make it very well known that I'm not welcome here, that they don't want me here, so it's scary. I go to school in a small town where the majority of people are great, but a small group of people make it very well known that they don't want me there and that I don't fit in or belong. So walk in the school halls, I'm always looking over my shoulder. When I'm sitting in class, I'm too paranoid about the people sitting behind me to focus on

the test in front of me because, you know, I'm 17, trans kid. I'm not the most well-liked person in a small town in Arkansas.

Q How would it feel if you had to stop your testosterone treatment because of the law at issue in this case?

A It would be really hard. It's something that I try not to think about. Because I know how well I'm doing now and I know how hard it was before I started this. So the thought of going back, I know that it would be probably a whole lot harder because I know how well it can be and I know how well I'm doing now. So going back is just not really an option.

Q What would you do if this law were to go into effect?

A We'd probably have to leave the state.

Q If you had to move, what would that mean for your family?

A It would mean uprooting our entire lives, everything that we have here. I have a job, my mom has a business, we have family, friends. We have a house, we have a community, we have a life here, and although we'll leave at some point, we're not ready. I still have a year and a half of high school left. My little brother still has his entire high school career left. We're not ready to leave yet. So being pushed out of a place that I've lived my entire life is really hard just because I've established a life here, I've established a community, I have friends. So it would be pretty hard to just up and leave it all behind.

Q Dylan, if you could describe the impact that your medical

treatment for gender dysphoria has had on your life in one word, what would that be?

A Hopeful.

Q No further questions. Pass the witness.

MR. JACOBS: Nothing from us, Your Honor.

THE COURT: You can step down, sir. Does that conclude our witnesses for today?

MR. STRANGIO: That's everything from us, Your Honor.

THE COURT: When are we starting Friday? Is the question to the floor. Anyone can respond.

MR. JACOBS: Your Honor, so our understanding is that the witnesses that are slated to go Friday, we've got two that are available starting in the morning at 9:00 a.m. so we'd suggest --

THE COURT: Nine it is unless you want to recommend another time.

MR. JACOBS: I think that works, Your Honor. I guess so recognizing we'll have a judgment as a matter of law motion prior to when we start. Would the Court like for that to happen now or Friday morning?

THE COURT: I don't think under the federal rules that that's necessary for you to file a motion for judgment despite what I might rule, but yes, I'll give you an opportunity to the extent I'm mistaken to make sure you cover

yourself, because it's not my problem if I'm wrong.

MR. JACOBS: To be honest, I agree with you.

THE COURT: So go ahead and prepare, be prepared to make it and that way we don't have to worry about it.

MR. JACOBS: So Friday morning, Your Honor?

THE COURT: Yeah.

MR. JACOBS: I'll be brief. I'll try to keep it at five or six minutes. From my understanding it's a formality, I agree with you, but to the extent some appeals court changes its mind later.

THE COURT: As I said, that would be your burden to bear, not mine, because if I'm wrong -- anyway, we are in accord. So yeah, whatever time you need for that to make sure you're covered. We all are. We'll do that.

MR. JACOBS: Nothing further from us today, Your Honor.

THE COURT: All right then. No court tomorrow. We'll go to wherever it takes us until we finish these three witnesses tomorrow no matter how long it takes to get it done, so be prepared. If it goes fast, fine, but if it doesn't, I plan to get these three out of the way on Friday.

MR. JACOBS: Your Honor, I know I said I didn't have anything else. Just to bring up the scheduling issue again for the week of the 28th, just to reup the fact that the plan that we've suggested if the Court's willing to go for the 28th of

November to December 1st, we can make that happen subject to one witness being remote if the Court can't block off those four dates and the plan is some sitting in the future and have everybody live --

THE COURT: Mr. Jacobs, my only reluctance is to have a day down on one of those that I don't know what it is. I'm fine on the 28th for those four days and to the extent you can tell me whether or not you need the morning or the afternoon so I can backfill like I've been doing at lunch, I'm fine with that. What I don't want is let's say Tuesday of that week we go till ten and then you go, that's all we got, we're going to do the rest Wednesday and Thursday and I've got -- I usually have enough to do back there, but I would like to know as soon as you might know the gaps that might come along.

And if you don't know, that's fine, we'll just set those four days aside now and plan on being back here on the 28th. And to the extent you know more and you can let me know, it would be appreciated so I can fill in some things that people are knocking at the door for.

MR. JACOBS: Understood. When we come back on Friday, I'll see if we can give updated information.

THE COURT: It doesn't necessarily have to be Friday, I'm just saying that as soon as you get a better feel for all of that, I can react to it by setting other stuff around you that won't necessarily get in your way if it's a

30-minute something, we can do that and then move back. But I would prefer not to set stuff on you just because it's your week.

MR. JACOBS: Understood, Your Honor. Thank you.

THE COURT: Last call.

MR. STRANGIO: Nothing from us, Your Honor. Thank you.

THE COURT: Nine on Friday then.

(Recess at 4:50 PM.)

REPORTER'S CERTIFICATE

I certify that the foregoing is a correct transcript of proceedings in the above-entitled matter.

/s/ Karen Dellinger, RDR, CRR, CCR
United States Court Reporter

Date: October 26, 2022