REPORTER'S RECORD
VOLUME 3 OF 4 VOLUMES
TRIAL COURT CAUSE NO. D-1-GN-23-003616
SUPREME COURT CASE NO. 23-0697

LAZARO LOE, individually and as parent and next friend of LUNA LOE, a minor; MARY MOE and MATTHEW, individually and as parent and next friends of MAEVE MOE, a minor; NORA NOE, individually and as parent and next friend of NATHAN NOE, a minor; SARAH SOE and STEVEN SOE, individually and as next friends of SAMANTHA SOE, a minor; GINA GOE, individually and as parent and next friend of GRAYSON GOE, a minor; PFLAG, INC.; RICHARD OGDEN ROBERTS III, M.D., on behalf of himself and his patients; DAVID L. PAUL, M.D., on behalf of himself and his patients; PATRICK W. O'MALLEY, M.D., on behalf of himself and his patients; and AMERICAN ASSOCIATION OF PHYSICIANS FOR HUMAN RIGHTS, INC. d/b/a GLMA; HEALTH PROFESSIONALS ADVANCING LGBTQ+ EQUALITY,	)	IN THE DISTRICT COURT
v.	)	TRAVIS COUNTY, TEXAS
THE STATE OF TEXAS; OFFICE OF THE ATTORNEY GENERAL OF TEXAS; JOHN SCOTT, in his official capacity as Provisional Attorney General; TEXAS MEDICAL BOARD; and TEXAS HEALTH AND HUMAN SERVICES COMMISSION	)	201ST JUDICIAL DISTRICT

HEARING ON APPLICATION FOR TEMPORARY INJUNCTION
AND PLEA TO THE JURISDICTION

On the 16th day of August, 2023, the following proceedings came on to be heard in the above-entitled and numbered cause before the Honorable Maria Cantú Hexsel, Judge presiding, held in Austin, Travis County, Texas;

Proceedings reported by machine shorthand.

A P P E A R A N C E S

FOR THE PLAINTIFFS:

KENNON L. WOOTEN
SBOT NO. 24046624
SCOTT DOUGLASS & McCONNICO
303 Colorado Street, Suite 2400
Austin, Texas 78701-2589
(512) 495-6300
kwooten@scottdoug.com

ALLISSA POLLARD
SBOT NO. 24065915
ARNOLD & PORTER KAYE SCHOLER, LLP
700 Louisiana Street, Suite 4000
Houston, Texas 77002-2755
(713) 576-2451
allissa.pollard@arnoldporter.com

LORI B. LESKIN
(Admitted Pro Hac Vice)
ARNOLD & PORTER KAYE SCHOLER, LLP
250 West 55th Street
New York, New York 10019-9710
lori.leskin@arnoldporter.com

OMAR GONZALEZ-PAGAN
(Admitted Pro Hac Vice)
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
120 Wall Street, 19th Floor
New York, New York 10005-3919
(212) 809-8585
ogonzalez-pagan@lamdalegal.org

KAREN L. LOEWY
(Admitted Pro Hac Vice)
LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC.
1776 K Street, N.W., 8th Floor
Washington, DC 20006-2304
kloewy@lambdalegal.org

HARPER SELDIN
(Admitted Pro Hac Vice)
AMERICAN CIVIL LIBERTIES UNION FOUNDATION
125 Broad Street, Floor 18
New York, New York 10004
(212) 549-2500
hseldin@aclu.org

A P P E A R A N C E S
(CONTINUED)

FOR THE DEFENDANTS:

JOHNATHAN STONE
SBOT NO. 24071779
HEATHER DYER
SBOT NO. 24123044
CHARLES K. ELDRED
SBOT NO. 00793681
Assistant Attorneys General
OFFICE OF THE ATTORNEY GENERAL
P.O. Box 12548, Capitol Station
Austin, Texas 78711-2548
(512) 463-2120
johnathan.stone@oag.texas.gov
heather.dyer@oag.texas.gov
charles.eldred@oag.texas.gov

I N D E X

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AUGUST 16, 2023

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PROCEEDINGS

THE COURT: As I understand it, we're going to resume with your case-in-chief. Who would you like to call as your next witness?

MS. WOOTEN: Your Honor, we'd like to call Nathan Noe, Mr. Noe. And he is a 16-year-old minor proceeding under pseudonym.

THE COURT: Okay.

MS. WOOTEN: So I just wanted to tell the Court that to ensure you're aware of it.

THE COURT: Thank you very much.

Hello. Mr. Noe, if you'll come right up here with me and I'll swear you in, and then you can take the witness stand, okay? Right here is fine. And if you'll raise your right hand.

(Witness sworn)

THE COURT: All right. You can make your way around the court reporter and up to this chair here. There is some water here if you need some, okay?

MR. SELDIN: Your Honor, may I?

THE COURT: Yes, you may.

NATHAN NOE,

having been first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. SELDIN:

Q. Good morning, Nathan.
A. Good morning.
Q. Are you Nathan Noe?
A. Yes, I am.
Q. Is that your legal name?
A. No, it is not.
Q. Why are you using a pseudonym in this case?
A. Today I'm using a pseudonym because we think that it would be safer for me and my family to not be publicly identified as a transgender person and the family of a transgender person. And I also would like to continue to be able to not have to disclose the fact that I'm transgender publicly, to everybody I mean.
Q. And do you live in Texas?
A. I do.
Q. What county do you live in?
A. We live in Williamson County.
Q. And who do you live with?
A. Currently I live with my mother and my father, my two younger siblings, and my elderly grandmother.
Q. Do you have pets?
A. I do. I have seven pets.
Q. We won't make you name them all. Does your family belong to PFLAG?
A. Yes.

Q. And how old are you?
A. I'm 16 years old.
Q. And what grade are you in?
A. This year I'm a junior.
Q. And where are you supposed to be today?
A. Today is supposed to be my second day of high school.
Q. And what do you do when you're not in school?
A. I like writing a lot. I like gardening. I participated in choir, and I swim.
Q. And when you were born, what sex were you assigned at birth?
A. I was assigned female at birth.
Q. And growing up, how did it feel for -- well, let me take a step back. How would you describe your gender identity today?
A. I'm male.
Q. And growing up, how did it feel for you when people saw you as a girl?
A. When I was a very young child, gender didn't really have much bearing in my life and my identity. I was kind of just a child rather than a girl child or a boy child. When I got a bit older, like 10, 11, that's when I started puberty, and gender became, like, a part of my life. It was -- it felt jarring to be perceived

as a female, and I couldn't necessarily describe why at the beginning. It felt like something was wrong with me or, you know, wrong with -- something wrong was happening to me, and I couldn't describe that.

Q. And how did that feeling that you couldn't describe -- how did that manifest for you in your life?

A. I isolated myself a lot. I didn't like, you know, being seen by people because I knew that they would see me as a girl, and so I sort of -- I didn't really participate in events with my family. I kept to myself, and I kind of -- I just -- I felt really badly about myself. And I didn't, like, really enjoy doing the activities I enjoyed before.

Q. It sounds like it was hard.

A. Yes, it was.

Q. Did there come a time when you began to figure out where maybe that discomfort came from?

A. Yes. I realized that I might not be a girl when I was about 11 or 12. I had sort of always known that transgender people existed, but I didn't really ever, you know, connect that idea to myself until at that point in time. Once I did realize, it kind of clicked. You know, it made a lot of sense what the feelings that I had been experiencing -- you know, what that meant, and it made everything sort of like, oh,

this is, you know, what's going on with me right now.

Q. And did there come a time when you told anyone that you thought you might be a boy?

A. Yes. A few months after I, you know, made that realization, I talked to my mom about it. I told her that I think that I might, you know, not be a girl and I might want to try using a different name, different pronouns, stuff like that.

Q. And what was her reaction?

A. Her first reaction was, you know, wanting to obviously do the best thing for me, make sure that, you know, everything -- that I was safe. She knew that transgender people faced a lot more issues, you know, discrimination as well as mental health issues, that she wanted to help me deal with the best that I could, so we signed up for like a mental health counselor as well as talking to my primary care doctor. But she also just -- you know, we made sure to have a lot more conversations so that we could figure out what the best thing was.

Q. And after that first conversation --

THE COURT: One second, sir. Yes?

MR. STONE: Your Honor, we have two people in the waiting room on Zoom, and I think they're our experts. I know the rule's been invoked, but they are expert witnesses, and we're wondering if they could be

let in so that they could watch this testimony since it might be relevant to some of their testimony later.

THE COURT: Okay. Let's just make sure. Grossman MD and -- okay.

MR. SELDIN: Your Honor, if I may, we don't object to having them be admitted, but if we could just confirm on the record that they don't have anyone in the room with them given --

THE COURT: Sure. Yeah. I guess go ahead and let them in and I'll just talk to them for a second. Excuse us. Let me do this.

Good morning, Dr. Laidlaw. I'm waiting for Dr. Grossman's audio to connect so I can speak with both of you at the same time. One second.

DR. LAIDLAW: Thank you.

THE COURT: I don't know if she's just not paying attention. Yeah. Of course, she's not going to hear me. I don't know if you can text her, Mr. Stone. It may just be a matter of -- yeah, if you can message her maybe.

Dr. Laidlaw, I guess I can start with you. I need to confirm that you don't have anyone else in the room with you at this time.

DR. LAIDLAW: That is correct.

THE COURT: And sir, just a reminder that

there's no -- no recording or broadcasting or any photography of our proceedings. Understood?

DR. LAIDLAW: Understood.

THE COURT: All right. Thank you.

MR. STONE: Your Honor, I sent Dr. Grossman -- I sent Dr. Grossman an email, and I'm trying to find her cell phone number. I'll text her.

THE COURT: Oh, sure. Sure. I guess -- I just don't want to interrupt you again.

MR. STONE: Your Honor, maybe we can just remove her from the room.

THE COURT: Sure.

MR. STONE: And once I'm able to reach out to her and get ahold of her, we can revisit it.

THE COURT: That's fine.

MR. STONE: I apologize.

THE COURT: Can you go ahead and move her back?

Okay. All right. And let me do one more thing because I don't like that. Okay. Go ahead.

Q. (BY MR. SELDIN) Nathan, we were just chatting a minute ago before we were interrupted. After you first told your mom that you were a boy, were there steps that you and your family took to affirm your gender identity?

A. The first steps that we took were, you know, as well as, you know, more conversations with the rest of my family, to just talk about what this meant. What those first steps looked like was just, you know, getting a haircut. I wore different clothes. The name that I was using, I changed that to be the name that I currently use and is my legal name, you know, using different pronouns. At this time it was during quarantine, so the only people that I was pretty much consistently in contact with were my family, so everybody in my family started using my new name and pronouns.

THE COURT: Nathan, can you scoot up just a little bit?

THE WITNESS: Oh, sorry.

THE COURT: No, that's okay. Just a little bit closer.

THE WITNESS: Is that good?

THE COURT: Yeah, I think so.

Q. (BY MR. SELDIN) And how did it feel to have your family see you and treat you like the boy that you are?

A. I would say that it was an immediate positive shift. I -- if I had been, you know, reserved and isolated before, I was able to, you know, really again

participate and, you know, talk with people I cared about. I felt more comfortable just doing the things I like doing because I didn't have to focus on this, you know, issue that was going, you know, unrecognized. I -- it felt really positive, and it was I think -- I felt like I lit up whenever somebody would use my name or the correct pronouns. Or, you know, if we went to a restaurant and someone called me "sir," I would just have the best day ever.

Q. And did there come a time when you sought medical care related to your gender?

A. Yeah. In those conversations, like I said before, that I had with my family, we talked about what the right steps would be. When I first realized I was transgender, I knew that I would eventually want to pursue, you know, medical care, be that in the form of surgeries or taking hormones. The decision that we had to make was when it would be appropriate to start that. Like I said, we talked to my primary care doctor, and I received a gender -- a diagnosis of gender dysphoria from him. And he referred us after a while to a specialist who specialized in gender-affirming care, hormone replacement therapy, and that was when I was about 14.

We talked with her, had appointments where

we discussed, you know, what starting these hormones would look like physically as well as making sure that I was ready to do that. And I believe it was November 16th of 2021 when I was 14 when I started taking testosterone.

Q. You remember the exact date that you started?

A. Yes, I do. It was a very big day for me.

Q. How did it feel?

A. If socially transitioning was a big change, then being on testosterone just really improved my life to a point where gender dysphoria almost doesn't bother me as much as it did at this point in my life. That was during about my freshman year, halfway through. And everyone around me could tell there was a shift from the beginning of the year to the end of the year. I felt like people were really able to see me as the me that I saw myself as. And having a body that aligned with that was -- it felt like a weight being lifted almost. You know, my voice changed and I was able to sound the way I wanted to sound, and I -- a lot of -- I just -- I felt better about myself. I was more able to do the things I loved again.

Q. And so how would you compare, you know, how you felt about yourself and your mental health before and after you started testosterone?

A. Well, before I started testosterone I -- I struggled a lot. I still had to -- gender dysphoria took up a lot of my time that I would have otherwise been able to do other things. I struggled to focus on my schoolwork. You know, everything that I did felt like it was a little bit off even when I was being referred to with my correct name and pronouns, just because I knew that some people wouldn't see me as my correct gender.

After starting testosterone, I just didn't have to deal with that burden as much anymore, especially, you know, publicly. The people around me just knew me as a boy, and that was all I wanted. I started my sophomore year having been on testosterone and having transitioned, and it felt like I was less stressed about everything else. I was able to just go about my life as a teenage boy the way that I had really wanted to.

Q. So for how long have you been on testosterone at this point?

A. At this point, it has almost been two years.

Q. How would you feel if you had to stop taking that medication?

A. Well, unfortunately, my -- the specialist who I referred to earlier, her practice was shut down this

May -- or this last May because of the threat of, you know, what was going on. And so I still had some of my medicine from, you know, previous refills, but the prescription is no longer, you know -- I don't have that anymore. And we weren't -- we didn't -- weren't able to communicate with her because, you know, she was no longer working there. We set up another appointment in Houston that just recently happened, but they were also not able to fill my prescription because of, you know, what was happening.

And it feels -- I feel very helpless, and it makes me feel like I am going to have to go back into a place mentally speaking that I was really uncomfortable in, and I don't want to do that. I want to be able to, you know, continue to focus on my high school and eventually graduate and not have to deal with not being on this medicine that's just really saved my life, I would say.

Q. What would it mean for your family if you couldn't access the medical care that you need in Texas?

A. That would mean that we would have to travel out of state to get the care that I need, which would be very difficult for a lot of reasons. Like I said before, my parents care for my littler siblings and my grandmother, so leaving periodically to go get a

prescription and then do the blood work that is associated with it would leave them to have to deal with that, as well as it would be disruptive to my life and my parents' life. I would have to miss school and work to go get this work done.

Q. Nathan, do you like living in Texas?

A. I do like living in Texas. I've lived here since I was like one or two. I love the weather here. I like the wildflowers. I love -- I love living in Texas. I really don't want to have to leave my home because of this.

Q. If you could describe the impact that this medical treatment has had on your life in one word, what would it be?

A. I'd say freedom. I feel free to live my life without having gender dysphoria as a heavy weight on me. And I also feel free to, you know, be perceived the way I want to without people, you know, questioning me or asking to hear my story. I'm able to just -- I'm free to do the things I like doing without having to focus on other things. I just have that freedom. I have that ability now.

Q. Thank you, Nathan.

MR. SELDIN: We will pass the witness.

THE COURT: Thank you. Cross-examination?

MR. ELDRED: No questions, Your Honor.
THE COURT: All right. Thank you, sir.
Thank you, Nathan. You're done on the witness stand. You can circle back around and head to the door that you came in. Thank you.
Next witness?
MS. WOOTEN: Your Honor, we have no other witnesses.
THE COURT: Okay. Thank you. Do you rest at this time?
MS. WOOTEN: Yes, we do, Your Honor.
THE COURT: Thank you. All right. Mr. Stone, let's try, I guess, dealing with having Dr. Grossman back in and check on that, and then we'll have you call your first witness.
MS. POLLARD: Your Honor?
THE COURT: Yes.
MS. POLLARD: Can we get access to the back room while you're doing that?
THE COURT: Sure. It looks like she might be away from her computer. Were you going to call Laidlaw first?
MR. STONE: Yes.
THE COURT: Okay. Well, I'll be on the lookout to see once she gets back. And we can

probably -- I guess we can -- do you want to pin Dr. Laidlaw, Ms. Gould, and see if -- or actually, if you'll unmute, sir, and see if once you talk if that puts you -- should we do that?

DR. LAIDLAW: Okay. I just turned off mute.

THE COURT: Okay. Yeah, I'd rather it pin to him, or even that's better than the other. That works, Tiffaney. That's okay.

All right. So Mr. Stone, who would you like to call as your first witness?

MR. STONE: Yes, Your Honor. Our first witness is Michael Laidlaw.

THE COURT: Okay. Make sure you've got the mic or whoever's going to question the witness has the mic so that -- all right. Dr. Laidlaw, if you'll please raise your right hand. I'm going to switch this to me so you know who's talking. If you'll raise your right hand for me.

(Witness sworn)

THE COURT: You can put your hand down. And I'm going to put this camera on the attorneys and maybe -- let me try and Zoom in just a little bit so that hopefully that helps. Okay. All right. Hold on. What happened? There. Okay. All right. Go ahead.

MR. STONE: Thank you, Your Honor.

MICHAEL K. LAIDLAW, M.D.

having been first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. STONE:

Q. What is your name?

A. Michael Laidlaw.

Q. What degrees do you hold?

A. I have a bachelor's degree in biology, a concentration in molecular cell biology, a medical doctor degree. I've completed residencies in internal medicine and endocrinology and have taken board certifications for both.

Q. And are you actually board certified?

A. Board certified endocrinologist, correct.

Q. Are you currently licensed to practice medicine?

A. Yes, in the state of California.

Q. How long have you been practicing medicine as an endocrinologist?

A. As an endocrinologist, I started in private practice in 2006 through current, so about 17 years.

Q. Do you hold any privileges at any hospitals?

A. I'm on staff here at the Sutter Roseville Medical Center.

Q. What academic appointments have you held?
A. I trained in an academic institution, but I have not held any academic seats or anything of the sort.
Q. Have you published at all in the area of endocrinology?
A. Yes, I have.
Q. Just generally, what have you published in the field of endocrinology?
A. I published an article in the *American Journal of Bioethics* about puberty blockers, cross-sex hormones for treatment of gender dysphoria. I've had a couple of letters to the editor accepted in our main endocrinology journal regarding similar topics. And I've written other articles for the lay public.
Q. Have you ever testified before as an expert in the subject of endocrinology?
A. Yes.
Q. Approximately how many times?
A. I want to say three. I can't think offhand, something like that.
Q. How many times have you testified as an expert in endocrinology on the subject of gender dysphoria treatments in minors -- for minors?
A. Yeah. Testifying in court or by Zoom, two

times, I believe.

THE COURT: Hold on, Dr. Laidlaw. Just hold on for me for a second.

Dr. Grossman, if you can hear us.

It's like she's in court, so I need her to sit down.

MR. STONE: Yes, Your Honor.

THE COURT: If you can hear us, I need you to stay put. It's distracting to have you walking around. And I also want to make sure there's nobody else in the room with you. Is that correct? Okay. You're on mute, but I think I read your lips to say that's correct. Okay. It just needs to be like you're in the courtroom. So if you're here, I need you to stay put, okay? Thank you.

Sorry about that. Go ahead.

MR. STONE: No problem. Your Honor, Dr. Laidlaw's CV has been previously admitted as Defendants' Exhibit 1. And at this time defendants proffer Dr. Laidlaw as an expert on research, study, and practice of endocrinology.

THE COURT: Any objection?

MR. SELDIN: Your Honor, can we do a brief voir dire?

THE COURT: Briefly.

MR. STONE: Your Honor, will this count against their time?

THE COURT: Yeah, it counts against them.

MR. STONE: Okay.

VOIR DIRE EXAMINATION

BY MR. SELDIN:

Q. Dr. Laidlaw, you have not performed any primary research regarding gender dysphoria; correct?

A. That's correct.

Q. You have not performed any primary research regarding transgender people; correct?

A. That's correct.

Q. You have not performed any primary research regarding gender identity; correct?

A. That's correct.

Q. And none of your publications pertaining to gender dysphoria are based on original research; correct?

A. If you're talking about using human subjects in research, that's correct.

Q. And you're not a member of WPATH; correct?

A. Correct.

Q. And you don't participate in WPATH conferences?

A. Correct.

Q. And you are not a surgeon; correct?

A. Correct.
Q. And you're not a mental health provider?
A. Correct.
MR. SELDIN: Your Honor, we would ask that Dr. Laidlaw's testimony be limited to endocrinology.
THE COURT: As I understand it, the request is research, study, and practice of endocrinology; correct?
MR. STONE: That is correct, Your Honor. So what they're asking for is already what we're --
THE COURT: Right.
MR. STONE: It sounds like we're in agreement.
THE COURT: So I'll go ahead and designate Dr. Laidlaw as an expert in research, study, and practice of endocrinology. Okay.
MR. STONE: Thank you, Your Honor.
THE COURT: Go ahead, Mr. Stone.

CONTINUED DIRECT EXAMINATION

BY MR. STONE:
Q. Dr. Laidlaw, what is endocrinology?
A. Endocrinology is the study of glands and hormones, diagnosing disorders with those, looking at hormone imbalances or structural problems with glands.
Q. How do you diagnose endocrine disorders?

A. Endocrine disorders are diagnosed, if we're talking about hormone imbalances, primarily through laboratory tests, blood tests, urine tests, so forth. Structural problems with glands are tested through imaging generally, such as ultrasound or MRI. Tissue can be sampled using biopsy techniques.

Q. Is gender dysphoria an endocrine disorder?

A. Gender dysphoria is not an endocrine disorder. It is a psychological disorder found in the *Diagnostic and Statistical Manual of Mental Health Disorders V*.

MR. SELDIN: Your Honor, we would object. We just asked to limit his testimony to endocrinology, which they agreed to.

MR. STONE: Your Honor, I just asked him if it was an endocrine disorder.

THE COURT: Yeah. Overruled. I think he's answered. Next question.

Q. (BY MR. STONE) Is gender dysphoria a condition that can be treated by endocrinologists?

A. Gender dysphoria is -- currently has different sets of recommendations throughout the world. Some places in Europe favor psychological treatment. Some advocacy --

THE COURT: Hold on. Now we're getting --

A. -- organizations such as WPATH --

THE COURT: Hold on, Dr. Laidlaw. Now we're getting past. You asked him the question if it was related to, but I don't think it's within his area of expertise to talk about how it's treated around the world.

MR. STONE: Understood, Your Honor.

THE COURT: Okay.

MR. STONE: I'm just trying to lay a predicate --

THE COURT: Sure.

MR. STONE: -- that gender dysphoria is -- right. Thank you, Your Honor.

THE COURT: All right.

Q. (BY MR. STONE) Okay. Dr. Laidlaw --

A. Yeah.

Q. -- is -- is gender dysphoria a condition that is treated within the field of endocrinology?

A. It is not an endocrine condition per se. There are endocrinologists who use hormones to treat this condition.

Q. How is gender dysphoria different from an endocrine disorder?

A. Gender dysphoria is elicited, the diagnosis, through psychological methods --

MR. SELDIN: Your Honor, the witness is

talking --

A. -- whereas endocrine conditions --

THE COURT: Hold on, Dr. Laidlaw.

A. -- are --

THE COURT: Hold on, Dr. Laidlaw. I have to deal with an objection. State your objection for the record, please.

MR. SELDIN: Objection, Your Honor. The witness is being offered for endocrinology. He's been talking about gender dysphoria, which he's already established is a psychiatric diagnosis outside of his field.

THE COURT: So I'm willing to let him answer this specific question. What happens is he then continues on to areas that I think go outside of what we designated him for.

MR. STONE: Well, Your Honor, he just testified that gender dysphoria is a condition that endocrinol- -- some endocrinologists treat using endocrinology. So I think this falls within the practice of endocrinology if it's a condition that endocrinologists treat.

THE COURT: Sure. But I think the question is does he do it, does he treat gender dysphoria as an endocrinologist. And if he doesn't, I

don't know -- well --

MR. STONE: He's an expert, Your Honor. We're not asking about what he does. We're asking about -- he's testifying as an expert in the field of endocrinology.

THE COURT: Okay. Understood. But I think that we're getting a little far afield when we start talking -- well, let's go ahead and start again and begin with a new question. I understand his designation, and I'm willing to let him testify. I'm the one that gets to decide the weight and the credibility of the evidence, so I'd rather get through it, okay? So go ahead.

Q. (BY MR. STONE) Doctor, can you describe to me the endocrine treatments that are -- that some providers provide -- some endocrinologists provide for the treatment of gender dysphoria in minors?

A. Sure. Some endocrinologists are providing hormones referred to as puberty blockers and other hormones referred to as cross-sex hormones, meaning testosterone for natal females and estrogen or similar for natal males.

Q. What are puberty blockers?

A. Puberty blockers are medications which affect a gland in the brain called the pituitary. They block the

normal signaling of the pituitary to the gonads, be it testicles of natal males or ovaries of natal females, such that those organs are unable to produce their hormones, estrogen for the female ovary or testosterone for the male gonad, testicle. And such as it is, if this occurs during the time of normal pubertal development, it will halt the progression of puberty.

Q. How old are minors -- well, at what stage during puberty would an endocrinologist prescribe -- would some endocrinologists prescribe puberty blockers to a minor for the treatment of gender dysphoria?

A. In the Endocrine Society Guidelines, they recommend beginning at Tanner stage 2, which is a stage of pubertal development. It's divided into five, with 1 being pre-pubertal and 5 being full adulthood. So Tanner stage 2 is the earliest stage of puberty this can occur, as early as age eight for girls or age nine for boys.

Q. How long are puberty blockers prescribed to minors for the treatment of gender dysphoria generally?

A. I've seen it can be for a few months to several years.

Q. What is the goal of prescribing puberty blockers to minors for the treatment of gender dysphoria?

A. The goals have shifted over time. Initially it was a time to help -- the thought was to help alleviate the distress from gender dysphoria and give the child time to fully recognize their gender identity. I think it's become over time a method to prevent normal pubertal development and the prevention of both secondary and primary sex characteristic development during puberty.

Q. Are you familiar with the Endocrine Society?

A. Yes. I am a member.

Q. What is the Endocrine Society?

A. The Endocrine Society is a group of professionals, medical doctors, scientists, and so forth who hold conferences, have journals, and contribute to the field of medical endocrinology and basic science of endocrinology.

Q. Has the Endocrine Society published guidelines for endocrinologists on the treatment of gender dysphoria in minors?

A. Yes, two that I'm aware of, in 2009 and 2017.

Q. Are you familiar with those guidelines?

A. Yes.

Q. What are the potential benefits of providing puberty blockers to minors for the treatment of gender dysphoria?

A. Potential benefits are allegedly to alleviate gender dysphoria to give a patient time to recognize their maybe true gender identity.

Q. Have you -- have you evaluated the scientific research and literature on the effectiveness of puberty blockers for the treatment of gender dysphoria in minors?

A. Yes. I've spent the last several years looking into this.

Q. What does the scientific literature and research say about the effectiveness of puberty blockers for the treatment of gender dysphoria in minors?

A. There's limited data on this, which is low-quality evidence. Systematic reviews have shown that there's limited evidence in the short or long term for efficacy or safety.

Q. What are the risks of providing puberty blockers to minors for the treatment of gender dysphoria?

A. There's multiple risks for providing puberty blockers to halt normal puberty, one being that puberty is the time of rapid development of bone and increased bone density. What happens is that bone density, instead of increasing rapidly, will flatline. That leaves a person at future risk for osteoporosis,

fractures of the hip, and so forth. There are changes to the brain which happen under the influence of the sex hormones which will be blocked.

There are -- most concerningly I feel is that stopping normal puberty at an early Tanner stage as recommended by the Endocrine Society, Tanner stage 2, will be before fertility is established, before menstrual cycle function and ovulation in female and sperm development of male, which means that continuing on to cross-sex hormones will lock this person in an undeveloped state and will remain infertile.

Most of the patients in studies from de Vries and the Dutch have shown that patients who start on puberty-blocking medications, the overwhelming majority go on to cross-sex hormones and then surgeries, which are permanently sterilizing procedures of the gonads.

Q. Are puberty blockers reversible?

A. Some aspects of puberty blockers are reversible; some aspects are not reversible.

Q. What aspects of puberty blockers are not reversible?

A. The effects that I described on bone are not immediately reversible. In other words, if medication is stopped and the person is allowed to progress through

puberty, they've lost time for bone development. I would add that the development with relationship to their peers is time lost that can't be gained. And then there are unknown effects on brain development.

Q. Have you evaluated the scientific literature and research on the safety of puberty blockers for the treatment of gender dysphoria in minors?

A. I have. One thing to recognize is that these medications are not FDA approved specifically for gender dysphoria, so there are no FDA type of safety studies that have ever been done. Again, the evidence that has been presented is low-quality evidence. Systematic reviews have not been able to establish safety in the short or long term for these medications specifically for gender dysphoria.

Q. Are you aware of any ongoing FDA safety studies on the -- on puberty blockers for the treatment of gender dysphoria in minors?

A. I am not aware.

Q. Are you aware if any of the manufacturers of puberty blockers that are used for the treatment of gender dysphoria in minors have requested FDA approval?

A. Not that I'm aware of.

Q. In your opinion, do the potential benefits outweigh the risks of providing puberty blockers to

minors for the treatment of gender dysphoria?

A. No. The potential benefits do not outweigh the risks.

Q. What is the likelihood that a minor taking puberty blockers for gender dysphoria will be harmed?

A. The likelihood depends on the length of time that they've taken the medication and whether or not they continue to cross-sex hormones. If they take it for a limited period of time, the harm will be minimal. The longer they take the medications, the greater the harm that's produced.

Q. I want to go back to the last question. I skipped -- I skipped a question. Why do you think that the -- that the risks of providing puberty blockers to minors for the treatment of gender dysphoria outweighs any potential benefits?

A. I think you have a group of medications which hasn't been -- for this particular condition hasn't been researched properly. There's lack of controlled studies, for example. There is -- the evidence base is poor in terms of quality of existing studies. Therefore, one can see that the risks -- and there are numerous risks already on the labeling for this medication and risks that we know, as I've said, for brain, bone development, and other unknown risks,

certainly fertility, that we know simply from endocrine practice, that the risks, both known and unknown, exceed the benefits.

Q. In your opinion, are puberty blockers a safe and effective treatment for gender dysphoria?

A. No.

Q. Why not?

MR. SELDIN: Objection, Your Honor.

THE COURT: Yeah, sustained. Treatment of gender dysphoria, he doesn't treat it.

MR. STONE: Your Honor, I --

THE COURT: Next question, Mr. Stone. I'm happy to read it back to you.

MR. STONE: Then, Your Honor, I would like to take this witness on -- I would like to --

THE COURT: Offer of proof?

MR. STONE: -- make an offer of proof, Your Honor.

THE COURT: All right.

MR. STONE: Sorry.

THE COURT: That's okay. Go ahead.

MR. STONE: Okay.

OFFER OF PROOF

BY MR. STONE:

Q. Doctor, why do you believe puberty blockers are

not a safe and effective treatment for gender dysphoria?

A. This is through my examination of the medical literature and my knowledge and experience as an endocrinologist dealing with conditions produced by these medications called hypogonadotropic hypogonadism.

Q. And Doctor, what is the basis for your opinions --

MR. STONE: That's the end of my offer of proof.

THE COURT: Understood. Thank you.

MR. STONE: Thank you, Your Honor.

CONTINUED DIRECT EXAMINATION

BY MR. STONE:

Q. Doctor, what is --

MR. SELDIN: Your Honor --

THE COURT: Hold on.

MR. SELDIN: We would object, Your Honor. We don't believe that proffer is sufficient. The question was whether he treats gender dysphoria.

THE COURT: Well, it's just an offer of proof, so it's sort of outside of this. So go ahead.

Q. (BY MR. STONE) Doctor, what is the basis for your -- the expert opinions that you've given about the risks and potential benefits of puberty blockers for minors today in the treatment of gender dysphoria?

A. They're based on my knowledge of endocrinology, of endocrine conditions, through training, through experience, and also a review of the literature and systematic evidence-based reviews.

Q. Dr. Laidlaw, what are cross-sex hormones?

A. Cross-sex hormones are hormones given in high dosages to -- which are higher than what's expected for the natal sex. For example, a female would be given -- a natal female given testosterone as a cross-sex hormone, a natal male given estrogen or similar as a cross-sex hormone.

Q. Dr. Laidlaw, how are cross-sex hormones used in the treatment of gender dysphoria by endocrinologists, some endocrinologists?

A. These hormones are used by some endocrinologists to -- in place of the hormone that is produced natively. In other words, a testicle will produce testosterone unless inhibited. In this case, estrogen would be given to help produce what we call secondary sex characteristics in a natal male, for example, gynecomastia or to develop breast tissue, changes that may be feminizing to the skin, for example, or a change in body habitus, fat distribution due to estrogen. If we're talking about testosterone effects, secondary sex characteristic effects may include growth

of hair on the face or chest or back, which we call hirsutism, deepening of the voice, change in musculature as examples.

Q. What age does the Endocrine Society recommend prescribe -- endocrinologists prescribe cross-sex hormones to minors for the treatment of gender dysphoria?

A. They have a general recommendation of around age 16, though it may be lower in certain circumstances.

Q. How long -- how long would a minor be prescribed cross-sex hormones by some endocrinologists for the treatment of gender dysphoria?

MR. SELDIN: Objection, Your Honor.

A. The potential is for it to be indefinite.

THE COURT: Hold on, Dr. Laidlaw.

A. Lifelong.

THE COURT: Hold on. Sorry. Do you want to state your objection?

MR. SELDIN: Your Honor, he's speaking to the practices of others in the field he said he doesn't practice in.

THE COURT: I think the way the question is worded is fine, so I'm going to overrule the objection.

I'm sorry, Dr. Laidlaw, if you'll

continue.

A. Yeah. I was saying that the potential is for this to be a lifelong or near lifelong treatment.

Q. (BY MR. STONE) What are the potential benefits of prescribing cross-sex hormones to minors for the treatment of gender dysphoria according to the endocrine society?

A. Stated potential benefits are allowing a person to have an appearance congruence or a similarity in appearance that's opposite to their natal sex with the goal of helping to alleviate psychosocial stress that occurs with gender incongruence.

Q. Have you reviewed the scientific research and what it says about the effectiveness of cross-sex hormones for the treatment of gender dysphoria in minors?

A. Yes.

Q. What does the scientific literature and research say about the effectiveness of cross-sex hormones for the treatment of gender dysphoria in minors?

A. There have been a number of systematic reviews on this topic, the NICE systematic reviews, McMaster's, which have shown that there is limited evidence for safety and effectiveness in the short or long term for

adolescents. WPATH said they could not do a systematic evidence review and so has no comprehensive data on this.

Q. How much -- well, let me stop. What is the -- what is the goal of prescribing cross-sex hormones to minors for the treatment of gender dysphoria?

A. The goal is to provide appearance congruence or try to provide some physical changes which allow the natal male, for example, to have an appearance that is congruent with a natal female and vice versa and such as it is to make the person feel comfortable in their -- in their body and within society.

Q. Would it be helpful to the Court to illustrate -- to illustrate the difference here in terms of hormones between those naturally occurring and those prescribed?

A. I believe it would be.

Q. Have you -- in your declaration, did you create or provide an illustration that showed the difference between naturally occurring hormones and those prescribed for the treatment of gender dysphoria in minors?

A. Yes, I did.

MR. SELDIN: Your Honor, we would just ask that we be directed to the page --

THE COURT: Sure.

MR. SELDIN: -- and just be allowed the opportunity to look at it before it's displayed.

MR. STONE: It's D-10.

THE COURT: Okay.

MS. WOOTEN: Your Honor, it's not a marked exhibit, so we're hunting.

THE COURT: It is in the Box in case that helps. Is it just that one page, Mr. Stone?

MR. STONE: Yeah, it's just -- it's just this one page.

THE COURT: Let me --

MR. STONE: Do you want me to find it in the expert report?

MR. SELDIN: Yes.

MR. STONE: Okay.

MR. SELDIN: That'll be sufficient.

THE COURT: It says Figure 4, so Figure 4 in the expert report.

THE WITNESS: It's Page 48.

MR. SELDIN: Your Honor, it's fine. Thank you. We appreciate your patience.

THE COURT: Thank you. No worries.

Okay. Go ahead, Mr. Stone.

Q. (BY MR. STONE) Dr. Laidlaw, do you recognize

the image that we're displaying on the screen?

A. Yes, I do. This is a chart that I produced.

Q. What is this chart of?

A. So what I'm showing here is levels of natal female testosterone. You can see across the bottom, zero being the lowest, 1,000 being the highest. And at the -- on the left-hand side there are three different conditions, endocrine conditions, and also the reference range for normal females, normal meaning not having any endocrine condition.

Q. What is PCOS?

A. PCOS is polycystic ovarian syndrome. It's a condition of natal females where there are higher than normal levels of testosterone.

Q. And how do you treat PCOS?

A. So PCOS can lead to things such as hirsutism, problems with fertility. It's treated by different methods. Some are hormonal. Some are metabolic such as treatment with Metformin.

Q. What is an -- I see endo -- endo tumor. What is an endo tumor?

A. So tumors can develop either -- in the endocrine glands primarily that produce -- overproduce testosterone or similar androgens. So what I'm showing here is that the normal -- normal range for adult female

testosterone, depending on the lab, is somewhere between 10 and 50. That's in blue. Polycystic ovarian syndrome may be somewhere between, say, 50 and 150. You can see with endocrine tumors, the levels can be much higher, on the order of 150 to 1,000, and these are serious conditions that often require -- always require treatment and sometimes surgeries.

Q. And last, I see female to male transition, but where -- let me start over. Where are you getting that figure for the FtM transition from?

A. This is from the Endocrine Society Guidelines 2017.

Q. And what -- what are you showing in this illustration of female to male transition testosterone levels?

A. So you can see here that the levels are somewhere recommended to be between 300 and 1,000, which is calculated about six to 100 times higher than natal female levels and on the order of endocrine tumors.

Q. Why is that significant?

A. It's significant because we recognize that high levels of testosterone is a unique endocrine disorder, which we call hyperandrogenism, and there are multiple health effects that occur because of hyperandrogenism. And this is a condition that endocrinologists would

diagnose and treat, but what strikes me is that this condition is being deliberately generated through endocrine treatment of gender dysphoria.

Q. Dr. Laidlaw, what are the potential risks of providing puberty blockers to minors for the treatment of gender dysphoria? I'm sorry. Strike that. Strike that. We're not talking about puberty blockers.

Let me start again. Dr. Laidlaw, what are the potential risks of providing cross-sex hormones to minors for the treatment of gender dysphoria?

A. Sure. There's cardiovascular risk. Dr. Irwig's review has shown increased risk of myocardial infarction and death due to cardiovascular disease in both sexes from cross-sex hormones. If we stick with natal females using testosterone, there is changes that can occur in the labeling of testosterone such as blood clots, which can be deadly, changes in cholesterol such as lowered HDL.

There are permanent changes of hair growth, which we call hirsutism, permanent deepening of the voice, changes -- direct changes to reproductive organs such as atrophy of the vagina, of the uterus, polycystic ovaries. If testosterone is given, testosterone I would add also given to natal females during normal pubertal development will stop native

pubertal development, so it will lead to infertility. If the pelvis hasn't developed fully under the influence of estrogen, it will halt pelvic development causing it to be -- decrease the size -- the ultimate size of the inlet -- pelvic inlet and outlet and could eventually cause obstruction or it's a risk for obstruction of labor.

In the male, there is increased risk of thromboembolism or blood clots, which could be deadly, five times increase in the Irwig paper. Gynecomastia or abnormal production of breast tissue, they found in one study 46 times increased risk of breast cancer of the male, which is ordinarily -- or natal male, which is ordinarily a rare condition. Sexual dysfunction, impotence, infertility. And again, if this is given during normal pubertal development, you will have a halting of penile growth, testicular development, infertility.

Q. Thank you, Doctor. And a slightly different question: Other than what you've already covered, what other -- are there any other potential risks to taking testosterone on a long-term or lifelong basis?

A. Other risks -- and I've written about this in my declaration -- is that with the ordinarily high doses of testosterone being recommended, the closest example

in the literature is anabolic steroid use. They found changes such as hyperactivity, aggressiveness, reckless behavior. 23 percent or so had met DSM criteria for major depression, mood disorders, mania. Something like 8 percent had psychosis. So there are physical effects, which are concerning, lifelong cardiovascular, as well as mental health side effects.

Q. Doctor, you mentioned sterilization a moment ago; right?

A. I believe I said infertility.

Q. Infertility. Sorry.

A. I may have said leading to sterilization. I don't recall.

Q. How -- how does -- how can potential -- how can cross-sex hormones potentially lead to infertility?

A. Sure. So infertility of the female, if there's disruption of normal menstruation and ovulation, the person will be infertile. If there's -- and I don't think this is known yet, but puberty blockers followed by cross-sex hormones could permanently damage the ovaries from what is known from pathology studies of patients who had their ovaries removed and there's polycystic changes and other changes. Same thing with a male. Puberty blockers stopping progression of normal testicular development and adding on cross-sex hormones,

it causes infertility in the short term. In the long term there's potential for sterility. And then, as I said, the studies starting with puberty blockers to cross-sex hormones to surgeries, which the majority in the de Vries series had gone on to do, led to ultimate sterilization by removal of gonads.

Q. Have you reviewed the scientific literature and research about the safety of cross-sex hormones for the treatment of gender dysphoria in minors?

A. Yes.

Q. What does the scientific literature and research say about the safety of providing cross-sex hormones to minors for the treatment of gender dysphoria?

A. Similarly, systematic reviews of the evidence such as the NICE review and other similar reviews have shown poor-quality evidence, lack of controlled studies, lack of long-term studies establishing safety of cross-sex hormones for the treatment of gender dysphoria for adolescents.

Q. In your opinion, do the potential benefits outweigh the risks of providing cross-sex hormones to minors for the treatment of gender dysphoria?

MR. SELDIN: Objection, Your Honor. It's outside the scope.

THE COURT: Well, he does say in his opinion, which I understand to be in this area. So I'm going to overrule the objection and let him answer the question.

A. In my opinion, based on my experience, training, and review of the literature, the benefits do not outweigh the risks for cross-sex hormones for adolescents.

Q. (BY MR. STONE) Are cross-sex hormones reversible?

A. Some aspects are; some are not. Some are unknown. For example, permanent side effects of testosterone, if a person decides to detransition or regrets their decision, they're left with some degree of beard growth on the face or hair on other parts of the body that aren't easily changed, permanent changes in deepening of the voice that to my knowledge has -- there are no treatments or it's very limited. For males, it can be very discomforting if they regret their decision to have gynecomastia or increased breast tissue that can be either uncomfortable or particularly having to be reversed by breast reduction surgery, which can be painful and costly and difficult.

Q. Doctor, are you familiar with the WPATH?

A. Yes.

Q. Have you reviewed the WPATH Standard of Care Version 8?

A. Yes.

Q. Doctor, what is informed consent in the practice of endocrinology?

A. In the practice of endocrinology, particularly if we're giving -- prescribing medications, which is what we would most often do, it's the practice of informing the patient about risks and benefits of the medication side effects, risks and benefits of not taking the medication, risks and benefits of not -- of the alternatives to not taking the medication, and also understanding the capacity of a person -- a patient to provide informed consent.

Q. Doctor, have you reviewed the WPATH guidelines about obtaining informed consent or assent from a minor for the treatment -- for the use of puberty blockers or cross-sex hormones?

A. Yes.

Q. Would it assist you if we -- if I showed you to refresh your recollection a copy of the WPATH's guidelines on obtaining informed consent or assent from a minor for the use of puberty blockers or cross-sex hormones?

A. That would be helpful.

MR. STONE: Your Honor, at this time we'd like to display on the screen Plaintiffs' Exhibit 26.

THE COURT: Okay.

MR. STONE: Page 63.

THE COURT: Which is not in evidence --

MR. STONE: It's not in evidence.

THE COURT: -- but just as a demonstrative.

MR. STONE: But it's in the Box.

THE COURT: Okay. Give me one second. All right. Go ahead.

MR. STONE: Thank you, Your Honor.

Q. (BY MR. STONE) Doctor, do you see the first sentence at the very bottom of the right hand? I think we're zooming in on it.

THE COURT: What page are you on, Mr. Stone?

MR. STONE: I'm on Page 63.

THE COURT: Okay. Thank you.

Q. (BY MR. STONE) The very first sentence at the bottom on the right-hand column, "The following questions may be useful." Do you see it on the screen? Okay.

A. Yes.

Q. Doctor, do you see the sentence on the screen

"The following questions may be useful to consider in assessing a young person's emotional and" -- it continues on -- "cognitive readiness to assent or consent to specific gender-affirming treatment"?

A. Yes.

Q. I want to ask you about each of these four questions. The first, do you see it on the screen? Can the young person think carefully into the future and consider the implications of a partially or fully irreversible intervention? Do you see that on the screen?

A. Yes, I do.

Q. Doctor, in your opinion, can a minor think carefully and -- into the future and consider the implications of taking puberty blockers and cross-sex hormones?

A. Given the long-term limited data on this and certainty of certain types of risks, especially that are lifelong, such as fertility complications, sexual dysfunction, cardiovascular function, I would say no.

Q. Second question: Does the young person have -- do you see on the screen where it says: Does the young person have sufficient self-reflective capacity to consider the possibility that gender-related needs and priorities can develop over time and gender-related

priorities at a certain point in time might change?

A. I think that a young person would have limited capacity to do so. They tend to, because of their age of development, prefer immediate gratification and can't perceive the long-term consequences or the possibility that their gender identity might change over time, so I would say they don't have that capacity.

Q. For the third question: In your opinion, do young people to some extent -- have they thought through --

MS. DYER: Sorry.

Q. (BY MR. STONE) Sorry. Let me -- okay. Let me just read it. Do you see on the screen where it says: Has the young person to some extent thought through the implications of what they might do if their priorities around gender do change in the future? Do you see that on the screen?

A. I do. I think it's again going to be very limited. You know, a 13-year-old may not be thinking about breastfeeding at age 28 or, you know, a 12-year-old, 11-year-old male may not be thinking about what it's like to be the father of a child. They simply don't have the experience, maturity, or development to comprehend those big changes that occur in adult life.

Q. All right. Last question on this.

MR. STONE: And I think we're almost done, Your Honor.

Q. (BY MR. STONE) Do you see on the screen where it says: Is the young person able to understand and manage the day-to-day short- and long-term aspects of a specific medical treatment? Do you see that on the screen?

A. Yes.

Q. What is your opinion about minors and their capacity to provide this informed consent or assent to the specific topic with respect to puberty blockers and cross-sex hormones?

A. It's difficult for -- medication adherence is a difficult general problem even for adults. But my experience with, say, even young people who have diabetes, adhering to taking insulin every day and on a regular basis can be quite difficult. And so I presume this type of treatment, which can involve regular injections, daily medications, would be difficult for the young person to appreciate how to stay on a regimen and continue their course.

Q. Dr. Laidlaw, did you have an oppor- -- have you had an opportunity to review the declarations submitted in this case?

A. Yes.

Q. Have you had an opportunity to review the declaration submitted by Dr. Shumer?

A. Yes.

Q. What -- what opinions, if any, do you have about the declaration submitted by Dr. Shumer?

A. I disagree with him on a number of key issues. I believe I pointed those out in my declaration.

Q. Okay.

MR. STONE: Okay. Your Honor, we pass the witness.

THE COURT: All right. Thank you, Mr. Stone. Let's go ahead and take our morning break. It's 10:15. We'll try and resume back at 10:30. And we're in recess until 10:30, and we'll continue with you, Dr. Laidlaw, as soon as we're back. But you're welcome to turn off your microphones and videos on our Zoom and be back at 10:30, which -- I don't know exactly where you are. I think you're in California, so it's still early, but 10:30 Texas time. Thank you.

THE WITNESS: Okay. Thank you.

(Recess taken)

THE COURT: Just for any new visitors, a quick reminder, there's no recording, broadcasting, or any photography inside the courtroom. Thank you very much. I think we are ready to proceed.

Dr. Laidlaw, are you ready to proceed? Oh, if you'll unmute yourself, sir.

THE WITNESS: Yes.

THE COURT: Okay. Perfect. Thank you.

CROSS-EXAMINATION

BY MR. SELDIN:

Q. Dr. Laidlaw, good morning.

A. Good morning.

Q. Less than 5 percent of your endocrinology practice is treating patients under 18; correct?

A. Correct.

Q. And puberty blockers, testosterone, and estrogen are all prescribed by endocrinologists to adolescents to treat other endocrine conditions; correct?

A. Yes.

Q. And in those cases, endocrinologists will review the risks and benefits of those medications for those conditions with their patients; correct?

A. Yes, they should.

Q. Earlier you referenced Figure 4 in your testimony from your declaration; is that right?

A. Yes.

Q. And this is a chart that you created; correct?

A. Correct.

Q. And Figure 4 doesn't include -- well, Figure 4 includes what you refer to as the normal female range of testosterone; is that correct?

A. It's, to be clear, the reference range for females without an endocrine condition affecting their testosterone.

Q. And Figure 4 doesn't include the normal male range for testosterone; correct?

A. That's correct. They have not indicated that.

Q. And you testified earlier that you reviewed Dr. Shumer's report; correct?

A. Yes.

Q. And Dr. Shumer in his report testified that the goal of treatment of gender dysphoria in adolescents is to raise testosterone levels to the range appropriate for their age and stage of development as compared to males who are not transgender; correct?

A. That's their goal, but they don't have evidence to support those numbers.

Q. What is the normal male range for testosterone?

A. Roughly 300 to 1,000 based -- depending on the lab.

Q. And your chart includes what you would call the FtM transition range from, it looks like, to about 300 to 1,000; is that correct?

A. Yes.
Q. So would you say then that also corresponds to what you would call the normal male range for testosterone?
A. Normal natal male reference range.
Q. Earlier you testified about a concern about abuse of testosterone and you compared it to the use of anabolic steroids in athletes; correct?
A. Yes.
Q. And so that concern would not apply to raising testosterone levels in accordance with Endocrine Society Guidelines to what you call the normal male natal range; correct?
A. Are you saying specifically raising natal female levels to 300 to 1,000?
Q. Let me rephrase. Earlier you talked about a concern about testosterone being overprescribed and compared it to the use of anabolic steroids in athletes; correct?
MR. STONE: Objection, Your Honor. This misstates prior testimony. Specifically, the question was about the long-term use, and he said it was analogous to -- the closest analogy in the literature was to anabolic steroids. He didn't say overprescribing, any of like the loaded language they're

using.

THE COURT: If you can rephrase. I don't know that he said it was over- -- well, I don't -- if you'll rephrase.

Q. (BY MR. SELDIN) Dr. Laidlaw, earlier you testified about a concern about the use of testosterone over time being comparable to the use of anabolic steroids by athletes; correct?

A. High dose testosterone.

Q. And when you say high dose testosterone, you meant in excess of the normal female range of testosterone as indicated by your chart; correct?

A. That's correct.

Q. Not in excess of the levels indicated by the FtM transition level on your chart; correct?

A. That could be in addition to it. In other words, levels could be potentially higher than 1,000, depending on how it's given, but that's the recommendation of the Endocrine Society is the range I have there.

Q. When you treat natal males, or as you call them, as the term that you're using, what is the goal reference range that you use for a normal testosterone level?

A. Typically, again, depending on the lab,

somewhere between 300 and 1,000, taking into account age and risks of treatment.

Q. And Dr. Laidlaw, you testified earlier you don't treat gender dysphoria in adolescents; correct?

A. That's correct.

Q. Dr. Laidlaw, you believe that minors who experience gender dysphoria have a false belief that they are the opposite sex; correct?

A. They may have a false belief that they're -- or that they could become the opposite sex.

Q. And you believe that minors with gender dysphoria have a delusion and are part of a charade when they live in accordance with their gender identity; correct?

A. If they live in accordance with their gender identity, they may be convinced that they can become the opposite sex, which is not medically possible.

Q. You believe that minors with gender dysphoria who live in accordance with their gender identity are engaged in a form of impersonation or play acting; correct?

A. They may be influenced to it by adults through social transition or hormones to acquire stereotypical mannerisms of the opposite sex, but they can't truly become the opposite sex.

MR. SELDIN: Your Honor, if I could just have a brief moment.

THE COURT: Uh-huh.

MR. SELDIN: Your Honor, we have no further questions. We pass the witness.

THE COURT: All right. Any redirect, Mr. Stone?

MR. STONE: Yes, just a little bit, Your Honor.

THE COURT: Okay.

REDIRECT EXAMINATION

BY MR. STONE:

Q. Going back to Figure No. 4, Dr. Laidlaw, what is the significance of a biological female receiving testosterone at the levels that you indicated in the figure?

A. There's a reason we have established laboratory what I'm calling reference ranges, so say a normal minimum and a normal maximum. In this case we're talking about testosterone. For some types of things, let's say sodium, to my knowledge you can check that in the lab, and the reference range is similar or nearly identical for males and females, as far as I know. But when you're talking about sex-specific hormones, the ranges are very different, and there's a reason for

that, because that person's body is meant to have a certain level of hormone to continue normal function, to develop normally through puberty, and excesses or very low levels of hormones will lead to medical conditions. And so in the female, high levels of testosterone beyond the normal reference range cause a medical condition, endocrine condition, we call hyperandrogenism. And this is being deliberately induced iatrogenically, is the term I would use, through medical treatments for gender dysphoria.

Q. Doctor, what is gender identity?

MR. SELDIN: Objection, Your Honor.

MR. STONE: Your Honor, they opened the door to this with their cross-examination. They specifically read him statements. They asked him about gender identity and his thoughts on --

THE COURT: All right, all right, all right.

MR. STONE: Okay.

THE COURT: Let's just ask him what his opinion is about what gender identity means.

MR. STONE: Thank you, Your Honor.

Q. (BY MR. STONE) What is your opinion --

A. Sure.

Q. Go ahead.

A. In the DSM-V, which I referenced earlier, gender identity is a social psychological concept distinct from biologic sex, which has to do with a person's internal feeling of being male or female or on a spectrum of male to female or some other gender identity.

Q. What is your opinion on whether there's a biological basis for gender identity?

MR. SELDIN: Objection, Your Honor.

MR. STONE: Your --

THE COURT: Hold on. I'll overrule the objection and let him answer if he can.

A. The problem with saying there's a biological basis, this is an ongoing area of investigation. They've done some limited studies, for example autopsies, of brains to look for evidence of a gender identity caused by biology that had some limited studies on genetics to look for this. But importantly, there is no brain study, there is no imaging, there is no blood test, there is no chromosome test, there is no genetic test which can definitively show diagnostically the gender identity of a given person. So there is no biological physical method to confirm the gender identity.

Q. And I just have I think two more questions.

What is -- in your opinion, can biological sex change over time?

A. When we say biological sex change over time, what I would say is that, one, there are two -- sex is binary. Physical sex is binary, male and female. A male cannot change into a female or female into a male by current medical technology.

Q. And last question: Do you believe that in your opinion that gender identity can change over time?

A. Yes, gender identity can change over time.

MR. SELDIN: Your Honor --

A. This is --

MR. SELDIN: -- we would object.

THE COURT: Hold on. Let's let the objection get on the record.

MR. SELDIN: Your Honor, we would object. This is outside the scope of his testimony on cross and redirect.

THE COURT: I'll overrule the objection. Finish your answer, Dr. Laidlaw.

A. There's a couple of ways of knowing this. One is what we call the desistance rate. In other words, most --

THE COURT: Well, hold on.

A. -- children 12 --

THE COURT: Hold on. I think you've answered the question. Is there a -- is there a next question?

MR. STONE: Sure.

Q. (BY MR. STONE) What is the -- why is that your opinion?

A. My opinion has to do with the desistant rate and the people who exist who are called detransitioners who once identified with one gender identity and have changed to another.

MR. STONE: Pass the witness, Your Honor.

THE COURT: All right. Anything further?

MR. SELDIN: Your Honor, we have no further questions, but we would move at this time to admit P-26 into evidence.

THE COURT: Okay. P-26 was the WPATH society No. 8?

MR. SELDIN: Yes.

MR. STONE: Your Honor, we object. This is hearsay, and it's not admissible, under 803, I believe, 15.

THE COURT: Did you -- but you used it with this witness, Mr. Stone.

MR. STONE: I only used it, Your Honor, to refresh his recollection and to show it to him. And

it's a -- or a learned treatise or guideline. Under 803.15 we can show it to a testifying person, but it doesn't make it admissible. Specifically the rule says -- 803.15 says -- I'm sorry. It's not 15. It's 18. 803.18, Statement in a Learned Treatise, Periodical or Pamphlet: A statement in a treatise, periodical, or pamphlet if the statement is called to the attention of an expert witness on cross-examination or relied on by the expert on direct examination and the publication is established as a reliable authority by the expert's admission or testimony, by another expert's testimony, or by judicial notice, then, if admitted, the statement may be read into evidence but is not received as an exhibit.

That's what we did. We read portions of it, but that doesn't make the document itself admissible. It's still inadmissible hearsay. It's just that we can read and ask questions from it.

THE COURT: A response?

MR. SELDIN: Your Honor, he didn't -- Mr. Stone did not lay the predicate for 803.15. He may have used the words "refresh your recollection," but there was no forgetting by Dr. Laidlaw in this respect. Further, Dr. Laidlaw has relied upon it. He has authenticated it. He's used it here today.

THE COURT: Right. So -- and there's not a jury, so I'm going to overrule the objection and admit P-26.

(Plaintiffs' Exhibit 26 admitted)

THE COURT: Okay. So Mr. Stone, your next witness?

MR. ELDRED: It's Dr. Cantor. And we're trying to get him to check in to Zoom.

THE COURT: Okay. We'll be on the lookout for that. Dr. Laidlaw, you're welcome to stay put as long as you turn off your microphone. You can also turn off your video if you'd like. It's up to you.

MR. STONE: He just emailed us and said he was getting on.

THE COURT: Okay. Perfect. I don't know how long you're going to be with this witness or the next one, but I do probably need to break about five minutes to 12:00 just to get downstairs for a meeting.

MR. ELDRED: Yes, Your Honor.

MS. WOOTEN: Your Honor, while we're waiting, if it's possible to confirm that the people participating via Zoom, in addition to having no one in the room, are not communicating with others via text or otherwise.

THE COURT: Sure. I can do that. I don't

know -- did Grossman specifically leave us or was that --

MS. DYER: Yes, Your Honor. Sorry. I meant to explain. She had a conflict right at 11:00. We thought we were going to get through the prior witness a little bit faster, and so she cannot testify any longer. We informed the plaintiffs.

THE COURT: Okay. Thank you very much, Ms. Dyer. Is there anybody in? Oh, there they are. There's Dr. Cantor. Yeah, it looks like Laidlaw is not with us anymore.

Good morning, Dr. Cantor. This is the judge. Can you hear me okay?

DR. CANTOR: Yes, I can. Thank you.

THE COURT: All right.

DR. CANTOR: Can you hear me?

THE COURT: Yes, I can, very well. Let me just confirm with you that there's no one else present in your room right now. Is that correct?

DR. CANTOR: That's correct.

THE COURT: And to the extent I guess -- the rule's been invoked. You have not communicated with any of the other witnesses in this proceeding, have you?

DR. CANTOR: That is correct. I have not.

THE COURT: All right. Thank you, sir.

All right. Please go ahead.

MR. ELDRED: Thank you, Your Honor. Dr. Cantor, I'm Charles Eldred.

THE REPORTER: Did you swear him in?

THE COURT: Oh, I didn't. I'm so sorry. Dr. Cantor, I need to swear you in, if you'll please raise your right hand.

(Witness sworn)

THE COURT: Thank you. And thank you, Ms. Crain.

JAMES CANTOR,

having been first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. ELDRED:

Q. All right. Dr. Cantor, I'm Charles Eldred with the Attorney General's Office. I'll be questioning you today on direct examination. Can you please state and spell your name?

A. Dr. James, J-a-m-e-s, Cantor, C-a-n-t-o-r.

Q. What degrees do you hold?

A. I have a bachelor's degree in interdisciplinary science concentrating in mathematics and physics, a master's degree in psychology, and my doctoral degree in clinical psychology with a dissertation in the neurobiology of sexual function.

Q. And do you have any postdoctoral follow -- I'm sorry. Do you have any postdoctoral fellowships?

A. Yes. I completed a postdoctoral fellowship again in the development of human sexuality at the Center for Addiction and Mental Health here in Canada.

Q. Where do you currently work?

A. I am currently the director of the Toronto Sexuality Center.

Q. What academic appointments have you held?

A. I was first appointed as a postdoctoral fellow, then assist professor, then associate professor of medicine at the University of Toronto Medical School.

Q. And have you published peer-reviewed articles?

A. Yes, I have, somewhat over 50.

Q. And what kind of things have they been about?

A. Again, primarily the development of human sexuality, concentrating really in the atypical sexualities. They've spanned gender identity, sexual orientation, and a group of atypical sexualities called the paraphilias, which refer to highly atypical interests that pertain to people who are sexually aroused by things that are not just male or female.

Q. Okay. Have you ever testified as an expert witness?

A. Yes, I have.

Q. About how many times and what about?

A. Oh, goodness. I've been involved one way or another in about 35 cases. The majority of those have been expert reports. Testimony has been in about half of those. The questions are one way or another about what is known about the science and the development of usually -- of some atypical sexuality of question -- of interest to the Court. Some of those have been about pedophilia, some of those have been about other sexual interests that can motivate sex offenses, and in the past two years or so about the development of gender identity and how to distinguish it from other atypical sexualities.

Q. All right. Do you have clinical and scientific expertise?

A. Yes, I do. Usually in forensic settings, the typical question is related to malpractice, whether a specific clinician correctly implemented a well-established procedure in clinical science. So in those types of expertise, it's very useful to have somebody else who engages in a similar activity.

That's very different, however, from today's proceedings and similar proceedings in other jurisdictions where the question is not whether a specific clinician correctly implemented a policy or

procedure. The question is over the validity of that procedure itself that requires a very different kind of expertise where you cannot use other people who engage in that activity because it represents a conflict of interest.

Q. All right.

A. To use a metaphor, you can't find out if fortunetelling is accurate only by asking other fortunetellers. You need people --

Q. Sir --

A. -- with expertise --

THE COURT: All right. Mr. Cantor, hold on. Your attorney has another question. Hold on.

Q. (BY MR. STONE) I'm sorry. We're getting a little bit into the substance of what you're going to talk about, and I'm just trying to get your qualifications right now.

A. Oh, sorry.

Q. That's okay. I probably asked you a bad question. I meant to ask you this. Have you ever personally treated patients with gender dysphoria?

A. Yes, I have.

Q. And can you talk about that just a little bit?

A. My license spans treating people ages 16 and up, and these have -- such cases have varied between

people who have questions about their own gender identity, what their decision is, whether medical transition would be best for them, and people for whom it's already clear and they're undergoing the transition process and need support while doing.

Q. And do you have training and experience in evaluating research methodologies?

A. Yes, quite a bit.

Q. What are the research methodologies and what is your training and experience?

MR. GONZALEZ-PAGAN: Objection, compound.

A. Well --

THE COURT: Hold on, Dr. Cantor. I just want the record to be clear. Do you have an objection?

MR. GONZALEZ-PAGAN: Objection, compound.

MR. ELDRED: I'll try again then.

THE COURT: Sure.

Q. (BY MR. ELDRED) Just briefly, generally what are research methodologies?

A. Research methods are systematic procedures that we use in order to answer specific questions, such as whether certain features or characteristics cluster together or how to predict outcomes given different types of treatments that we might apply.

Q. And do you have training with evaluating

research methodologies?

A. Yes, I do, quite a bit.

Q. What is that training?

A. In most of the training programs I've been in, it's actually been integrated into the rest of the training programs, so understanding the full range of what -- of the scientific methods that we can apply in science to answer different kinds of questions. My experience then includes applying that in many different circumstances, for example, evaluating other researchers who submit various manuscripts for publication in peer-reviewed journals and evaluating the proposed methods that a scientist would use when they, for example, apply for granting for the funding in order to perform a series of experiments.

Q. Have you ever served on the editorial board of any peer-reviewed journals?

A. Yes, several. The most relevant ones are the *Archives of Sexual Behavior* and the *Journal of Sex Research*. Oh, I'm sorry. And I've also served as editor-in-chief of *Sexual Abuse*, so I was in charge of the peer-review system for that journal.

Q. That's the name of a journal?

A. Yes, it is. Actually, the full name of it when I was editor was *Sexual Abuse: A Journal of Research and*

Treatment. It's since shortened its name. Now it's just called *Sexual Abuse*.

Q. Thank you. And you said before you have testified -- have you ever testified as an expert on scientific research relating to the treatment of gender dysphoria in minors?

A. Yes, I have.

Q. Can you list some of those cases?

A. The most recent one was last week in Georgia. The name slips my mind. *Koe vs. Noggle*. The others are listed on my CV.

MR. ELDRED: And Your Honor, his CV has been previously admitted as Defendants' Exhibit 5.

THE COURT: Thank you.

MR. ELDRED: And at this time defendants proffer Dr. Cantor as an expert on the scientific research related to the treatment of gender dysphoria in minors.

MR. GONZALEZ-PAGAN: A brief voir dire if I can, Your Honor.

THE COURT: Sure. Mr. -- and I'm sorry.

MR. GONZALEZ-PAGAN: Gonzalez-Pagan.

THE COURT: -- Gonzalez-Pagan is going to have a few questions for you, Dr. Cantor.

THE WITNESS: I understand.

VOIR DIRE EXAMINATION

MR. GONZALEZ-PAGAN:

Q. Dr. Cantor, you previously testified in the -- here in Texas last year in the *PFLAG v. Abbott* case; is that correct?

A. Yes, it is.

Q. And in that case you testified that you have not conducted any original scientific research on the efficacy or safety on the medical treatment of gender dysphoria; is that correct?

A. I haven't collected data specifically on such a sample, that is correct.

Q. And you yourself have not conducted any original scientific research on the safety and efficacy of medical treatment of gender dysphoria in adolescents; is that correct?

A. Mostly correct. The data that I have collected myself would be indirectly relevant such as the development of the brain, the development of various facial features over the course of puberty, and the development of sexual orientation, which is highly integrated into the development of gender identity.

Q. But my question is: Have you conducted any research regarding the treatment of gender dysphoria in adolescents? Have you?

A. Not directly, no.

MR. GONZALEZ-PAGAN: Your Honor, we would object to the expert being proffered on the evidence of safety and efficacy provided by the research, but he can speak to research methodologies, which clearly has been established through the voir dire.

THE COURT: All right. Mr. Eldred, what I have noted is scientific research related to treatment of gender dysphoria of minors. Is that the subject area?

MR. ELDRED: Yes, Your Honor, that's what we offer -- that's what we are proffering him for.

THE COURT: And tell me again exactly what you think he can testify about.

MR. GONZALEZ-PAGAN: Research methodologies. If he wants to speak to the methodologies used by any study, that would be certainly within the -- we would concede that that would be something within what's been established within the voir dire.

THE COURT: As opposed to?

MR. GONZALEZ-PAGAN: To what the actual research speaks to with regards to safety and efficacy of treatment of gender dysphoria in minors.

THE COURT: Okay. So I understand the

distinction. Is there anything further you want to add to that, Mr. Eldred?

MR. ELDRED: I don't think the distinction has a difference because he's testifying about what the research says about such things. He's an expert on that kind of a topic.

THE COURT: All right. So I'm clear on what I think -- I'm clear, so I'm going to go ahead and allow the designation under the topics as you've stated, Mr. Eldred, and so you can continue your examination.

MR. ELDRED: Thank you, Judge.

CONTINUED DIRECT EXAMINATION

BY MR. ELDRED:

Q. I want to start by just defining some terms. I want to start with safe and effective. What is safe in a clinical research context?

A. Within clinical research, we simultaneous -- to answer any decision-making question, we need to -- we need to assess the risk-to-benefit ratio of any given treatment. We need to know -- or the decision-makers need to know are the risks posed by any particular treatment worth the potential benefits that might come out of that treatment. So we assess safety relative to potential benefit, and we assess benefit relative to the potential safety.

So when we discuss safety, we discuss the probable, the necessary, or the potential downsides that would apply either to a person's physical health and well-being or mental health and well-being. The flip side to benefits are how it might improve a person's physical objective functioning or how it might improve a person's subjective account of their own mental health status.

Q. And same question for effective. What is effective in a clinical research context?

A. Effective would be if we have a reliable indication of improvement in a person's either physical or mental well-being. So there can sometimes be disagreement over what counts as a benefit according to an individual -- individual person's values, but in order to demonstrate that something is effective, we need to be able to show it in some reliable way. That is, we need to be able to know that another treatment provider or policymaker engaging in the same procedures should be able to expect or should reliably expect to get the same outcomes.

Q. Okay. I'm going to ask you about something called the pyramid of evidence. Have you ever heard of that?

A. Yes, I have.

Q. What is that?

A. It's ubiquitous really in clinical science and in outcomes research. Not all research studies have the same value. Some are more reliable than others. Some provide results that are more ambiguous than others. So the pyramid of evidence is a hierarchy describing the various levels of evidence going from low-quality evidence that are relatively uncertain or ambiguous up through high-quality evidence that is highly reliable and worth generalizing to other people.

MR. ELDRED: Judge, this is Defendants' Exhibit 11. We would like to offer that in evidence, the pyramid. It's a one-page diagram called Pyramid of Standards of Evidence.

THE COURT: Any objection?

MR. GONZALEZ-PAGAN: Yes, Your Honor. This is a graphic obtained from a random website called OpenMD.com. It is hearsay. It is not authenticated. We would object to it being entered into evidence.

THE COURT: Any response, Mr. Eldred?

MR. ELDRED: May I ask the doctor one more question about it in response to that?

THE COURT: Sure.

Q. (BY MR. ELDRED) Doctor, you just heard plaintiffs' counsel object to it that it comes from

OpenMD.com. I think I heard you say it's ubiquitous. Can you explain? Go ahead.

A. That is correct. It is a standard hierarchy that is ubiquitous throughout clinical science. I picked this particular copy from this particular website because it's not copyrighted. Exactly the same setup is identifiable in any standard research textbook, and I found the same hierarchy on the NIH websites.

MR. ELDRED: With that clarification, I'd like to reoffer D-11 into evidence.

THE COURT: Any other --

MR. GONZALEZ-PAGAN: Your Honor, that offer of proof does not attend to either of the objections. It's both hearsay and it's not authenticated.

MR. ELDRED: It's a learned treatise at the very least. We can at least use it as a learned treatise.

THE COURT: Well, I think we can use it as a demonstrative.

MR. ELDRED: That's -- that -- I'm sorry. That's fine too, Judge.

THE COURT: All right. D-11 is not --

MR. ELDRED: Do you have a copy of it?

THE COURT: It is not admitted. It is a

demonstrative.

Q. (BY MR. ELDRED) Do you see it on the screen?

A. I do see it, but now it started an echo on the audio system.

Q. I think we fixed it. I'll try again. Do you see it on the screen now?

A. Yes, I do.

Q. Great. And is that the pyramid of evidence you were talking about?

A. Yes, it is.

Q. Okay. So there's a diagonal line on the left side called quality. What is meant by that? Actually, no --

A. It --

Q. Let me cut you off there. I'm sorry. Let me try this again. Just give us a general picture of what it is we're looking at right now, a big picture.

A. These, as I described, are the different types of research methodologies that are available in performing different kinds of systematic studies. The general idea of quality is the reliability of the study; that is, how well can we expect to be able to take the results of the study and expect that somebody else performing the same study would get the same results because, of course, especially within clinical science,

the whole point is to be able to take a treatment that was studied by one person and to be able to use that with other people in order to have a good idea of what kind of outcomes to expect.

The pyramid shape was chosen for this in order to describe the number of studies that come out. The lower-level studies are very, very common because they are fast to perform and they are inexpensive to perform. So the low-quality studies are very numerous in the research literature exactly because or as a side effect of their being easy to perform, but they're less reliable. The more systematic and the more reliable studies are harder to perform, take more time to perform, and take much more thorough analysis, so there are fewer of them.

So again, the shape of the pyramid is meant as a reminder that you can't just take a vote of studies. The high-quality studies are almost by definition rarer than the easier studies which are almost necessarily more numerous. Then at the top of the pyramid are the systematic reviews which review all the other studies beneath it assessing them according to their relative qualities.

Q. Okay. And I see on the bottom there's another arrow called information volume. Can you explain how

that relates to this diagram?

A. That again is a reference to the cheaper and easier-to-conduct studies being more numerous. We can't take a number of studies just as a vote and say something along the lines of more studies show one thing versus another thing because the studies vary in quality, systematically vary in quality. We have to assess them according to their research methods, not according to how many studies found one thing versus how many studies found another thing. As a metaphor, it doesn't matter how many naked eye observations we have once we have a high-powered telescope taking a high-resolution picture.

Q. And I think I'm counting six different types of studies in this pyramid. Do I have that right?

A. That's in this particular pyramid. Again, I chose it because it didn't enumerate each of the sublayers. There exist many, many more than just six different types of studies. They tend to -- they tend to cluster. And again, this one provided a sufficient level of detail in order to understand the relative qualities of the research studies that have been conducted of the outcomes for transition of minors without going into excessive detail talking about the different kinds of other studies that could have been

done but have not been conducted.

Q. All right. Thank you. So I also see on the right side of the pyramid is something called unfiltered information and filtered information. Can you explain those?

A. Certainly. Unfiltered information are the -- I'm sorry. I couldn't see if that meant an objection. I just heard a voice.

Q. No. I'm sorry. I don't think there was one.

THE COURT: No. It must have just been a little bit of an echo. Sorry about that. Go ahead.

A. No problem at all. The unfiltered information are the original actual research studies. In some fields, of course, you know, there are many, many studies with many, many scientists working on them, and they can be producing hundreds of studies, and it's not realistic for somebody to be reading in detail every single one of them. In other fields, they are slow enough and small enough where that is possible.

The filtered information is then the systematic method of making sure that somebody has considered all of the relevant original studies. The point of the apex, the systematic review, is to avoid bias when somebody is trying to assess the other studies. Especially in large fields when there are many

studies, there are opportunities for bias such as cherry-picking, picking studies that come to one conclusion but avoiding or ignoring the studies that come -- that came to another conclusion. So the filtered information are the systematic ways of making sure that somebody has considered all of the relevant original base unfiltered information.

Q. Okay. Let's start at the bottom. What is background information and expert opinion?

A. Those would the hunches that the experts have, the ideas, the hypotheses that experts come up with as we're beginning to ask a question about any particular research program. They're valuable because a person can consider other kinds of research, analogous research in related fields that give us an idea of what questions to ask and what we might expect. But that's not yet at all reliable because they're still only hypotheses and guesses. Nobody's yet tested that kind of information. Nobody's yet tried to verify whether those hunches or hypotheses, which are often contradictory -- nobody's yet tried testing if they're correct.

Q. Just for clarification, the expert opinion on this chart is different than the expert opinion you're offering now; is that true?

A. That is correct. Expert opinion in the legal

context is different from expert opinion within the specifically scientific context.

Q. All right. So moving up to the next level, I see case series and reports. What are those?

A. The case series and reports are generally retrospective. It's when somebody wants an idea of what kind of treatments might produce what kind of outcomes, but it's not yet systematic. These, as I say, are generally retrospective studies where somebody would go through hospital records, for example, pull out cases of specific diagnoses and see what happened amongst those people. It gives -- it can give some idea of what to expect if nothing is done, but because these are not systematic, they're not yet ready for any kind of generalization to other cases. We can't yet know if there's some systematic bias such as people who go to the hospital versus don't go to the hospital, so we have a record of them versus don't have a record of them.

Q. Okay. The next level up is called case-controlled studies. What does that signify?

A. Case-controlled studies are another type of observational study. It's not an experiment where the scientist has systematically assigned people to groups to see what would happen. These would be people where we get somebody with a particular condition and want to

compare them to people without that condition. So we wouldn't be randomly assigning them. We would just be comparing, you know, people, for example, who had smoked with a group of people who have not smoked, but we didn't assign who the smokers were and not. We're just looking for patterns of what happens in different groups of people or what makes different groups of people different from each other. So we would look for -- I guess I'll say the reverse of my prior example, if we looked at people who developed lung cancer and looked for features that they had in common with each other and compared them with people who didn't develop lung cancer and see how they were different from the people who did.

Q. Okay. How about cohort studies, the next level up? What are those?

A. In cohort studies, we're now checking on a single group of people but over time. We're looking to see what happened, for example, before or after they were exposed to a treatment or exposed to some not just substance. So instead of just taking a look at them at one point in time, we're taking the same group of people and looking at them over several groups of time. So it's another type of observational study that also gives us correlational data but gives us an idea of what changes over whatever period of time the study was.

Q. And above that I see randomized controlled tests. What is that?

A. The RCTs, that's now -- we've now graduated above the observational studies and now we're talking the actual experimental studies. The experimental studies and the randomized controlled trials are the ones where we take a group of people, randomly assign which ones are going to receive the experimental treatment and which ones are going to receive either no treatment or some other comparison treatment such as treatment as usual, a placebo treatment, or some other -- some other intervention. It's because we have randomly assigned people to which groups they are we are now able to decide -- or now able to conclude whether the treatment we're talking about has caused the actual effect.

In observational studies we only get correlational data. We know what clusters with what, but interpreting observational studies is necessarily ambiguous. There's always more than one thing that can explain why a correlation happened.

When we're randomizing the groups that people are in in these experimental studies, including the RCTs, we can now conclude that the treatment that we gave is what caused whatever treatments, positive or

negative, in those specific people. So this, as I say, is what gives us experimental data. This is the actual test that can tell us -- that can differentiate for us when the treatment is still near the experimental or has been successfully passed by the experimental process.

Q. And at the very top -- I think you may have talked a little bit about this already. What are systematic reviews and meta-an -- analys- -- meta-analyses?

A. Meta-analyses.

Q. Sorry.

A. No problem at all. That wouldn't be the first time that I too trip over some of the technical words.

The systematic reviews are again a way to analyze all of the studies and all of the layers that were beneath it. Again, especially in large fields with many people, there are many, many studies, and especially for very busy clinicians, it's not possible to read and integrate every single one. So the purpose of systematic reviews is to get the big picture of what all of the other studies have shown, but as I say, to do it in a systematic way that removes the potential for bias. The biggest bias, as I mentioned, was cherry-picking where people pick out the positive studies but don't mention the studies where the

experiment failed.

Similarly, the other big bias that can happen is when somebody looks at only part of a study or only mentions -- holds different studies to a different standard according to whether a person likes the results, that is, holding the bar higher or lower according to whether the conclusion of that study agreed or disagreed with the scientist. So the process of a systematic review is to make sure that all studies are included, not just cherry-picking, and to make sure that all studies are assessed, you know, with the same criteria rather than, as I described, raising and lowering the bar according to whether one likes the studies.

The only difference between a systematic review and a meta-analysis is that we would use a meta-analysis when we are looking for a particular number as the outcome, for example, what the optimal dose of a drug might be, and it could be high, it could be low, it could be somewhere in between. And a systematic review is the same basic process, but that's what we use for yes and no kinds of questions, does the treatment work at all or not.

Q. And just briefly summarizing this, a systematic review is of higher quality than the studies below it on

the chart; is that correct?

A. That is correct. It's a study, again, that it doesn't collect its own data; it summarizes and gives us a big picture of what all of the data ever reported has in as unbiased a means as we have available.

Q. All right. What are surveys?

A. A survey -- and these days surveys are very, very common because it's so easy to conduct a survey, for example, on the Internet. Surveys can, you know, help us give, you know -- help us produce hypotheses, can help give us ideas, but they don't represent evidence at all. Surveys don't appear on the pyramid of evidence at all. As I say, they can give us a good idea of questions to look at, but they don't represent any kind of outcomes evidence.

Q. And did you review the declarations submitted by the plaintiffs' experts in this case?

A. Yes, I did.

Q. Where would you say they fall on the pyramid of evidence?

A. There were some mentions of some of the cohort studies that exist, but the great majority of the studies that were referred to were surveys.

Q. And surveys are not on the pyramid of evidence; is that true?

A. That is correct. They don't count as medical evidence, they don't count as outcome evidence, but the conclusions of the experts depended largely on what doesn't count as evidence. Anybody can take a survey if they want to or not. In many of these surveys, they can take the same survey over and over again. The purpose of everything that's on the pyramid of evidence is that it's systematic. And just a general survey over the Internet of anybody who wants to take it, they have no regular diagnosis, none of the facts on it are checked, just doesn't count as systematic evidence at all.

Q. So it has uses, but it's not evidence. Is that a fair -- a fair summary of surveying?

A. Yes, it is.

Q. And are you aware -- have there been surveys conducted on the safety and efficacy of medical interventions used on minors for the treatment of gender dysphoria?

A. There have been claims of safety and effectiveness that are based on -- based on survey -- based on surveys, but again, I wouldn't exactly call them evidence because it's so easy for advocates or people with one or another political persuasion to be able to affect a survey. If, for example, one advertised a survey on an Internet site or website or a

listserv of people -- a discussion group of a particular mindset or of a particular bent, well, then the results of the survey are going to reflect the people, you know, with that -- with that bias. So if somebody just says that I drank this kind of tea and I felt better afterwards, therefore this tea is the cure for whatever it is the person thought was wrong with them, well, that's good for that person, but that just doesn't count as medical evidence.

Q. It could be the start of a process for getting to medical evidence about that, but it's not medical evidence itself; is that true?

A. That's correct. If there are large groups of people claiming that a nutritional supplement or a tea or anything else helps them, it's worth investigating. If there are people who tried several different things and started reporting an effect, it's worth then subjecting to systematic scrutiny, but it by itself doesn't consist of a systematic piece of evidence.

Q. Let's move up the pyramid. Have there been any case series and reports conducted on the safety and efficacy of medical interventions used on minors for the treatment of gender dysphoria?

A. Yes, there have been a handful published over the years. But again, they generally came out with

ambiguous -- with ambiguous results but results that, again, suggested that it was at least worth looking at more systematically.

Q. Okay. Same question for case-controlled studies. Have there been any case-controlled studies conducted on the safety and efficacy of medical intervention used on minors for the treatment of gender dysphoria?

A. I am aware of one where people undergoing transition were compared to people who didn't qualify undergoing medical transition. That was a particularly low-quality study because we can't tell, you know, what changes, you know, what improvements and, you know, what got worse amongst these people. We can't tell what was attributable to the treatment itself and what's attributable to the fact that the comparison group were people who didn't qualify for transition. They were in a poor mental health status to begin with.

THE COURT: Ms. Dyer, can you stop your share screen? I just want to be able to see it larger. Thank you. Sorry about that.

MR. ELDRED: No problem, Judge.

Q. (BY MR. ELDRED) The next level up is cohort studies. Have there been any cohort studies conducted on the safety and efficacy of medical interventions to

minors for the treatment of gender dysphoria?

A. Yes. There have been exactly 13, and these are the 13 that I summarize in my own report. This is the highest level study that so far has been conducted at all for the medical transition of minors.

Q. And what's your summary of the 13?

A. There have been --

MR. GONZALEZ-PAGAN: Objection, calls for --

A. -- roughly three clusters --

THE COURT: Hold on.

A. -- of results.

THE COURT: Hold on, Dr. Cantor.

A. There have been roughly four studies --

THE COURT: Hold on, Dr. Cantor. Hold on. Hold on. What's the objection for the record?

MR. GONZALEZ-PAGAN: Objection, Your Honor, calls for a narrative.

THE COURT: Well, let's go to a question. I guess it does call for a narrative, Mr. Eldred. If you can just rephrase and have him break it down.

MR. ELDRED: Sure.

Q. (BY MR. ELDRED) Can you break down what the 13 cohort studies showed about the safety and efficacy of medical interventions used on minors for the treatment

of gender dysphoria?

A. Certainly. I outline such a breakdown as I describe them in my report. There were four of them which showed essentially no improvement at all. The medical transition did not demonstrate any benefits to the mental health status of the kids.

In another group, roughly half of the studies, roughly six of them, there were some improvements in some mental health parameters, but we can't conclude that it was the intervention, that it was the medical interventions itself that caused the improvement because the people were getting psychotherapy at the same time. That's what we call a confound, because they were getting two kinds of treatments, both medical treatment and mental health treatment, at the same time. For the people who showed benefits, we don't know if it was the medicalized transition that caused the benefit or if it was that they were in psychotherapy that produced the mental health benefit.

And then there were two studies which were designed in a way that allowed more direct comparison trying to allocate how much of the improvement was due to the medical interventions versus how much of the improvement was due to the mental health interventions.

And both of those demonstrate -- and both of those failed to demonstrate that the medical interventions produced any more benefit than did the mental health -- the psychotherapeutic interventions.

Q. And are there any randomized --

A. Oh, I'm sorry. I left one out. And there was one other very recent study that just did not indicate whether the people were in psychotherapy at the same time, so the results -- we can't assess whether the medical interventions were superior because we don't know how many were getting psychotherapy at the same time.

Q. Thank you. Are there any randomized controlled trials -- I'm sorry -- randomized controlled studies conducted on the safety and efficacy of medical intervention used on minors for the treatment of gender dysphoria?

A. No. It's never been tried yet.

Q. Same question for systematic reviews.

A. There have now been several systematic reviews, none conducted in the U.S. They've all been conducted by the national public healthcare systems in Europe.

Q. And what do those --

A. I'm sorry. Again --

Q. Go ahead.

A. They've all been conducted by the national healthcare systems in Europe, but they have not yet been conducted by any groups in the U.S.

Q. And what do they show?

A. They all showed exactly the same thing, which, again, is the purpose of a systematic review. The idea of doing it systematically is that anybody engaging in such a review should come out with the same result, and these did. And they said essentially what I just did, that there is no evidence to suggest that medicalized interventions provides any benefits superior to the mental health interventions.

Q. All right. I want to switch topics a little bit. Oh, sorry. So can you summarize what the studies show about the safety and efficacy of medical interventions used on minors for the treatment of gender dysphoria?

A. The safety issues are the well-reported -- are relatively well-reported because they're objective and they're physical. For example, one of the largest downsides, one of the largest risks of medical intervention is the sterility of the child. When a child is subjected to puberty-suppressing drugs, what we used to call chemical castration, when they go from a pre-pubescent physical state and are then exposed to

cross-sex hormones, they are sterilized. That is, of course, you know, the -- I hate to call it a risk to safety because the outcomes are so definite. And the others include problems in bone development, bone health, as well as --

MR. GONZALEZ-PAGAN: Your Honor --

A. -- there are some indications of --

MR. GONZALEZ-PAGAN: -- I'm going to object at this point.

A. -- changes in development.

THE COURT: Okay. Hold on.

A. It's because we have --

THE COURT: Hold on, Dr. Cantor.

MR. GONZALEZ-PAGAN: This is beyond the scope. He is now talking about risks and benefits of treatment, and he's here to talk about just --

THE COURT: We need to --

MR. GONZALEZ-PAGAN: -- the research.

THE COURT: We need to stick to the systematic review.

Q. (BY MR. ELDRED) And I may have asked the question poorly, Your Honor -- Doctor. Based on the research that you've looked at, can you summarize any conclusions about the safety and efficacy of medical interventions used on minors for the treatment of gender

dysphoria?

A. Each of the systematic reviews came to the same conclusion, that the evidence for benefits are outweighed by the evidence of the risks of harm.

Q. Did McMaster University in Canada do a systematic review?

A. I'm aware of some people from McMaster University having conducted one at the request of a hearing in Florida. I was tangentially involved, and I also submitted a report at that same hearing, but I wasn't otherwise involved in the rest of the hearing or in that review. McMaster University itself is significant because it is essentially home to evidence-based medicine and the process for conducting systematic reviews.

Q. All right. I'd like to move on to another topic. According to the research that you reviewed, are there different types of gender dysphoria?

A. Yes, there are.

Q. What are those types?

A. It's been well known really for almost -- over a century at this point that more than one thing can lead a person to feeling gender dysphoric. It's not simply a -- it's unlike sexual orientation where somebody is just attracted to men or women and the

subtypes are just different ways in which a person likes to have sex.

Gender dysphoria is a symptom, and it can result from any -- more than one different situations. The best metaphor I have would be if somebody comes in -- a patient comes in complaining of a headache. We don't immediately diagnose the person with headache disorder and send them to headache treatment. We find out what causes the headache. It could be a migraine. It could be a head injury. It could be an aneurysm. It could be a brain tumor. What we do is according to what causes the symptom we're observing.

With gender dysphoria, the major types that have been well known for decades are -- we nickname according to -- we nickname them or we classify them according to when in life they kick in, either a childhood onset gender dysphoria or adult onset gender dysphoria.

The adult onset gender dysphoria almost always are in men. There are virtually no cases of biological females reporting adult onset gender dysphoria. These are men who are attracted to women. They refer to themselves as heterosexual. They're unremarkable and fade into the background. They seem heterosexual. But usually by middle age, you know,

they've decided that they've lived a heterosexual life and that it's just not working for them. They experience a sexual interest pattern that we call autoandrophilia where they actually experience sexual arousal to the image of themselves as female. For some people it's just a kink and part of their sex life and they're perfectly happy and healthy that way, but for some people, just cross-dressing, just looking female in the mirror isn't enough and they actually want to live their life 24/7 as female. And the research shows if they're otherwise mentally healthy, they do perfectly fine having transitioned.

Q. I'm going to cut you off because this case is about minors. So can you talk about --

A. And that's -- yeah. That's the other type.

Q. Yes.

A. I detail the adults really in order to demonstrate the level of contrast between the two.

Q. Okay.

A. The childhood onset are kids who feel like they're the opposite sex pretty much from the get-go. They start reporting it prepubertally really since childhood. The majority are still biologically male, roughly three-quartersish, but there is a substantial portion of them who are biologically female.

In those cohort studies -- there have been 11 of them -- the majority of them, you know, three-quarters of them, 80 percent of them, stop feeling gender dysphoric by puberty. Instead, when puberty kicks in and they start experiencing sexual arousal and sexual interest patterns, they realize instead they were gay or lesbian. They were either effeminate boys. They were tomboyish girls. But when puberty hits and they start developing attractions and developing crushes on other people, they realize that what made them feel like not a regular boy or not a regular girl was just an early manifestation of what will be their sexual -- their sexual orientation. In a minority of them, as I say, roughly 20 percent, the feeling of gender dysphoria does not go away.

Since -- in the past ten years or so, really coinciding almost identically with the advent of social media, a third group has started coming to clinics, and these are completely unlike either of the first two clinics. They do not report childhood gender dysphoria like the childhood onset types. They're majority female, and they have a completely different mental health pattern, again, unlike the other two groups. This is the group who now is the large, large majority of people coming into clinics saying that they

feel unhappy with their gender and want to live in some other way. Also unlike the other two types, they're very frequently picking some neologism or some ambiguous status such as being fluid or non-binary, unlike the other two groups.

So where we have outcome studies on the childhood onset type and we have outcome studies on the adult onset type, we have absolutely no data, we have no outcome studies on this -- what I'll call the adolescent onset type even though they are now suddenly the large majority of people coming into clinics.

Q. All right. Thank you. What is -- what does desist mean in this field?

A. We use that word to refer -- originally we used that word to refer to the child onset cases who ceased to feel gender dysphoric over the course of puberty. As I said, the majority of them, 80 percentish, cease to feel gender dysphoric. We refer to them as the desisters. And the minority of them who continued to feel gender dysphoric during and after puberty we refer to as the persisters.

Q. Does desist have a meaning with adolescent onset -- I'm trying to -- adolescent onset gender dysphoria?

A. Gender dysphoria. It seems to, but it's much

more ambiguous. As I say, we don't have any systematic studies following up the adolescent onset type, so it's tough to tell.

The cases that have come to attention are the people -- the adolescent onset cases who have started medicalized transition realized or decided that it was a mistake and so they stopped or tried to reverse the medicalized procedures they underwent. It's perfectly reasonable to refer to them as desisters because they're reporting that they no longer feel gender dysphoric. The other term that is used very commonly with them are detransitioners. Some people, you know, choose one term or the other because sometimes it's just the feelings that change, and for some people there's been a medical process that they're trying to reverse. And people use those words sometimes very ambiguously, and it's tough to tell who should really be called a desister --

MR. GONZALEZ-PAGAN: Your Honor --

A. -- versus who should be called a detransitioner, but both are definitely on the table and both are in play.

MR. ELDRED: Stop for a second.

THE COURT: Hold on.

MR. GONZALEZ-PAGAN: Your Honor, at this

point I would object to this line of inquiry. It is beyond the scope of what he was qualified for. He was qualified to speak about the research regarding the safety and efficacy of the treatment of gender dysphoria.

THE COURT: Treatment of gender dysphoria in minors. Scientific research related to treatment of gender dysphoria of minors. And --

MR. GONZALEZ-PAGAN: He's now speaking about different types of gender dysphoria, the desistance and what is desistance. This is beyond safety and efficacy of treatment.

THE COURT: Well, but safety and efficacy wasn't the specific --

MR. GONZALEZ-PAGAN: It's beyond the word treatment.

THE COURT: Well, I'm going to overrule the objection. I think -- but ask him a next question, Mr. Eldred.

MR. ELDRED: We're almost done with this topic.

THE COURT: Okay.

MR. ELDRED: And I'll try to ask the questions better.

Q. (BY MR. ELDRED) What's the scientific research

say about the predictability of who will detransition or desist?

A. That we can't do it with any kind of accuracy. Several studies have attempted to, but other than some small correlations, nobody's yet been able to identify a reliable method of which people will persist and which people will desist.

Q. Okay. Some of these studies about gender dysphoria, do any of them talk about suicide and suicidality?

A. Yes. That's been attempted to be measured in very many of these studies, again, primarily the survey studies.

Q. What's the difference --

A. The --

Q. -- between the two --

THE REPORTER: I couldn't hear.

A. The common misunderstanding --

THE COURT: Hold on. Hold on. Hold on, Dr. Cantor. We're talking over each other.

Mr. Eldred, if you'll go ahead and restate your question.

Q. (BY MR. ELDRED) Yeah. I'm sorry. I tried to cut you off on Zoom, which is sometimes hard to do.

What's the difference between --

A. I can see the waving, but the picture I'm seeing everybody in is small.

Q. Yeah. I'm sorry. When I wave my hand, I'm trying to get you to stop.

What's the difference between suicide and suicidality?

MR. GONZALEZ-PAGAN: Objection, Your Honor, beyond the scope.

THE COURT: Well, I think the question was what the research indicated with respect to suicide and suicidality, but I guess if you'll phrase a next question.

MR. ELDRED: Sure.

Q. (BY MR. ELDRED) From your research of -- you already said that some of the research discusses suicide and suicidality. Is that true?

A. That is correct.

Q. And what does the research say about the difference between those two terms?

A. They are independent phenomena. Suicidality is -- suicide refers to actual death and an actual intent to die. The great majority -- this is well known in psychology. The great majority of suicides are impulsive, mostly in biological males, and mostly middle-aged. Suicidality --

MR. GONZALEZ-PAGAN: Your Honor --

A. -- refers to suicidal ideation --

MR. GONZALEZ-PAGAN: -- again, beyond the scope.

THE COURT: Hold on. Hold on. State your objection.

MR. GONZALEZ-PAGAN: He's speaking now about research about middle-aged men and suicidality.

THE COURT: I agree, it's probably a little bit more than we need, but I'm going to overrule the objection. And just try and ask a more specific question, Mr. Eldred.

Q. (BY MR. ELDRED) Okay. What is suicidality related to gender dysphoria in minors?

A. Suicidality --

Q. According to scientific research -- I apologize.

THE REPORTER: I didn't hear the end.

A. Suicidality, unlike suicide, is --

THE COURT: Hold on. Sorry, Dr. Cantor.

THE WITNESS: That's no problem.

THE REPORTER: Start over.

MR. ELDRED: It's my fault. I've been stopping and starting. I will try to ask the question again.

Q. (BY MR. ELDRED) The scientific research that you've described and study about gender dysphoria, as you stated, discusses suicidality. And what does it say about suicidality, what it is, and what else does it say about it?

A. The studies have pertained to suicidality and not suicide. It would be a mistake to generalize the studies that have been conducted to say something about suicide. They don't. They refer to people with, for example, suicide ide- -- suicidal ideation. Suicidality is not just a -- is not a preliminary form of suicide. It's generally a sign of psychological distress and a cry for help. That's been widely studied and widely reported amongst minors, especially the adolescent onset gender dysphoria, but it does not pose the great potential for death the way that it's often discussed in the media. It's a serious condition and it merits mental health treatment, but it is not the -- it does not imply if you don't give the person what they're asking for they will kill themselves. That's not shown by the research. As I say, it's a sign and it's an indicator of profound and substantial psychological distress, but the -- but it indicates that the person is in need of psychotherapy for dealing with that distress itself.

MR. ELDRED: Judge, may I have one moment to consult with my co-counsel?

THE COURT: Certainly.

MR. ELDRED: All right, Judge. We're ready for some more questions.

THE COURT: Go ahead.

Q. (BY MR. ELDRED) I'm going to switch gears a little bit. From your knowledge of studying standards of evidence and methodologies, what is an established treatment?

A. That's a good question. It's really -- that would be more of a subjective account of the particular --

MR. GONZALEZ-PAGAN: Objection, Your Honor. Dr. Cantor --

A. -- scientists that --

THE COURT: Hold on. Hold on, Dr. Cantor. What's the objection?

MR. GONZALEZ-PAGAN: Again, beyond the scope. This is beyond the scope of speaking to treatment of gender dysphoria in minors. He's now speaking to standard of care and how to establish one.

THE COURT: If you can ask a more specific question, Mr. Eldred.

MR. ELDRED: Sure. I'll try.

Q. (BY MR. ELDRED) In the research you've been talking about, do they -- do the studies talk about established treatment of gender dysphoria in minors?

A. The studies themselves don't determine what's established versus not. Whether a study is established usually would be handled subjectively by a committee that's evaluating the entire body of research, including its safety and its efficacy.

Q. And the same question: Do these studies talk about experimental treatments of gender dysphoria in minors?

A. They would if any existed, but there have not yet been any studies of the RCT or at the experimental level.

Q. Is medical intervention for the treatment of dysphoria in minors an experimental treatment?

A. Yes, it is. It has not yet been tested with experimental studies, so it's necessarily still within the experimental status.

Q. All right. We're almost done. Have you assessed the clinical guidelines put out by WPATH?

A. Yes, I have.

MR. GONZALEZ-PAGAN: Objection, Your Honor. He's speaking to the research, not to the standard of care guidelines.

THE COURT: A response?

MR. ELDRED: Judge, I'll try to ask a better question.

THE COURT: Okay.

MR. ELDRED: One moment, please. Sorry.

THE COURT: No worries.

MR. ELDRED: Thank you.

Q. (BY MR. ELDRED) Do the research studies that you have looked at and have been talking about, do they study -- do they support the conclusions reached by WPATH about the treatment of gender dysphoria in minors?

A. When taken as a whole, no, they do not. The contents of the WPATH guidelines engaged very much in the cherry-picking that the systematic review process was designed to prevent.

Q. How about the same question for the Endocrine Society?

A. Similarly. The Endocrine Society conducted -- I hesitate to call it a systematic review. The review consisted of exactly one study, and the study that they reviewed was not at all about the safety of puberty blockers.

MR. ELDRED: And I will pass the witness.

THE COURT: All right. Given the time, I'm going to go ahead and take our lunch break at this

point, and we can expect to return at 1:30. Dr. Cantor, we'll be on break for about an hour and a half, just over that, so you're welcome to -- I'd probably stay signed into the Zoom, maybe just turn off your camera and your microphone during our lunch break.

THE WITNESS: Oh, I'm sorry. I forgot the time zone. You said 1:30, so to me that'll be 2:30.

THE COURT: I believe so. I'm not sure exactly where you are.

THE WITNESS: I'm sorry. I'm in Toronto, which is Eastern Standard Time.

THE COURT: So about an hour and a half.

THE WITNESS: Yep.

THE COURT: All right.

MR. STONE: I just wanted to check that Dr. Cantor would be available. When we talked to him earlier, we thought that we'd be done by lunch. Dr. Cantor, will you still -- will you be able to come back?

THE WITNESS: Yes.

MR. GONZALEZ-PAGAN: Well --

THE COURT: Yeah, he kind of has to. Sorry. Sorry. So yes, so we'll be on break until 1:30. And again, you're welcome to turn off your microphone and your camera during that time, okay?

THE WITNESS: Understood.

THE COURT: Thank you. All right. We're excused for lunch. I'll be back at 1:30. Thank you.

(Lunch recess taken)

THE COURT: Dr. Cantor, are you ready to proceed?

THE WITNESS: Yes, I am.

THE COURT: All right. To the extent we have anybody new in the gallery, just a reminder no recording, broadcasting, or any photography.

And so, Mr. Gonzalez-Pagan, it's your turn.

MR. GONZALEZ-PAGAN: Thank you, Your Honor. And if it's okay, I'll move over there.

THE COURT: Yes. That'll be fine. And actually, let me -- well, I think he can still see you on that camera.

MR. GONZALEZ-PAGAN: I'm in the corner.

THE COURT: All right. Go ahead.

CROSS-EXAMINATION

BY MR. GONZALEZ-PAGAN:

Q. Good afternoon, Dr. Cantor.

A. Good afternoon.

Q. Dr. Cantor, you have never diagnosed a child or adolescent with gender dysphoria; is that correct?

A. Not child, but adolescents, yes.
Q. You testified at a hearing in Alabama; is that right?
A. That's correct.
Q. At that hearing you testified -- when asked have you -- you have never diagnosed a child or an adolescent with gender dysphoria, you said no.
A. I don't recall the question specifically, but what I'm pointing out is the distinction between child, meaning prepubescent, versus adolescent teenager, teenagehood. As I said, my license permits a diagnosis of ages 16 and up. I don't remember the context around that particular question.
Q. That's all right.
A. If they --
Q. There's no need to -- I have limited time, so I appreciate the answer.
So then you would -- you would agree then that you have never treated or diagnosed a child or adolescent under 16 for gender dysphoria?
A. Correct.
Q. In your testimony earlier today, you discuss instances in which you have purportedly served as an expert; is that right?
A. Correct.

Q. You have never testified in a trial relating to the treatment of gender dysphoria in minors; is that correct?

A. I don't believe any of those cases have yet gotten to the trial phase. The most advanced would be the --

Q. A simple no is fine. You have testified at only three hearings, one in Alabama, one in Georgia last week, and one in Texas last year; is that right?

A. I would have to check my notes to be sure, but that sounds about right.

Q. And the Court in Alabama found that your testimony should be given very little weight; is that correct?

A. I don't remember the details of the finding. I think I was the only expert actually mentioned at all. I can't speak to the judge's frame of mind, but it was essentially me versus the entire medical establishment, and the judge's comments were why he -- he needed to say something about me in order to say why he was finding essentially for the medical establishment. I don't believe he said anything specifically about my credibility.

Q. Understood. Notwithstanding your interest and concern relating to medical treatment for gender

dysphoria in minors, you have not sought to conduct any original research in this area; is that correct?

A. I haven't -- not in the sense that I collected data on them directly, that's correct.

Q. And you have not sought to conduct and publish a systematic review of the evidence pertaining to the treatment of gender dysphoria; is that right?

A. Almost. What I have done -- not systematically in the sense of a systematic review, but what I have done exhaustively is to evaluate, for example, the --

Q. I understand, Dr. Cantor.

A. -- American Academy --

Q. I just want to speak to the question that's asked.

MR. ELDRED: Objection.

THE COURT: Yeah, hold on. Hold on. First of all, let's not talk over each other. And so I think that if you can finish -- I'm going to let him finish this specific answer, Mr. Gonzalez-Pagan, and then we'll go from there.

But you were -- finish, Dr. Cantor.

A. But I do compare the contents, for example, the policy of the American Academy of Pediatrics conducting a peer-reviewed facts check of its claims against the scientific literature.

Q. (BY MR. GONZALEZ-PAGAN) But you have not yourself published a systematic review of the evidence; is that correct?

A. That's correct.

Q. You pointed to the limitations of some of the studies pertaining to the treatment of gender dysphoria in adolescents in your testimony. Do you recall that?

A. Yes, I do.

Q. You would agree that every study has limitations; right?

A. That's correct.

Q. None of the studies you discussed concluded or showed that the provision of puberty blockers or hormone therapy to treat gender dysphoria in adolescents is harmful; is that correct?

A. No, I couldn't say that's correct. Many of the studies, as I said, do point out the downsides, the changes in bone density and so on and other objective variables. What's questionable or what's -- what's usually in debate is whether there's sufficient documentation or objective documentation of benefit in order to make those objectively shown harms worth it.

Q. Understood. I'm asking about the studies' conclusions. None of them concluded that the provision of medical treatment for gender dysphoria in adolescents

is harmful. Yes or no?

A. No, they -- they did conclude -- the ones that were investigating safety of such -- certain blood parameters, bone density, did denote the changes themselves -- did denote the changes. They tend not to make the subjective assessment that the, you know, decrease in bone density is itself harmful. You know, that's usually done by the candidates which then interpret the evidence. The job of the study itself is just to document changes in -- the example I'm using is bone density.

Q. Sure. Studies have a discussion and a conclusion usually when they're in peer-reviewed literature; is that right?

A. Yes. That's the standard format.

Q. Okay. So my question is about the conclusion. Did any of them conclude that the provision of gender-affirming medical treatment for gender dysphoria in minors is harmful?

A. Yes, I would say that that's a fair assessment, they do conclude that.

Q. Which study concluded that?

A. Oh, goodness. I couldn't give the names of the studies offhand, but I did include in my report, as I said, summaries of exactly what they did say, the

systematic reviews that covered them -- the systematic reviews that covered them, which in turn cited them, but I couldn't tell you by name. I couldn't cite the study off the top of my head -- such studies off the top of my head.

Q. Isn't it true actually that all of the studies concluded in some form that the provision of gender-affirming medical treatment showed beneficial or positive effects for the adolescents treated?

A. Those were different studies. Some of the studies, as I say, were investigating the harms with regard to specific physical parameters, and other studies -- other studies tried looking at the benefits, usually the mental health benefits. And the ones that looked at harms, again, the objective physiological parameters were indeed able to document the decreases in physical health, and it's the studies that were trying to look for potential benefits that were looking -- the mental health parameters, which some claimed and some did not claim that there were benefits. So I'm not -- as I say, I'm not exactly sure which study you're referring to. The studies of harms are usually distinct from the studies of benefits.

Q. Sure. Dr. Cantor, I'm asking about what studies you're referring to because you never mentioned

any particular study, so I'm asking.

A. No, I cited the studies quite thoroughly in my report. I'm just pointing out that I can't recall their names off the top of my head. If you're asking me to refer to my report to name them, I can do that.

Q. Sure. The cohort studies that you discussed pertaining to the mental health benefits for seeking to assess mental health benefits or efficacy of the provision of medical treatment for gender dysphoria in adolescents, these studies fall within the middle of the so-called ubiquitous pyramid of evidence that you discussed; is that right?

A. Yes. They're cohort studies.

Q. Is it your testimony that cross-sectional peer-reviewed studies based on survey data are not valid forms of evidence?

A. Not for outcomes of interventions, no.

Q. Dr. Cantor, you support the provision of medical treatment for gender dysphoria in adults; is that correct?

A. That is correct.

Q. The evidence pertaining to the provision of medical treatment for gender dysphoria in adults is of the same kind and level of evidence pertaining to the provision of medical treatment for gender dysphoria in

adolescents; is that right?

A. It's of the same kind, but when the interventions are aimed at an adult body, the risks are lower.

Q. You do not dispute that there are medical treatments that are provided to adolescents for which there are no randomized controlled trials?

A. Such -- such interventions exist, yes. Again, the basic decision-making process is risk to benefit. So when there is a low-risk intervention, then we -- then it's permissible or it's legitimate to employ only low-quality evidence of benefit. But when it's a high risk of harm, such as sterilizing --

Q. Dr. Cantor --

A. -- a child --

THE COURT: Hold on.

MR. GONZALEZ-PAGAN: I'm on limited time. I'm going to object --

THE COURT: Yeah. So Dr. Cantor, your attorney will have a chance to ask things in more detail, so if you could just stick to what Mr. Gonzalez-Pagan -- they're worried about time. They only have a certain amount of time, each side. So if you can concentrate on just his question and answer that.

THE WITNESS: I understand.

Q. (BY MR. GONZALEZ-PAGAN) Dr. Cantor, you have testified that there is no study showing that psychotherapy alone can resolve an adolescent's gender dysphoria; is that right?

A. It depends on what somebody means by resolve.

Q. You testified here in Texas last year on this very question I asked of you -- you have testified that there is no -- I asked you: Are there any studies showing that psychotherapy alone can resolve an adolescent's gender dysphoria? Is that correct? And you said that's correct. Do you recall that?

A. I can't say that I do in the sense that -- again, I'd need to know the context of the questions around it. It's true in the sense that the person doesn't -- a person who is genuinely gender dysphoric doesn't cease to feel dysphoric. What usually can happen is the person's distress which they are mistaking to be gender dysphoria a person can come to realize wasn't gender dysphoria to begin with.

Q. Dr. Cantor, you would agree that the peer-reviewed process is an integral part of scientific research; right?

A. Yes, that's fair.

Q. You discussed some purported systematic reviews

earlier today. Do you recall that?

A. Yes, I do.

Q. With the exception of a paper from Finland, none of the purported systematic reviews that you discussed have been subjected to the readers of external peer review or been published in a peer-reviewed scientific journal; is that right?

A. A systematic review conducted by the healthcare system of a government typically does not. It's a different means of assessing -- of assessing the literature. For example, if the --

Q. So is that a no?

A. -- NIH was to --

Q. Dr. Cantor, were they --

A. Understood.

Q. Were they submitted to external peer review? Yes or no?

A. So far as I know, it was the Swedish study that was, the Ludvigsson.

Q. So just the Swedish study?

A. That's my recollection, yes.

Q. Counsel for defendants made reference to a purported systematic review from McMaster University in Canada. Do you recall that?

A. Yes, I do.

Q. This review was commissioned by the administration of Governor DeSantis in Florida in support of the rule prohibiting coverage for medical treatment --

THE REPORTER: Can you start over, please?

THE COURT: Whoa, too fast.

MR. GONZALEZ-PAGAN: I apologize. That was very fast.

THE COURT: Slow down.

MR. GONZALEZ-PAGAN: That's on me.

Q. (BY MR. GONZALEZ-PAGAN) Dr. Cantor, I'm going to slow down for the court reporter before I get thrown out of here.

A. I'm from New York. I have the same problem.

Q. This review was commissioned by the administration of Governor DeSantis in Florida in support of their rule prohibiting coverage for medical treatment for gender dysphoria. Is that correct?

A. That's my understanding of it, yes.

Q. And you testified that you submitted a declaration in relation to this matter?

A. To the general matter, not to that specific review, yes.

Q. That rule was recently found to be unconstitutional; is that right?

A. I -- that's a good question. I don't follow each state's individual policy, but I seem to recall such a thing being reported in the media.

Q. That review has never been submitted to external peer review; is that right?

A. Not that I know of, no.

Q. And it has never been published in a scientific or medical journal; is that right?

A. So far as I know, it hasn't.

Q. You said that systematic reviews account for all the evidence. Do you recall that?

A. When properly conducted, that's their purpose, yes.

Q. But systematic reviews are conducted and authored by people who establish criteria of what studies qualify for the review or not. Is that not correct?

A. That is correct. The proper procedure would be to register what those criteria are before conducting the review itself.

Q. So none of the systematic reviews that you discussed actually account for all the peer-reviewed studies regardless of design pertaining to the medical treatment for gender dysphoria. Would you agree with that?

A. Sort of. Again, the criteria were to select the best and most relevant ones and to take out the ones that were irrelevant because, following the metaphor I used before, once you have the results of the telescope, there is no point to including the naked eye observations.

Q. Understood. You mentioned that gender dysphoria is a symptom. Do you recall that?

A. Yes.

Q. Gender dysphoria is a diagnosis under the DSM-V; is that correct?

A. That's correct.

Q. There are two and only two diagnoses for gender dysphoria under the DSM-V, gender dysphoria in children and gender dysphoria in adolescents and adults; is that right?

A. Yes, that's correct.

Q. In discussing the alleged types of gender dysphoria, you mentioned adolescent onset gender dysphoria as a third type; is that right?

A. That is correct.

Q. In support for your opinion in your declaration, you have cited to an article by Lisa Littman based on survey data; is that correct?

A. That is correct.

Q. This is the same kind of survey data that you said earlier is not evidence; is that correct?

A. Not evidence of medical outcomes. It's evidence of what features cluster together with what features.

Q. Is there any case-controlled study, cohort study, randomized controlled study, or systematic review that you can cite as evidence for this so-called third type of gender dysphoria?

A. There's -- there can't be. Again, for diagnosis, that's about clustering, what features go together with what features. The randomized clinical trials and so on are to test the outcomes of a particular intervention. We would use one set of methodology to answer one kind of question and the other set of methodology to answer the other kind of question.

Q. Dr. Cantor, you discussed some studies pertaining to desistance. Do you recall that?

A. Yes, I do.

Q. In these studies that followed prepubertal children that you discussed in relation to desistance rates, none of the subjects of those studies were diagnosed with gender dysphoria under the DSM-V; is that right?

A. Correct. They were conducted before the DSM-V,

and they are part of the data on which the DSM-V was based. It's -- the research literature is necessarily one step ahead of the DSM-V.

Q. The subjects of those studies were diagnosed with gender identity disorder under prior versions of the DSM; is that right?

A. Yes, that's correct.

Q. And the diagnosis criteria for gender dysphoria under the DSM-V differ from the diagnostic criteria for gender identity disorder under those prior DSM versions; is that right?

A. Right. That's the nature of how the system works. The scientists publish the studies, and then the committees that form the DSM form their decisions on the basis of those studies, and then the studies going forward use the DSM-V. And then the results of those studies will be used to form the DSM-VI. As I say, the results of the studies are necessarily one step ahead of the DSM.

Q. Well, these studies are actually steps behind the current DSM; is that right?

A. No. The DSM only knows what to do on the basis of the studies that already exist, and so they form the DSM criteria on the basis of the existing studies as a suggestion for what to do in the next generation of

studies.

Q. The DSM-V criteria were changed to actually make it stricter in order to avoid false-positives. Do you know that?

A. Yes. That was part of the intent, yes, but the DSM-V criteria -- all diagnostic criteria are a committee decision in order to compromise together several competing principles, and one of them is to simultaneously create as many hits as possible, that is to diagnose as many people as appropriate, without overdiagnosing or underdiagnosing.

Q. Thank you, Dr. Cantor.

MR. GONZALEZ-PAGAN: No further questions at this time, Your Honor.

THE COURT: All right. Thank you.

Mr. Eldred, some redirect?

MR. ELDRED: No, Your Honor.

THE COURT: All right. Thank you, Dr. Cantor. We are done with you on the witness stand. You may stay in the proceeding if you'd like and just make sure and turn off your microphone, but you are also welcome to leave.

THE WITNESS: Thank you very much.

THE COURT: Thank you. All right. Your next witness?

MS. DYER: Defendants now call Katrina Taylor to the stand.

THE COURT: And I'm sorry. Katrina?

MS. DYER: Katrina Taylor.

THE COURT: Taylor. Okay. Please step forward, ma'am. You can step right up here and I'll swear you in.

MS. TAYLOR: Okay.

THE COURT: If you'll raise your right hand.

(Witness sworn)

THE COURT: You can make your way around there up to this chair here. There should still be some water if you need it.

KATRINA TAYLOR,

having been first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MS. DYER:

Q. Good afternoon, Ms. Taylor. Could you state your name and spell it for the record, please?

A. Yes. My name is Katrina Taylor. So my legal name is Y-e-k-a-t-e-r-i-n-a, last name T-a-y-l-o-r. I do go by Katrina colloquially.

Q. Perfect. And what degrees do you hold?

A. Yes. So I have a master's in counseling

psychology from St. Edward's University.

Q. And when did you obtain your master's?

A. I graduated in 2014.

Q. Perfect. And what type of clinical training have you done?

A. I have done quite a bit of clinical training. After graduation I completed a two-year integrative training program focused on working with families and couples, children, adolescents, family systems. And I also have completed six years of psychoanalytic training to be able to conduct psychoanalysis and intensive psychoanalytic psychotherapy.

Q. And are you licensed in anything specifically?

A. Well, I am a licensed marriage and family therapist in the state of Texas.

Q. Is Texas the only state you're currently licensed in?

A. Yes.

Q. And what year did you receive that license?

A. I received my provisional license in 2015, and I received my full license in 2017.

Q. Okay. And then you just testified that the psychoanalytic psychotherapy -- would you consider that your specialty inside the practice of family and marriage therapy?

A. Yes. Yes, absolutely. That's the main lens through which I view people and families and development, correct.

Q. Okay. And do you teach anything related to the field that you practice?

A. Yes. So I teach for my institute, which is the Center for Psychoanalytic Studies in Houston. I typically teach one class per year. I've done it the last two years, and I have a class coming up this academic year that I'll be teaching.

Q. Okay. And how many years would you say you've been working as a psychoanalytic therapist? I guess we can do the math with your licensure, but it's a little easier just to ask you.

A. I would say psychoanalytically since 2017, but I've been working clinically since 2014 in my pre-grad internship. All together I have over 10,000 clinical direct hours, clinical contact hours.

Q. Okay. And within those 10,000 hours, what experience do you have treating patients with gender dysphoria, both adolescent and/or adult?

A. I would say some experience, but it's not the majority of my practice.

Q. In terms of treating adolescents, what majority -- what portion of your practice is that?

A. Well, currently -- so there were not -- there were no children or adolescents with gender dysphoria for a long time. And it's only recently that we have seen an influx of patients coming in with this diagnosis. You know, I would say in the last few years I've probably worked with about 30 children and adolescents and their families.

Q. Specifically with --

A. With the gender dysphoria, yes.

Q. And just generally, what experience do you have treating minors for psychological conditions generally, not just gender dysphoria?

A. I have experience going all the way back to my pre-grad internship working with minors, working with their families.

Q. Okay. And have you done any research with regards to this subject?

A. I have not myself conducted research, no.

Q. What research have you done, not yourself, but have you looked into with regards to the topic?

A. I've done extensive research on this topic. I've done a lot of reading. I'm a member of the Gender Exploratory Therapy Association, and they have a lot of research, webinars, resources, you know, on their website in the private community that we have for the

therapists. So I've really delved into the writings on the topic as well as psychoanalytic writings, which tend to be not official research but more so clinical writings, expanded case studies of working with gender confusion in minors as well as adults.

MS. DYER: Your Honor, Ms. Taylor's CV is Defendants' Exhibit 7. And at this time defendants would proffer Ms. Katrina Taylor as an expert in clinical psychotherapy and the diagnosis, treatment, and care of gender dysphoria and other psychological conditions.

MR. SELDIN: Your Honor, can I do a brief voir dire?

THE COURT: Sure.

VOIR DIRE EXAMINATION

BY MR. SELDIN:

Q. Good morning. So you have not conducted any original research on the treatment of gender dysphoria in adolescents; is that correct?

A. That's correct.

Q. You haven't published any research on that topic either?

A. That's correct.

Q. Has any of your training taken place in a multidisciplinary clinic for the treatment of gender

dysphoria?

A. Specifically for the treatment of gender dysphoria, no.

Q. And do you have any specialized training in adolescent mental health?

A. Yes.

Q. What training is that?

A. That's the training through the Center for Psychoanalytic Studies in Houston.

Q. And --

A. As well as in my master's program.

Q. Of the 30 children and adolescents that you say you've treated in this area, how many of them -- or do those children or adolescents have a gender dysphoria diagnosis?

A. Some of them, yes. I have diagnosed them with gender dysphoria. I have given them that diagnosis. Some I have not.

Q. About how many of the 30?

A. That I have given a diagnosis to, I would say about five.

MR. SELDIN: Your Honor, we would object to the extent that this witness intends to offer expert testimony on the treatment of gender and diagnosis -- diagnosis of gender dysphoria given that it's a very

small number and limited. Her clinical experience seems to be mostly focused on psychoanalysis in adults.

THE COURT: Ms. Dyer, do you have any other response or follow-up with this witness?

MS. DYER: Your Honor, I mean, she's a qualified therapist who does treat these children, including adolescents of all different types of psychological conditions. And to the extent it could help the Court in any capacity, I think she should be designated as an expert.

MR. SELDIN: Your Honor, we would ask that it be limited then to psychoanalysis and not the medical treatment.

THE COURT: All right. So I'll accept the designation with the caveat that it's related to the psychoanalysis piece from this witness.

MR. SELDIN: Thank you, Your Honor.

THE COURT: All right. Go ahead.

CONTINUED DIRECT EXAMINATION

BY MS. DYER:

Q. Okay. Ms. Taylor, we're going to back up just a little bit. So first can you explain to me how you define and/or how you have been taught based on your experience -- what is gender dysphoria?

A. So gender dysphoria is a feeling of not being

in the right body, a feeling of a fundamental incompatibility with one's sexed body and that these feelings should persist for six months or more.

Q. And how do therapists treat gender dysphoria in minors?

A. Well, the current prevailing treatment is to affirm, is to affirm the child or adolescent's belief that they are of the opposite sex or that they are not in the right body.

Q. And what would you say is the goal of therapy to a minor for the treatment of gender dysphoria?

A. Well, I think it's important for us to say that a minor is not separate from their family, that -- you know, in my training, in having a grounding in both a family systems theory and a psychoanalytic theory, we can't separate the child from the family because the child lives with the family and the child is an integral part of the family.

So when there is gender confusion -- and I specify the difference between diagnosing with gender dysphoria versus more of a gender confusion because I think that's an important difference. But when there is gender confusion or gender dysphoria, I see it as a symptom for the family. The child is an identified patient for the family, and there's something going on

in that family system that is awry, that is dysfunctional that needs to be addressed.

Q. Would you say that therapy is safe -- is a safe treatment for gender dysphoria in minors?

A. Yes, absolutely.

Q. And do you think it's an effective treatment for gender dysphoria in minors?

A. Yes, absolutely.

Q. How -- I know you mentioned it earlier about the gender confusion, but how does gender identity -- and that phrase is with regards to how you understand it -- relate to a diagnosis of gender dysphoria?

A. Well, I don't -- I don't use the phrase gender identity very much. I don't prefer to use it. Gender identity, it's not an empirical statement. We have no proof that there's such a thing as a gender identity. I have come to see it as a personal or spiritual belief about the self. Therefore, I don't agree that one can have a gender identity that is fundamentally different from one's sexed body. What is possible are feelings of hatred, of revulsion for one's own body, whether it has to do with sex and the sexed body or whether it has to do, you know, with weight like we see in eating disorders.

Q. And would you say there's a diversity of

opinion in the psychological realm with regard to diagnosing and treating of gender dysphoria?

A. Unfortunately, no.

Q. Is that because everyone is -- you just testified that everyone -- the current model is to affirm. Is that the primary method that you're -- that you're saying that that's why there's no diversity of opinion?

A. Yes. By and large the current method is to affirm. Clinicians who don't affirm or who put forth different ways of thinking about children and families, you know, more critical ways, more thoughtful ways, they're often censored. They're often ostracized in their therapeutic communities. I've experienced that myself. And so a lot of people are afraid to say much. And I think this is where the Gender Exploratory Therapy Association of which I am a member is a very important voice in this -- on this topic.

Q. And who is Diane Ehrensaft?

A. Yes. So she is a psychologist, and I believe she's the founder and quite involved in the University of San Francisco Child and Adolescent Gender Center, Benioff Center. And so I've actually -- I have seen Dr. Ehrensaft speak in person, and she came to our institute back in 2019. She has some theories about how

gender develops in children which I believe to be unfounded and go contrary to everything we know about child development.

Q. What is she known for in the area of psychology?

A. Well, one of the things she's known for -- I don't know if a lot of people know this, but she was involved in the Satanic panic, the accusations against daycare teachers --

MR. SELDIN: Your Honor, we would object to this being outside the scope.

THE COURT: Ms. Dyer?

MR. GONZALEZ-PAGAN: And inflammatory.

MS. DYER: To the extent that she's talking about another opinion in the psychiatric community with regards to treating the -- we can reframe the question so we don't discuss the latter of the response.

THE COURT: All right. So reframe the question.

Q. (BY MS. DYER) Okay. With regards to Ehrensaft's opinions on gender identity, can you explain to me what her stance is on that?

A. So her stance is that children can know what their so-called gender identity is in infancy,

toddlerhood, even going back to the womb. She has spoken about sort of children rejecting gender stereotypes and that that says something about them having a gender identity that is opposite of their sexed body. So, for example, she's spoken about a baby girl ripping out a barrette, you know, from her hair and that indicates that that baby girl is actually a baby boy. Another example --

MR. SELDIN: Your Honor, we would object at this point as a narrative answer to the question.

THE COURT: I'm more interested in her opinions. I don't necessarily need to get into what she might think about somebody else's.

MS. DYER: That's fine, Your Honor. I was going to follow up with her opinion on that.

THE COURT: Okay. Then let's do that.

Q. (BY MS. DYER) Okay. Given what you've just stated --

A. Right.

Q. -- what is -- do you share her opinions? Or what are your opinions in response to that?

A. I absolutely do not share those opinions. Again, there's no empirical basis for this. It's pseudoscientific. It's pseudoreligious. It really points to this idea of a personal or spiritual belief

about the self that, you know, when in the case of young children is actually inculcated by the parents in my opinion.

Q. Okay. And so let's shift gears just a little bit. In terms of your direct clinical practice with patients in adolescence, among the patients that you've treated for either significant body hate, I think as you phrased it earlier -- I'm sorry if I misspoke -- or gender dysphoria, have you noticed any patterns amongst them?

A. Yes. So some of the patterns I've noticed is that these children and adolescents come from dysfunctional families, that there can be marital discord. Sometimes there's divorce. Sometimes when we really dig into it, there is trauma in each of the parents' or one of the parents' histories, you know, for example, mental illness in the extended family, suicidality in the extended family.

I have also noticed that these are parents who have a permissive parenting style. You know, so we have three parenting styles: authoritarian, permissive, and authoritative. We know children do best with an authoritative parenting style. These are quite permissive parents. There is a sense of anything goes. And these parents really struggle to set boundaries with

their children, to impose consequences for, you know, negative behavior.

Q. And you mentioned trauma a minute ago. Is underlying trauma something that adolescents or children are quick to give you details about when you first meet with them?

A. No.

Q. How many sessions would you say or hours -- I'm not sure how long your sessions are -- would you say that it takes for youth to open up to you about those types of things?

A. It takes a while. It really depends on the individual, you know, child or adolescent. I mean, I would say we have to probably work together at least eight to ten sessions to build up a sense of trust and rapport before we can get into anything deeper.

Q. And roughly how long are your average sessions?

A. 50 minutes, five zero.

Q. Okay. And out of the individuals that you have made a gender dysphoria diagnosis for, roughly -- without any specific details about the individuals, how many generalized sessions have you taken to give them that diagnosis?

A. I would say on average probably six to eight sessions.

Q. Do you believe that a diagnosis could be made during an initial assessment?

A. No, I don't believe it can be.

Q. And what's your basis for that belief?

A. One session is barely long enough to say hello. It's certainly not long enough to delve into the history, to understand the context of the presenting symptoms, to get more of a sense of the family and the family structure. And also, I -- when it comes to children and adolescents, I prefer to meet with the parents first to do either a parent meeting or to have as many members of the family come in so I can observe how they interact together. Then I would meet with the child adolescent one on one and we'd have more sessions. So it just really takes some time to get a feel for what is happening there.

Q. Okay. So going directly to how you would treat an individual, let's take one of the plaintiffs, for example.

A. Sure.

Q. Have you reviewed the affidavits attached to plaintiffs' complaint?

A. Yes.

Q. And so I will give you a brief summary to jog your memory of which one we're discussing. In

particular, Sarah Soe, who's a plaintiff, that began -- or her parents -- began to express gender dysphoria around the age of 12 and in her parents' affidavit stated that she never fit the boy gender stereotypes. That was a quote. Do you recall reading that affidavit?

A. Yes, I believe --

MR. SELDIN: Your Honor, we would object to this line of questioning as it appears to be going toward offering an opinion from the plaintiffs specifically in this case, who she's --

THE COURT: And was that --

MR. SELDIN: -- never met.

THE COURT: I'm sorry. So complete that.

MR. SELDIN: We would object, Your Honor. We appear to be leading down a path of asking questions about offering expert opinions on plaintiffs that she's never met.

THE COURT: Right.

MR. SELDIN: And so --

THE COURT: So she reviewed the affidavits and you're going to ask her --

MS. DYER: What her line of psychotherapy approach -- psychotherapeutic approach based on her knowledge she would have recommended for that patient.

THE COURT: Based on the affidavits.

MS. DYER: Based on the affidavits.

THE COURT: I understand that context. So I'm going to overrule the objection and let her ask the question.

Q. (BY MS. DYER) So do you recall reading that affidavit?

A. Yes, I believe so. So Sarah Soe, that's the 12-year-old girl -- right? -- who identifies as a, quote, trans boy?

Q. Sarah Soe identifies as a trans girl, was a bio- -- was born a biological boy.

A. Oh, right. And is that the one where the onset began at age four?

Q. No. This --

MR. SELDIN: Objection, Your Honor. At this point counsel appears to be testifying.

THE COURT: Yeah. I mean, if you've got a more --

MS. DYER: I was just trying to clarify.

THE COURT: -- specific question for her --

MS. DYER: Yeah.

Q. (BY MS. DYER) Okay. Let's -- the second one that you were referring to at the onset of four --

A. Yeah.

Q. -- would you like -- do you recall that one?

A. I do recall that one.
Q. Okay.
MS. DYER: Then can I -- is it okay if I jump to that one?
THE COURT: Try that.
Q. (BY MS. DYER) Okay. So this was plaintiff Maeve Moe. She's currently nine. And like you mentioned --
MR. SELDIN: Objection, Your Honor, at this point.
THE COURT: I mean --
MS. DYER: It's her --
THE COURT: Yeah, but you're -- well, you're not supposed to be leading this witness.
MS. DYER: I'm sorry. I was just trying to refresh her memory as to the exact affidavit without --
MR. SELDIN: Your Honor, there's --
MS. DYER: -- being able to show it to her.
MR. SELDIN: There's --
THE COURT: Hold on. We cannot talk over each other.
MR. SELDIN: I apologize.
THE COURT: Okay. Let's get a question

out and then get me an objection and we'll deal with that.

MS. DYER: Okay. I will reframe.

THE COURT: Don't start your answer yet.

Q. (BY MS. DYER) Hypothetically, if there was a patient that came into your practice, given your years of experience, who was roughly five years old, born a biological boy and was expressing symptoms -- or expressing things that they were interested in pink and more feminine type things, how would you go about treating or recommending treatment to that minor and/or family members?

THE COURT: All right. Do you have an objection?

MR. SELDIN: No, Your Honor.

THE COURT: All right. Answer that question.

MR. SELDIN: I haven't been shot.

A. I would say let this boy wear pink. He is still a boy.

Q. (BY MS. DYER) Is there any type of psychotherapeutic specific type of treatment or counseling you would offer to the family?

A. Well, I would work with -- with the family. That's a very young age. That's an age when kids are

still in preschool. Maybe they're starting kindergarten. That's an age of pretend play, of dress-up, of -- you know, maybe one day he's a girl, maybe another day he's a dog or a cat or a dinosaur. And children are playing. Play is a way that children learn about the world and figure out their own identities and other people's identities. I would tell the family to let him play.

I would say if the family is coming into my office with this as a presenting issue and they are concerned about their boy identifying as a girl, I would again see it as an identified patient for the family. What kind of distress is this child expressing for the family? And I would probably meet with the parents for quite a bit to understand more about their marriage, what's happening in the family, you know, as a whole, are there other siblings, does this child, for example, feel like he's not getting enough attention and adopting this kind of identity as a way to get more attention.

Q. And what would you say the overarching goal of therapy is for any of your patients that have been diagnosed with gender dysphoria or are suffering from body hate?

A. I would say the overarching goal is to learn to accept one's body, the body that the person was born

into. We all only ever get one body, to accept it, to make peace with it, and to focus on what really matters in life, which is work and love, so completing schooling, figuring out a career that they would like to pursue, and love, which includes romantic partnerships, friends, family. Those are really what lead to healthy psychological functioning in life.

Q. And have you seen positive -- I don't want to say outcome -- I guess outcome is the right word -- positive improvement, however you would like to define it, in the patients that you've been treating with psychotherapeutic approaches that have gender dysphoria?

A. Well, maybe here we should clarify between gender confusion and gender dysphoria.

Q. Yes. I apologize.

A. That's okay. I don't think every one of those children meets a diagnosis for gender dysphoria. But if they're showing up with gender confusion -- and again, sometimes it could be gender dysphoria -- yes, I absolutely have seen positive outcomes where they gain insight, they are more able to put words to their feelings, they're able to get to a place of accepting their body, of being more comfortable with who they are, and going through what can be a very difficult and scary time, which is puberty, you know, learning to be able to

go through puberty with less distress.

Q. Is puberty something that causes your other -- different patients distress as well, not necessarily adolescents suffering from gender dysphoria or body hate?

A. Oh, yes, absolutely. Absolutely. Yeah.

Q. Do they have any kind of distress associated with puberty?

A. I think a lot of children have distress associated with puberty, especially girls. Girls going through puberty, you know, go through a lot of unwanted changes to their body, which are painful and can be embarrassing, such as menstruation. I think it's very common for girls to feel like they hate their body at just that point in time that they're receiving unwanted attention from boys and even men to want to hide and to want to hide behind a trans identity, to take on this trans boy identity as a way to escape the distress and consequences of puberty.

Q. So potentially my last question: In your opinion, do you think that therapy is in fact a safe and effective treatment for minors with gender dysphoria?

A. Yes, absolutely.

MS. DYER: Can I have just one second to confer?

THE COURT: Of course.

MS. DYER: Okay. At this time we will pass the witness.

THE COURT: Thank you. Cross-examination?

MR. SELDIN: Your Honor, just one moment to confer.

THE COURT: Sure.

MR. SELDIN: I will have brief cross.

THE COURT: Sure.

CROSS-EXAMINATION

BY MR. SELDIN:

Q. You testified that you belong to an organization called the Gender Exploratory Therapy Association; is that correct?

A. That's correct.

Q. You said that there are some writings that you reviewed from them that inform your practice; is that correct?

A. Correct.

Q. Have any of those writings been subjected to randomized controlled trials validating their recommendations?

A. I can't be sure if they have or not.

Q. Have they been subjected to any longitudinal studies validating the recommendations?

A. I can't be sure.
Q. Have they been subjected to any cross-sectional or any other kinds of research studies validating their recommendations?
A. I can't be sure.
Q. Do you know if there's been any follow-up in terms of outcomes for patients who have been treated in accordance with those writings?
A. I am aware of clinical case studies. You know, Lisa Marchiano is one writer. Alessandra Lemma is another, Roberta D'Angelo, Robert Withers. They all have written clinical case studies on their work with -- describing their work with patients. And some of those papers do describe positive outcomes with patients.
Q. So those would be studies of individual clinical --
A. Correct.
Q. -- patients, not large sets of people; correct?
A. Not large sets of people, correct.
Q. Would you agree that consent is principally a parental function?
A. Yes.
Q. You testified that the -- that there's no diversity of treatment in this area because the prevailing treatment is to affirm a child's gender

identity; is that correct?

A. By and large --

Q. So --

A. -- yes.

Q. I didn't mean to cut you off. I'm sorry.

A. By and large. There's little diversity is how I would put it.

Q. So the treatment that you're describing in your practice would be outside of the mainstream of prevailing standards of care; correct?

A. Correct.

Q. You testified earlier that you did not believe a three-year-old had the capacity to understand their gender identity; is that correct?

A. That's correct.

Q. Do you believe that a three-year-old who has been assigned male at birth has an ability to know that he is a boy?

A. Yes, a three-year-old has the ability to know he is a boy because he is a boy.

Q. Based on his genitalia?

A. That is one marker of being a boy.

Q. Are there other markers of being a boy?

A. Boys behave differently from girls in terms of their energy level, their activity levels.

Q. Earlier you testified that if a hypothetical patient presented to you who was assigned a boy but liked pink, you would say go ahead and let them like pink; correct?

A. Correct.

Q. Is liking pink the kind of a sign of being a boy or a girl like high energy level that you just described or is it something different?

A. Liking pink or not liking pink is an interest. Energy level is a behavior.

Q. Do you think that a three-year-old who's been assigned female at birth has an ability to understand that their gender identity may be something other than female?

A. No.

Q. Earlier you talked about patterns that you had seen in your practice. You also -- that would be based on the five people or so that you have given a gender dysphoria diagnosis to?

A. It would be based on the 30 people I have worked with with some level of gender confusion.

MR. SELDIN: Your Honor, I may be done, if I could just have a brief moment.

THE COURT: Sure.

MR. SELDIN: I apologize. Thank you.

Q. (BY MR. SELDIN) Of the 30 patients that you just referenced, how many of them were minors?

A. I would say all of them except for maybe two. The vast majority were minors.

Q. And about how old were they?

A. Ranging in age from 12 to 17.

Q. And of the five that you did diagnose with gender dysphoria, about how old were they?

A. So some right around puberty, 12, 13, and some a little bit older, adolescents, like 17.

MR. SELDIN: Your Honor, I have nothing else for this witness. I pass the witness. Thank you.

THE COURT: Thank you. Any redirect?

MS. DYER: I have one quick question.

THE COURT: Sure.

MS. DYER: Maybe two, actually. Sorry.

REDIRECT EXAMINATION

BY MS. DYER:

Q. What would you say informed consent is in the context of therapy for minors?

A. Informed consent is the parent agreeing -- allowing the therapist to treat the child and to treat the family.

Q. And what risks are present in therapy for minors?

MR. SELDIN: Objection, Your Honor. I think this is outside the scope of cross.

MS. DYER: Respectfully, Your Honor, he just asked about informed consent.

THE COURT: I'll allow it. Go ahead.

A. The risk of therapy for minors? I would say there are few risks unless the therapist behaves unethically and seeks to alienate the minor, turn them against the family, or gives the family advice that is ultimately harmful.

MS. DYER: Okay. I think that's it. Give me just one second. Okay. We pass the witness.

THE COURT: Any other redirect -- or cross-examination?

MR. SELDIN: None, Your Honor. Thank you.

THE COURT: Okay. All right. Ms. Taylor, you're done on the witness stand. You may be excused.

All right. Next witness?

MR. STONE: At this time, Your Honor, defendants call Dr. Hopewell, Dr. Alan Hopewell.

THE COURT: Hopewell. Okay. If Dr. Hopewell's here, if you'll step forward, please. I assume that's the man in the white coat.

MR. STONE: Yes, Your Honor.

THE COURT: If you'll raise your right

hand for me, sir.

(Witness sworn)

THE COURT: All right. You can make your way around and up to this witness chair.

C. ALAN HOPEWELL, PH.D.,

having been first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. STONE:

Q. Good morning, Dr. Hopewell.

THE COURT: Actually, we're in the afternoon. Both of y'all said morning. I wanted to remind you of the time you have left.

MR. SELDIN: Your Honor, the days go by quickly.

MR. GONZALEZ-PAGAN: It's afternoon. That's what I meant to say.

THE COURT: I don't know where y'all are at, but I'm in the afternoon. Go ahead. Sorry.

MR. STONE: Thank you, Your Honor.

Q. (BY MR. STONE) Could you state your name for the record?

A. My name is Clifford Alan, and that's A-l-a-n, Hopewell.

Q. Dr. Hopewell, what degrees do you hold?

A. How many or which ones?

Q. Which ones?

A. I have a bachelor's degree in psychology from Texas A&M University, which I was also commissioned at the same time. I have a master's degree in clinical psychology from what is now the University of North Texas. I have a Ph.D. in clinical neuropsychology with my minor in experimental --

MS. WOOTEN: Your Honor?

THE COURT: Hold on.

MS. WOOTEN: I'm not sure you administered the oath.

THE COURT: Oh, my -- yes, I did. Yes, I did.

MS. WOOTEN: Did we miss it?

THE COURT: I did administer the oath to you.

THE WITNESS: Yes, ma'am.

MS. WOOTEN: I'm so sorry. We all missed it. Thank you.

MR. SELDIN: We were distracted by the white coat.

THE WITNESS: I'm also an expert in memory testing.

MS. WOOTEN: Well, that's coming at the end of today.

A. My third degree, I think -- I have to keep track here -- is a Ph.D. in clinical psychology with a minor in experimental. I forgot to mention my minor at the A&M is in languages, in German. And then I have a postdoctoral master's degree in clinical psychopharmacology.

Q. (BY MR. STONE) Doctor, what year did you obtain your Ph.D. in psychology?

A. 1978.

Q. Did you do a residency?

A. Yes.

Q. What was your residency in?

A. I was a resident at the University of Texas Medical Branch, and the residency was in primarily clinical psychology, but I went there specifically to work in the division of neurosurgery in clinical neuropsychology. I'm the first neuropsychologist trained in the state of Texas.

Q. Doctor, do you hold any board certifications?

A. Yes.

Q. What are you board certified in?

A. In clinical neuropsychology. I was the first board certified clinical neuropsychologist in Texas.

Q. Doctor, have you served in the military?

A. Yes.

Q. How long did you serve in the military and in what branch?

A. United States Army, a total of 27 years. I had both reserve and active duty service, and I retired as a regular army officer.

Q. What was your rank when you retired?

A. Major.

Q. Did you achieve any awards or commendations during your military service?

A. Yes, sir.

Q. What awards or commendations did you receive?

A. I received the Bronze Star Medal for medication research and directing the brain injury services in Iraq during the War on Terror. I was the senior brain injury consultant for the United States Army during that period of time. I also received two meritorious service awards. One was for surviving -- for my working with the assassination attempt at Fort Hood of which I'm a survivor. And the other was for my -- again, my work in -- at Fort Hood with organizing the brain injury services, the neuropsychological laboratory. I have extensive other Army awards, earning achievement for helping them achieve the Joint Commission accreditation at Fort Hood Darnall, things like that. The list is pretty extensive.

Q. I want to follow up on something you just said. What do you mean the assassination attempt at Fort Hood?

A. Well, Colonel Platoni and I were the two targets of the assassination attempt there, but fortunately we survived. I was in charge of some of the survivor organization after that and -- I mean, we were there during that assassination attempt.

Q. So you're saying the phrase assassination attempt. Who -- who tried to perform -- or who was attempting to carry out an assassination at Fort Hood? Can you just clarify?

A. Well, it was a psychiatrist who worked with me, Nidal Hasan.

Q. Okay.

A. And he was a colleague psychiatrist, and he attempted to kill some of his colleagues. He killed, of course, 13 people.

THE COURT: The Court's familiar with the circumstances.

MR. STONE: Sorry, Your Honor. I was just trying to --

THE COURT: That's okay. Just don't want you to spend your time on it.

Q. (BY MR. STONE) Doctor, what states are you -- what states are you currently licensed to practice

psychology in?

A. I've been licensed in Texas since I think 1979. I'm licensed by the Louisiana -- medical board in Louisiana, although I allowed that to lapse when I kind of retired. I'm semi-retired. And I'm currently licensed by the Louisiana Psychological Board. I'm also licensed in Missouri as a clinical neuropsychologist.

Q. What states have you previously been licensed in that you are no longer licensed in the practice of psychology?

A. When I taught at the medical school in North Carolina I was, of course, licensed in North Carolina. I was also licensed in New Hampshire. I'm licensed by the medical prescription board in New Mexico. And I was also licensed in Nevada. Again, I'm semi-retired, so I've retired some of those licenses.

Q. Have you ever held a DEA registration to prescribe controlled substances?

A. Yes.

Q. When did you hold a DEA registration?

A. During my service at Carl Darnall Medical Center at Fort Hood. So that was between 2006 and I retired there in 2014. So when I left federal service -- I was also a federal employee. When I left

federal service, I left that federal license and was planning on retiring, so I never pursued a state license.

Q. What experience do you have teaching in the field of psychology?

A. Extensive. I've taught at two different medical schools. I've taught at several universities as adjunct professors, such as University of North Texas, several schools with military psychology students, such as Central Texas College and things like that.

Q. What professional awards and recognitions have you received in the field of psychology?

A. I've -- gosh, I can't remember all. I've been -- I was the clinical neuropsychologist for Texas by the Texas Psychological Association. Probably the most important one is I was selected to be a fellow of the American Psychological Association, which is the highest award they give other than outstanding -- you're the outstanding guy in the world, I guess. But that's the highest category they have, and that was based mainly on my research on medication management and brain injury in Iraq.

Q. How long have you been practicing clinical psychology?

A. 50 years.

Q. What experience do you have with gender dysphoria?

A. I was the chief resident at the University of Texas Medical Branch on their sexual surgery team. We also had specialized studies. Of course, that was a long time ago, and so that was where some of the initial studies by John Money, who's clinic was closed, but we studied extensively John Hopkins models and John Money's work at that. And we were part of the -- I also served on the sexual surgery team at the medical branch. And then since then I've dealt with it in my private practice.

Q. What education and training do you have as it relates to the psychological development of minors?

A. Well, that was an extensive part of our training at University of North Texas, learning theory, child theory. Then at the medical branch at Galveston, my first rotation was in the division of child and adolescent psychiatry. My second rotation was in the department of pediatrics with pediatric children and with some medical and sexual disorders. My third assignment, again, was on the sexual treatment team. And then, again, I specialized in the division of neurosurgery and neuropsychology, and that overlaps quite a bit with developmental issues of children, and

we had children who had various neurological illnesses and injuries.

Q. Doctor, what -- what training and experience do you have in the field of informed consent as it relates to the practice of psychology and neuropsychology?

A. Well, like any psychologist, I'm bound to the ethics of the American Psychological Association. And I've been on many hospital committees and research panels where we've had to adhere to those principles. Probably the specialty association that I've had is the president of the psychological association who followed me as president of the Texas Psychological Association was Melba Vasquez, and Melba was -- and I was on the board. Melba was involved intricately in revamping the APA ethical principles, and so we reviewed those extensively at that time. I didn't -- I didn't do that myself. She was doing that. But yeah, those are my familiarity with those issues.

MR. STONE: At this time, Your Honor, we'd like the Court to know that Dr. Hopewell's CV is Defendants' Exhibit 6. And at this time we proffer Dr. Hopewell as an expert in the practice of neuropsychology and clinical psychology and as it relates to informed consent.

THE COURT: Any objection?

MR. GONZALEZ-PAGAN: No objection, Your Honor.

THE COURT: All right. So designated.

Q. (BY MR. STONE) Doctor, why is informed consent important?

A. Primarily probably because of the old Latin phrase *nolo nocere* damage. We -- the phrase means above all do no harm. And informed consent in terms of both the philosophical underpinnings, the American Medical Association and the American Psychological Society -- or American Psychological Association, those -- that has to be our primary ethical duty is to do no harm to a patient.

The other consideration is, if you read the ethical guidelines of the APA, for example, extensive issues on human dignity and working with the person, and so the other component of that is that the patient is informed and involved and is part of the informed or treatment process, so treating the patient with dignity and respect and helping them to be an informed consumer of healthcare as well as being well educated about problems or difficulties or potential injuries.

And there's a third component which is equally important, and that is informed decision-making,

to make a decision with information about what treatment the individual will accept or be involved in.

Q. Doctor, are you familiar with the WPATH?

A. Yes.

Q. What is the WPATH?

A. Well, it's a quasi-professional organization that is mostly an advocate for their positions. They're interested in sexual medicine or sexual issues. And they're -- it's an organization of a wide range of people who can join to, you know, participate in their issues.

Q. How is WPATH different from an organization like the International Neuropsychological Association -- or Society?

A. Society. Oh, International Neuropsychological Society, I am no longer a member because I'm not -- I haven't been traveling overseas, but that's an organization of the preeminent scientists in the world who are involved with neuropsychology. I don't think you can join if you don't have a Ph.D. I may be wrong about that. But you have to demonstrate very strict criteria to be a member.

WPATH will allow people to join if they're just associated with the mental health field. And for example, we hired a receptionist lately who we're

teaching to give -- proctor some of the tests because she's allowed to do that by law. She would be eligible to join because she's working in a mental health office. So there aren't any real requirements like there are for an organization like National Institute of Health or International Neuropsychological Society.

Q. Are you familiar with the WPATH Standard of Care Version 8?

A. I think that's related to informed consent or something. You'll have to --

Q. Sure --

A. -- be specific.

Q. Sure. Are you familiar with the WPATH Standards of Care?

A. I've read them, yes.

Q. Okay. I'm going to show you what has been already admitted. This is Plaintiffs' Exhibit 26.

MR. STONE: Your Honor, if we --

THE COURT: Oh, sorry.

THE WITNESS: This is one of our Army eye tests; correct?

THE COURT: It should be there too.

THE WITNESS: I see that.

THE COURT: Yeah, it's on them to make it bigger.

MS. DYER: I'm trying.

MR. STONE: Can you Zoom in on this right here?

Q. (BY MR. STONE) Doctor, I'm going to show you Statement 6.12.C. And -- sorry. We're going to try to highlight this to make it easier to read.

MS. DYER: I'm not going to do that.

MR. STONE: All right. I'm not going to try to highlight.

Q. (BY MR. STONE) Doctor, can you see it on the screen? I'm just going to read it so that you can follow and tell me if I'm reading this correctly.

In most settings for minors, the legal guardian is integral to the informed consent process. If a treatment is to be given, the legal guardian, often the parent/caregiver, provides the informed consent to do so. In most settings assent is a somewhat parallel process in which the minor and the provider communicate about the intervention and the provider assesses the level of understanding and intention.

Now, do you see where I -- do you see on the screen where those two sentences are?

A. Yes, I read that.

Q. Okay. Now, I want to -- and I will try to read slower. Let me go to the very bottom of the page of 63

and then going on to Page 64, and then I've got four questions I'm going to be asking. So follow along and tell me if I'm reading this correctly.

The following questions may be useful to consider in assessing a young person's emotional and cognitive readiness to assent or consent to a specific gender-affirming treatment.

Do you see where I read that?

A. Yes.

Q. Okay. I want to go through each of these in turn. The first one is: Can the young person think carefully into the future and consider the implications of a partially or fully irreversible intervention?

Do you see that?

A. Yes.

Q. Do you believe that adolescents can think carefully into the future and consider the implications of a partially or fully irreversible intervention like puberty blockers, cross-sex hormones, or gender surgery?

A. Well, when you're speaking of adolescents, we're talking, I presume, from 13 to 19, 18 -- well, 18. 13 to 18. So that's a wide range. And youngsters that age will vary widely in what they can do. The best way to answer that question is that even the most mature 18 -- 17-, 18-year-olds will have an extremely difficult

time -- and let's just look at this -- looking into the future and considering the implications of things that are irreversible. That's going to be very difficult if not impossible. Young adolescents have a very difficult time because of the nature of their brain organization.

And I remember we were here in Austin probably two or three years ago and I pointed out -- you look at the students -- I don't know which way the university is. Wherever the university is, look at those students, and probably half will change their minds about their minors -- or majors by the time they enter and leave.

So the answer to your question is that could be very difficult at best to know, and worse for the younger kids, depending on their maturity, and the reason is because of the way the brain functions in adolescents.

Q. Well, let's follow up on that. How does -- can you explain us and the Court, how does the brain function in adolescents?

A. In adolescents, the brain functions mainly through the limbic system. The limbic system is only part of the brain. The limbic system is the emotional part of the brain. Everybody in here who has kids and adolescents know what I'm talking about. And the

emotional part of the brain is wired into their development, but the prefrontal areas of the frontal cortex, the frontal lobes, have not yet developed yet. Settled science; it's uncontestable. The neurology shows that that part of the brain doesn't fully develop until people are 23, 24, 25 years old.

So the answer to your question is that at that stage of life, those youngsters are reasoning on an emotional level. They're not able to -- the executive functions of the brain are exactly what's pointed out here, being able to plan, being able to make decisions, being able to rationalize, and they're really not able to do that yet.

Q. Doctor, would it be helpful if we put up an illustrative of a human brain to talk about the different portions of it and how they function?

A. If you'd like.

Q. Doctor, what -- what are we looking at here?

A. You're looking at a cross-section of a human brain.

Q. And are you familiar with this particular image of a cross-section of the human brain?

A. Yes.

Q. How are you familiar with it?

A. I provided it to you.

Q. Where did you get it from?

A. I don't know. One of my textbooks. We have -- again, for the medical students, we have hundreds of these that we teach the medical students, mainly at this point the psychiatric residents.

Q. Why don't we talk about -- I'd like to talk about the different portions of what's shown on this image. What is the amygdala?

A. The amygdala is a nucleus of cells which processes fear and anxiety. And if you'll notice, it's close to what's labeled up here the mammillary bodies and the hippocampus. Those are memory centers of the brain. And the reason I point that out is because learning what hurts us and learning what is threatening is absolutely critical to survival of both the species as well as the individual. And so that area is tied directly into the memory centers.

So if you put your hand on a hot stove and get burned, you'll remember that. And those are -- the green areas are basically what I mentioned before, the emotional areas of the brain. Those have to develop first because otherwise the child wouldn't survive. The child wouldn't learn, you know, safety and wouldn't learn, you know, to avoid dangerous things.

Q. So how does -- how does this change over time

as a child grows and goes through adolescence?

A. The rest of the brain develops. The frontal part of the brain, which is to the left of the green curve, is what's designated by neuroanatomists, to include Vesalius. Vesalius demonstrated this as early as the 16th century. So this is not new. Everybody knows this for 400 years. It is the frontal area of the brain. It comprises about one-third of the surface of the brain, so it's massive. That's what makes us humans.

And the gray area is the prefrontal area, but those are the last areas to develop, partly just because the brain takes a long time to develop and, again, also partly because those aren't really necessary for children. Children are learning on a more basic level, so they have to learn these emotional things first, and then later they'll learn -- with the prefrontal area they'll learn calculus or they'll learn history or something like that.

Q. So you kind of covered it, but I want to specifically ask about it. What does the prefrontal cortex do?

A. It does what you -- you've taken it off the screen here. It does what you just asked me, make decisions about future events, be able to rationalize,

be able to reason, and be able to weigh consequences of things that are abstract. Jean Piaget was the Swiss child psychiatrist in the '20s and '30s who laid the foundation for child learning with his operational stages of child development. There are four stages: sensorimotor with the babies; preoperational, kids up to seven and nine; concrete operations; and then abstract operations. And with that area not being developed, youngsters in the age that we're talking about are basically concrete and preoperational. So they can figure certain things, but they can't do the abstract reasoning really. They can't form those more difficult concepts.

And an example is -- I'll give you one example. You can tell a youngster you have a headache. What do you do for headaches? Everybody in here's done it. You take an aspirin. And the aspirin will make you feel better. But what will aspirin also do? It might make your stomach bleed where you'll die because aspirin's a blood thinner. The kid can't understand that. The kid is just, oh, give me aspirin. And if my head aches more, I'll take more aspirin and more aspirin because it makes it feel better. So that's the rationalization of a youngster because they're not able to understand the more abstract or far-reaching

consequences of, well, there might be some dangerous consequences to even an innocuous thing like aspirin-taking.

Q. Okay. So I want to go back to the four -- the questions of the four elements from the WPATH. So going to the second question, does the young person have sufficient self-reflective capacity to consider the possibility that gender-related needs and priorities can develop over time and gender-related priorities at a certain point in time might change?

Do you see that on the screen?

A. I see it.

Q. Do you --

A. But frankly, I'm having a little bit of trouble following that. I don't think most adolescents can. So again, that's kind of the difficult rationalization that they're requiring people to do or they expect people to do I guess that youngsters probably have a hard time with.

Q. Do you believe that minors have sufficient self-reflective capacity to consider that their gender-related needs and priorities can develop and change over time such that they can provide consent or assent to puberty blockers, cross-sex hormones, or surgeries?

A. I don't think that's realistic.
Q. Why not?
A. They don't think like that.
Q. Why do -- why do you say they don't think like that?
A. I just explained it. And I know how children think. Again, children think concretely. And the child's going to think, well, let's just -- you're talking about adolescents. Anybody in here who's had a wonderful, marvelous pubescent adolescence, raise your hand. No. Everybody has a hard time in adolescence. And you talk to an adolescent and you say, You're having a hard time; here's something that'll fix it, and they'll think that's wonderful. They'll just, yeah, yeah, I feel bad; I'll fix that. They -- they don't reflect on consequences or all the -- they don't know all the ins and outs and all the implications. They're just not able to do that really. And we all know that.
Q. What about number 3? Has the young person to some extent thought through the implications of what they might do if their priorities around gender do change in the future?
Do you see that on the screen?
A. No. My -- my post-doc fellow told me yesterday -- his son's in college. He goes to Tarrant

County Junior College. The kid's I guess 17. And the kid was talking to him about he might want to go to medical school, but if that doesn't work out, he'll be a tattoo artist. So, you know, what -- come on. And that's if your -- if your priorities change, they don't do that kind of reasoning yet. Their reasoning is pretty limited. And they're not able to -- if priorities are going to change, it's very difficult for them. So they, you know, come up with statements like that. It's always later that you're able to rationalize much better.

Q. What about number 4? Is the young person able to understand and manage the day-to-day short- and long-term aspects of a specific medical treatment?

A. Gosh, look at the psychiatric literature, which I can't quote the number, probably hundreds of studies on noncompliance with not only adolescents but adults. We can't get adults to comply with diabetes treatment, so, again, very difficult for children to do to, you know, be fully compliant with a lot of things. You know, kids -- well, one example is attention deficit medications. It's very difficult sometimes to get the kids to stay on their medications the way they're supposed to. That's a -- that's a problem with children.

Q. Let's go to Page 258. Okay. Doctor, do you see on the screen where the WPATH has their criteria for prescribing puberty-blocking agents?

A. This is what you've highlighted in yellow?

Q. I'm going to ask about that in a moment. I'm just asking if you can see it on the screen.

A. Where it says puberty-blocking agents?

Q. Yes.

A. Yes, I see that.

Q. Okay. Under C, do you see where it says demonstrates the emotional and cognitive maturity required to provide informed consent/assent to the treatment?

A. I see that, yes.

Q. Do you believe that minors can demonstrate the emotional and cognitive maturity sufficient to provide informed consent or assent to puberty blockers?

A. Let me assure you they don't know what puberty blockers are. They could be told that that's going to stop their puberty. That's not the whole story. They don't -- no, they don't know that. And from what we know of the effects of puberty agents, these agents change the entire functioning of the brain. Everybody in this room's had that because we all went through puberty. And these are agents that normally are in like

testosterone and estrogen. That's their function. That's what they do is change the nervous system and brain. An adolescent doesn't understand that, doesn't understand what it does, no.

Q. What about under E, informed of the reproductive effects, including the potential loss of fertility and the available options to preserve fertility? Can a minor understand that sufficient to give informed consent or assent to puberty blockers?

A. Well, I don't know. I think, yeah, you can tell an adolescent you'll never have children, you'll be sterilized, and I think they probably understand that to some extent. But what does that mean? That not only means you're not going to have children; that means loss of, you know, a child in your later life. That means all sorts of emotional things. That means loss of familial things. I don't think they understand those things.

So I think they -- I think they can get the concept that I might never have kids, but when you're -- when you're talking about informed consent, again, let's look at the philosophical underpinning. It's not just, oh, this isn't going to happen. That's really being able to understand all the implications of something.

And for example, I'm just going to pick somebody at random, a female having a mastectomy because she has breast cancer. Well, you don't just tell the lady, well, you're just going to lose the breasts. The other consequences are there's pain problems. There are prosthetic problems. There are social problems. That's what informed consent is, is understanding all of those implications, not just, oh, it's going to be gone.

Q. I want to look at the criteria for hormonal treatments. Sorry about all the highlighting. I did that. Under C, do you see where it says demonstrates the emotional and cognitive maturity required to provide informed consent/assent to the treatment for hormonal treatments?

A. Well, again, no, not really. You took the slide down, but this is -- it's not my saying, but this is the consensus of the scientific community with the citation I had in that children this age are thinking through the amygdala. And the amygdala is purely emotional -- fear, anxiety, or emotional issues. So that's not -- emotional and cognitive maturity is completely the antithesis of amygdala. That's not what the amygdala is.

Q. What about the -- number E, informed of the -- and this is similar to above, being informed of the

potential loss of fertility and available options for preserving fertility before losing that opportunity. Do you believe that a minor can appreciate the consequences of that decision?

A. I think I've answered that. Again, I -- I think -- I think an adolescent can probably understand no, I won't have kids. In fact, I remember I was in high school and one of my best friends was informed that he had a medical problem, and I can't remember what it was, and he would not have children. I clearly remember the discussion. And so we understood that he would never have children, but I don't think that you understand the other implications, you know, around that.

So yeah, you might be able to understand, again, on a limited basis, yeah, I'm not going to have kids, but my whole point is there are other implications too that probably aren't understood. And we see this -- we see this with some of the people who have gone through some of these procedures that -- we're seeing more and more of those folks now who say I just didn't understand fully what would happen to me as a human being and, you know, expressing that in some of their therapy or their communications.

Q. Lastly I want to talk about surgeries. And I

apologize if some of these questions are redundant, but these are different procedures. Under C, do you see where it says demonstrates emotional and cognitive maturity required to provide informed consent/assent to the treatment?

Do you believe that minors have the emotional and cognitive maturity required to provide informed consent or assent to surgical procedures for the treatment of gender dysphoria?

A. Again -- again, not fully.

Q. Under F, it says -- do you see the criteria where it says at least 12 months of -- before beginning surgical procedures, they have to have at least 12 months of gender-affirming hormone therapy or longer unless hormone therapy is either not desired or is medically contraindicated?

Do you see that on the screen?

A. I see it, yes.

Q. Okay. So my question is: Do you think that if a minor is taking cross-sex hormones for a year that -- would that change your analysis of whether or not they are having emotional and cognitive maturity required to provide informed consent or assent to a surgical procedure?

A. Not really, no. It wouldn't change my opinion.

Q. Well, why not? If they're getting testosterone, for example, wouldn't that -- that hormonal development -- couldn't that play a role in their development and maturity if they're not on -- couldn't that play a role in development and maturity?

A. Well, number one, that's not going to do anything in terms of accelerating their executive function process, so that's irrelevant. It's not going to accelerate it. And number two, just a year is not long enough to appreciate the full effects of some of these medications. And we're now -- some of the recent research is starting to document the side effects of these medications as well as --

MR. GONZALEZ-PAGAN: Objection, Your Honor, beyond the scope.

THE COURT: So the scope was related to informed consent.

MR. STONE: Actually, we designated Dr. Hopewell as an expert specifically on the practice of neuropsychology and clinical psychology and on informed consent. So to the extent that he's testifying about neuropsychology and clinical psychology and the practice thereof, I think this would fall within that. But I don't have a whole lot of questions on that.

THE COURT: Sure.

MR. STONE: I mean, this is it.
THE COURT: Anything else?
MR. GONZALEZ-PAGAN: No, Your Honor. He's talking about the effects of medical treatment, which we would argue is beyond the scope.
THE COURT: Okay. Well, I guess let me go ahead and let you finish your answer. And that question specifically was: If they're getting testosterone, for example, wouldn't that hormonal development -- couldn't that play a role in their development and maturity if they're not on -- couldn't that play a role in development and maturity? Sorry.
MR. STONE: It's a bad question.
THE COURT: Which I think you may have answered.
A. Well, I think I answered the first part of that. The second part, as a neuropsychologist, as well as a licensed prescriber, again, that's not enough time for those medications to have their full effects. So you're going to have a longer interval time to see some of the consequences of them, and that plays a part in decision-making. We had testimony -- well, I won't even go into that. But we've had testimony similar to that from people who say I was on these medications for a long time, and it took me --

MR. GONZALEZ-PAGAN: Your Honor --

A. -- this long to understand it.

MR. GONZALEZ-PAGAN: Objection, Your Honor.

THE COURT: Hold on. Hold on. We're not doing very good question/answer, so let's ask the next question.

Q. (BY MR. STONE) Doctor, is -- do you believe that informed consent or assent is required from a medical perspective from a minor for a procedure for which there could be irreversible consequences?

A. That it's required?

Q. That -- yeah, required.

A. I think there are many instances where it's not required. One example might be a blood transfusion where the youngster may not want to or give assent, but it's lifesaving. Did I understand your question correctly?

Q. Sure. Let me rephrase it. In the context of the treatment -- medical interventions for the treatment of gender dysphoria, in your opinion is the -- just as the WPATH requirements state, do you believe that informed consent or assent from the minor is necessary before beginning one of those treatments?

A. For sex dysphoria or -- I'm --

Q. Let me ask --
A. I'm not following the question I guess.
Q. Sure. So let me ask it differently. Do you agree with the WPATH Standard of Care 8 that what we've just been reviewing, that these are all things that a clinician should be evaluating before beginning these courses of treatment in terms of getting informed consent or assent to that treatment from a minor?
A. Well, I agree that if it's possible, you should get assent for any treatment, whether it's, you know, sex related or anything else. The question I have is what their capability is to do.
MR. STONE: Your Honor, pass the witness.
THE COURT: All right. Thank you. Can we -- do we need -- okay. It's about 3:15, which is usually when I take the afternoon break, so we're going to do that and resume at 3:30.
MR. GONZALEZ-PAGAN: Thank you, Your Honor.
THE COURT: And you can step off the witness stand, Dr. Hopewell.
(Recess taken)
THE COURT: All right. Go ahead.
MR. GONZALEZ-PAGAN: Thank you, Your Honor.

CROSS-EXAMINATION

BY MR. GONZALEZ-PAGAN:

Q. Good afternoon, Dr. Hopewell.

A. Good afternoon.

Q. My name is Omar Gonzalez-Pagan.

A. I'm sorry?

Q. Omar Gonzalez-Pagan is my name.

A. Pagan?

Q. Yes, Gonzalez-Pagan. Thank you. Dr. Hopewell, have you diagnosed any patient under 18 for gender dysphoria?

A. Yes.

Q. When?

A. I think we have a couple now.

Q. And have you treated any patient under 18 for gender dysphoria?

A. Oh, yes.

Q. You do not have any peer-reviewed publications relating to gender dysphoria; is that correct?

A. Now, I'd rather -- I'd rather use the term sex dysphoria. Gender is a literary term. But no, I haven't published on that.

Q. The diagnosis in the DSM-V is of gender dysphoria; is that correct?

A. Well, they got it wrong.

THE COURT: All right. Well, we're calling it gender dysphoria, Doctor. If you don't want to use that term, that's fine, but he's going to use that term.

THE WITNESS: Yeah. I'm a scientist, so I try to use correct terms.

THE COURT: I don't need the extra commentary. Let's get to the question.

Q. (BY MR. GONZALEZ-PAGAN) So have you conducted any -- do you have any peer-reviewed publications related to gender dysphoria?

A. No.

Q. Have you conducted any original research relating to gender dysphoria?

A. No.

Q. You made reference to the capacity of children and adolescents to consent to medical care. That was your testimony; right?

A. Yes.

Q. Minor patients assent to care and their parents or guardians consent to care; is that correct?

A. That's my understanding, yes.

Q. Medical treatment is provided to minor patients for all kinds of medical conditions; is that right?

A. Yes, of course.

Q. Is it your testimony that no minor can assent to medical treatment if such treatment has long-term effects?

A. Well, I've already testified at length that when you talk about minors, it's a wide period of time. And I think that the AMA specifically answers that question by saying that the assent needs to be tailored to the child, to the developmental age, to the maturity, to the understanding of the child. So I'm not going to issue a blanket statement because the time period is too long and children are different. Maybe I'm not understanding your question.

Q. No. Thank you. That's very helpful. So you would agree then that a minor can assent to medical treatment when such treatment has long-term effects depending on their developmental stage, maturity, cognitive level?

A. Except I've already testified that minors don't have the capacity to understand fully all the long-term consequences of anything really.

Q. So given that minors cannot understand the long-term consequences of anything really, does that mean that they cannot assent to --

A. Really their assent's going to be --

Q. -- medical care --

A. Their assent's going to be --
Q. Let me finish my question.
THE COURT: Hold on. Hold on.
THE WITNESS: I'm sorry.
THE COURT: Hold on. We can't talk over each other because Ms. Crain's going to get very upset with us. So if you can finish your question.
MR. GONZALEZ-PAGAN: Thank you, Your Honor.
THE COURT: Okay.
Q. (BY MR. GONZALEZ-PAGAN) If you'd please let me finish my question before answering, I'll strive to do the same as well. Thank you.
Is it your testimony then that a minor, because they do not have the ability to comprehend long-term effects, cannot assent to medical treatment if such treatment has long-term effects?
A. I think that's basically correct. Again, you're asking me a yes or no question, which is not readily answerable with either yes or no, but certainly the assent's limited. And with what I've testified before, I -- I would basically say no because they don't have the capacity to make those decisions or to form that complete understanding.
Q. Are you aware of the body of literature

indicating that adolescents are capable of deliberative decision-making in the presence of adults and when the decision-making occurs over a protracted period of time?

A. I'm aware of some of it.

Q. You have testified in favor of bills similar to SB 14; is that correct?

A. Yes.

Q. In your testimony before the Texas Legislature, you said in reference to the provision of gender-affirming medical care that it is -- quote, "This is really a hysterical phenomenon," closed quote. Is that right?

A. It is.

Q. You were deposed in a case *In the Interest of J.A.D.Y. and J.U.D.Y.* in 2019; is that right?

A. I gave a deposition in 2019, but I think you're using terms I don't know what --

Q. Sure.

A. -- what that is.

THE COURT: I think he's just using the initials of the children. That's typically how the case style works.

A. Okay. I think I know what you're referencing.

Q. (BY MR. GONZALEZ-PAGAN) You were deposed in September of 2019 in relation to a custody matter?

A. To a what?
Q. A custody matter.
A. Yes.
Q. In that deposition when you were asked "Is it possible for a person to be born one sex and want to identify as the opposite sex at some point?" you responded "That's not possible." Is that right?
A. What was the question again?
Q. "Is it possible for a person to be born one sex and want to identify as the opposite sex at some point?" Your response was "That's not possible."
A. Well, you can --
Q. Do you recall that testimony?
A. I don't remember specifically. But yeah, you can identify with whatever you wish. I think my intent was that you can't change your sex, which is not possible, but people can identify with lots of different things.
Q. In that deposition you testified, quote, "There aren't transgender children," closed quote. And when asked "Are there transgender adults?" you said "No."
A. You can't change your sex, no.
Q. In that deposition when asked "What's the definition of a transgender individual?" you responded "Well, I don't know. It's a meaningless term." Is that

consistent with your testimony?

A. That's -- after I discussed it with Dr. Zucker, I agreed with him that that was essentially meaningless because an individual can say whatever they wish. They can identify however they wish, so it's meaningless.

Q. Are you aware that Dr. Zucker -- and you're referring to Kenneth Zucker; is that right?

A. Right.

Q. And Dr. Zucker, who is in Canada at the Center for Addiction -- used to head the Center for Addiction and Mental Health in Canada; is that right?

A. That's the one that I spoke with, yes.

Q. Yes. Are you aware that he actually provided gender-affirming medical treatment to adolescents after the onset of adolescence -- of puberty?

A. Well, he can do whatever he wishes. I assume he has done that. That doesn't change the fact of his definition of it.

MR. GONZALEZ-PAGAN: No further questions, Your Honor.

THE COURT: All right. Any further redirect?

MR. STONE: Just a couple of follow-up questions, Your Honor.

THE COURT: Okay.

REDIRECT EXAMINATION

BY MR. STONE:

Q. What did you mean when you said that the cases were hysterical? I didn't quite catch the whole quote, but something about cases being hysterical.

A. Well, all the evidence points to this recent phenomenon which the -- I think the -- part of the term now is rapid onset dysphoria as having a genuine hysterical component. Admittedly, there are youngsters who -- I'm trying to -- I'm trying to phrase this correctly -- who genuinely have sexual disorders and have had them, but we have -- this is not a unitary phenomenon. Not everybody who walks in and says I have back pain has all of a sudden back pain.

So we have different groups of children or adolescents or adults who claim different problems for different reasons. The evidence shows that a large number of youngsters are being influenced by social media, by peer pressure, things like that. And this has gone in cycles in the United States. The last big cycle which we had in Texas, which the Texas Legislature investigated, was that of multiple personality disorder, which resulted in hospitals being built essentially. So there's a hysterical component to this issue that needs to be acknowledged.

Q. Doctor, you testified earlier in response to a cross-examination question that you treat patients who are minors for gender dysphoria; right?

A. We -- we have a few. My practice is varied, mostly to neurological issues. We also treat a number of -- I say we; my staff. We treat a number of veterans and veterans' families, and so we have -- at this moment we have two or three youngsters with these kinds of issues that we're -- that we're following and following for different reasons. So it's not something that I've never seen or never done. Again, I've served on a sexual surgery team, but this was -- again, since there's this component -- you never saw these kinds of children, you know, more than 10 years ago or 15 years ago. This is -- you know, just this surge has just happened really since about 20 -- two thousand, I guess -- 25.

Q. How do you treat those patients for gender -- minors for gender dysphoria?

A. Well, they're treated properly in terms of 80 percent have emotional difficulties. The testimony earlier here alluded to that. So the primary treatment and the primary treatment that's really recommended is to address the emotional issues of the family and the youngsters and explore what's best for them and what's

going to be helpful and also to treat any comorbid emotional disorders.

70 percent -- the research has documented that 70 percent of girls claiming that they want to change sex and be a boy are -- that there's a large autistic component, for example. That's a comorbid disorder. So that's how we treat those youngsters, is by working with all those disorders.

Q. Thank you.

MR. STONE: Pass the witness, Your Honor.

THE COURT: Anything further?

MR. GONZALEZ-PAGAN: Nothing further, Your Honor.

THE COURT: All right. Dr. Hopewell, your time on the stand is done.

THE WITNESS: Thank you, ma'am.

THE COURT: You are excused.

THE WITNESS: I'm sorry for talking over people.

THE COURT: That's okay. I've just got to -- I'm the referee.

All right. For defense, who's your next witness?

MR. ELDRED: Dr. John Perrotti.

THE COURT: I'm sorry. The last name

again?

MR. ELDRED: Perrotti.

THE COURT: Perrotti. All right. Dr. John. If you'll raise your right hand for me.

(Witness sworn)

THE COURT: All right. You can make your way around up to this witness stand. Go ahead.

MR. ELDRED: Thank you.

JOHN PERROTTI, M.D.

having been first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. ELDRED:

Q. Please state and spell your name.

A. Sure. J-o-h-n, P-e-r-r-o-t-t-i.

Q. How do you pronounce that last name?

A. Perrotti.

Q. Thank you. What is your profession?

A. Plastic surgery.

Q. Go ahead and pour yourself some water.

A. That's okay. I can wait.

Q. What degrees do you hold?

A. I hold a bachelor of science and an MD, medical doctor.

Q. Where did you go to medical school?

A. New York Medical College.

Q. And what year did you graduate from medical school?

A. 1991.

Q. What year did you -- or I'm sorry. Where did you do your resident --

A. I did --

Q. -- residency?

A. I did two residences, the first in general surgery at St. Vincent's Hospital in New York City, and I did a subsequent plastic surgery residency at the Cleveland Clinic, and I finished the second residency in 1998.

Q. Do you hold any board certifications?

A. American Board of Plastic Surgery certification.

Q. Are you currently licensed to practice medicine?

A. I am, in both New York and Florida.

Q. How long have you been practicing medicine as a plastic surgeon?

A. Since -- well, subsequent to residency, since 1998. It's almost 25 years.

Q. What hospitals do you hold privileges at?

A. Currently I hold privileges at Lenox Hill Hospital and its subsidiaries in New York and

Metropolitan Hospital also in New York.

Q. Have you ever held any academic appointments?

A. Assistant clinical professor of surgery at New York Medical College.

Q. Do you still have that appointment?

A. Yes.

Q. Have you published in the area of plastic surgery?

A. I have.

Q. What kind of things have you published?

A. I've published some reconstructive surgery articles, some cosmetic or aesthetic surgery articles.

Q. Have you ever testified as an expert on the subject of plastic surgery?

A. In general, yes.

Q. How many times?

A. I don't know.

Q. More than five?

A. Probably closer to ten.

Q. Okay. Do you have education and training concerning obtaining informed consent to plastic surgery?

A. Yes.

Q. What education and training do you have?

A. Well, informed consent is something that we

learn -- we learn it before residency -- before residency while we're still in medical school by shadowing the residents, but informed consent in the surgical field is something that we learn day one in internship and basically throughout the years of surgical training, and it's something that surgeons do, you know, every time that they operate or do a procedure.

Q. And I think you may have answered this already, but do you have experience with obtaining informed consent for plastic surgery?

A. I do.

Q. And just tell us what that is.

A. What is -- what is my experience?

Q. Yes, sir.

A. Explaining the risks, benefits, and alternatives, and limitations of surgical procedures or interventions to patients, and I've been doing that for almost 30 years.

Q. Have you performed any particular research on obtaining informed consent for plastic surgery?

A. I have not -- I'm sorry. Could you repeat that?

Q. Have you performed any research concerning obtaining -- concerning -- concerning obtaining -- let

me try this again.

Have you performed any research on obtaining informed consent to plastic surgery?

A. I have not.

Q. Okay.

MR. ELDRED: And Your Honor, Dr. Perrotti's CV is Defendants' Exhibit 2. And at this time we'd like to proffer him as an expert in the practice of plastic surgery and informed consent in plastic surgery.

THE COURT: Any objection?

MR. SELDIN: Can we have voir dire very briefly, Your Honor?

THE COURT: Okay. Very briefly.

VOIR DIRE EXAMINATION

BY MR. SELDIN:

Q. Dr. Perrotti, good afternoon.

A. Good afternoon.

Q. Have you received any specialized training in the treatment of gender dysphoria in adolescents?

A. I have not.

Q. Have you conducted any research on the safety of surgical procedures to treat gender dysphoria in adolescents?

A. I have not.

Q. Have you conducted any research on the efficacy of surgical procedures to treat gender dysphoria?

A. I have not.

Q. Have you published any peer-reviewed research on surgical procedures to treat gender dysphoria?

A. I have not.

Q. Have you ever provided surgery to treat gender dysphoria in an adolescent?

A. I have not.

Q. Have you ever provided surgery -- have you ever been a part of providing informed consent for surgery to treat gender dysphoria in an adolescent?

A. I want to answer that question carefully. I -- if we're talking about gender-affirming procedures, then the answer would be no. If we're talking about treating transgender patients for issues that turn up which -- in transgender surgery, then the answer would be yes.

MR. SELDIN: Your Honor, we would ask that this -- we would proffer the -- proffer for this expert is sufficient only for informed consent as to surgery generally and not as to the outcomes of any particular gender-affirming surgery.

THE COURT: Let me ask you this, Dr. Perrotti. How much of your practice is plastic surgery on minors?

THE WITNESS: Minors in general would probably be somewhere around 10 percent.

THE COURT: All right. Because that's where I think he could talk about that, but it's -- it would be specific to that as opposed to -- so I guess I just gave my ruling, which is --

MR. SELDIN: I'm happy to argue with you, Your Honor, but I think you've ruled.

THE COURT: Just so that I'm clear on, you know, sort of -- I mean, to the extent -- I mean, he's -- I've understood his caveats about what he has not -- has and has not done. And I think with respect to informed consent, it's in the areas of -- in the area of plastic surgery in minors, okay?

MR. SELDIN: Thank you, Your Honor.

THE COURT: Thank you. Not that I expect you to agree with me, but...

MR. SELDIN: Very happy to.

THE COURT: All right, Mr. Eldred.

MR. ELDRED: Thank you.

CONTINUED DIRECT EXAMINATION

BY MR. ELDRED:

Q. What kind of surgical procedures -- what kind of plastic surgical procedures are commonly offered for the treatment of gender dysphoria?

A. There are several broad categories, one being so-called top surgery or breast or chest surgery. The second would be types of facial surgery. And the third would be so-called bottom surgery or genital surgery.

Q. What's top surgery more specifically?

A. So top surgery describes surgery used to treat the chest in gender dysphoria.

Q. What kind of surgical procedures are included in top surgery?

A. So there's two broad categories, obviously. One is for female to male and one is for male to female. Male to female is one of the more common procedures. That procedure is -- it's got several names, double mastectomy, bilateral mastectomy.

Q. That's male to female or female to male?

A. That is female to male.

Q. Okay.

MR. ELDRED: Your Honor, may we approach? Can counsel approach the bench?

(Discussion off the record)

THE COURT: Is it those three?

MS. DYER: May I approach the witness and just give it to him?

THE COURT: Yes.

Q. (BY MR. ELDRED) Doctor, we're going to talk

about some of these procedures. Do you think it would be beneficial to the Court when we talk about procedures to show pictures of what they entail?

A. Yes.

Q. And did you send me some pictures of some of these procedures -- well, send our office some pictures of some of these procedures to help demonstrate what we're talking about?

A. Yes.

Q. And would showing this picture -- let's start with a double mastectomy. Would showing pictures of a double mastectomy help the finder of fact, Her Honor, demonstrate what you're talking about?

A. Yes.

Q. So I think we're showing you some pictures of double mastectomies now that you sent us before from the National Institutes of Health website. Do you recognize those pictures?

A. Yes.

MR. ELDRED: And Your Honor, can you see them?

THE COURT: Yes.

Q. (BY MR. ELDRED) And just for the record, we have decided not to show these in the courtroom, but the judge can see them and the witness can see them.

So why don't you just tell us what we're looking at here.

A. Right. So before I tell you that, I'd just like to say that there are several different ways and procedures to do a double mastectomy or a top surgery, and this is -- this is one of them. So these photographs show preoperative images above with normal healthy breast tissue and postoperative images below of one of the post-mastectomy procedures.

Q. And when this procedure is done on a minor for the purpose of gender dysphoria, are these pictures equally demonstrative of what happens?

A. They are for one of the techniques that's used to perform a double mastectomy.

Q. Can you describe the techniques?

A. Sure. There are several techniques. This appears to show a technique where there's only a periareolar incision. That means an incision around the nipple. There's other surgeries that have more extensive incisions. That depends on the patient's anatomy, the amount of breast tissue that they have, the amount of skin that they have. It's individualized to the particular patient.

Q. And do minors who undergo this -- first of all, have you performed this procedure on minors before?

A. I have not performed mastectomies on minors, no.

Q. For any purpose?

A. For any purpose.

Q. Okay. Are these pictures of -- the after pictures comparable to what a minor who received a double mastectomy would appear?

MR. SELDIN: Objection, Your Honor. He's just testified that he has not performed this procedure.

THE COURT: So I guess for my clarification, these aren't -- these aren't necess- -- are these photos of your patients, Dr. Perrotti?

THE WITNESS: They are not.

THE COURT: Okay. But --

THE WITNESS: And -- I'm sorry.

THE COURT: No, that's okay. But they're examples that you have located of mastectomies in -- but not in minors -- or -- right? Or you don't know?

THE WITNESS: If I can clarify my answer.

THE COURT: Sure.

THE WITNESS: So I have not performed -- I forget what your question was, if it was specific to transgender surgery. I have not performed subcutaneous mastectomies or bilateral mastectomies through a periareolar approach for transgender patients, but I

have performed this procedure for other issues such as gynecomastia, and I have performed them in minors under 18.

Q. (BY MR. ELDRED) Okay. All right. I don't think we really -- why don't you just explain briefly the ways you do a double mastectomy.

A. Okay. There's -- there's two ways. There's at least two ways. One way is through a periareolar approach as in this particular patient. That is where the surgery is done with incisions around the nipple, no other incisions, as can be seen in this photograph -- in these photographs. Another more common I believe procedure is a double incision where there's an incision that's made underneath the breast as well as around the nipple. And no, I have not performed that type of mastectomy in minors.

Q. Okay. What are the potential long-term complications of double mastectomy?

A. So the short-term complications to surgery, which is bleeding, infection, wound healing problems, and those are really all types of surgery and all different techniques. The long-term complications of a double mastectomy and particularly a double mastectomy for transgender patients are long-term problems with wound healing, long-term problems with contour

deformities. Depending on how the nipple is treated, some of these procedures treat the nipple with a -- with a free nipple graft where the nipple is removed and then placed as a skin graft. Those patients can have problems with nipple -- well, they do have problems with nipple sensitivity. They can have problems with nipple projection, nipple pigmentation, and other deformities like that.

Q. Can this affect the breastfeeding function?

A. Certainly a mastectomy that removes the breast tissue and/or devitalizes the nipple renders the patient unable to breastfeed.

Q. How about the other top surgery, breast augmentation? How do you perform that?

A. So breast augmentation is obviously performed in the transgender population for male to female. And no, I have not performed trans -- I have not performed breast augmentation in transgender, but I certainly have performed many, many breast augmentations. Breast augmentation is basically through various incision locations on the chest that basically a breast implant is placed usually under the pectoralis muscle.

Q. And I think this is a dumb question, but if a male gets a breast augmentation, can that male breastfeed?

A. Of course not.
Q. Why not?
A. Because the male has no native breast tissue.
Q. Are there potential long-term complications of breast augmentation?
A. So breast augmentation complications, the short term, are the same that I previously mentioned. The long-term complications are wound healing, infection, what we call -- what's known as capsular contracture where scar tissue forms around the implant. Scar tissue always forms around an implant. Sometimes that implant becomes problematic. Breast implants are known to rupture. Breast implants are known to leak. So the complications are -- the long-term complications are almost specifically due to the implant themselves.
MR. ELDRED: And Judge, I think --
Q. (BY MR. ELDRED) Have you only -- I want to go back to the double mastectomy picture. Have you looked at just one picture? Or how many pictures have you looked at?
A. I've only seen one. Well, the set. The one set, yes.
MR. ELDRED: Can you show him the other two sets?
MR. SELDIN: If we could just have an

identification of what number in Box we're at, please.

THE COURT: Sure. I'm assuming you're wanting him to see D-15 and D -- oh.

MR. ELDRED: I believe D-13 -- one of them has two sets and one of them has one set. I apologize.

MS. DYER: This is 14.

THE COURT: You're at 14, Ms. Dyer?

MS. DYER: Yes. D-13 was the initial one. This is D-14. And I'll show him D-15 in just a moment.

THE COURT: Okay. I'm at D-14.

MR. ELDRED: Okay. I got you. I got you.

Q. (BY MR. ELDRED) Does D -- what does D-14 show, the one you're looking at now?

A. So this is the other technique of double mastectomy where there's two incisions. There's an inframammary incision, which is in the breast crease, and there are incisions around the nipple and most likely free nipple grafts where the nipples are taken off and they're replaced as skin grafts.

MR. ELDRED: And can you show him Exhibit -- it's 16?

MS. DYER: 15.

MR. ELDRED: 15. I apologize.

THE COURT: I'm there.

A. And --

Q. (BY MR. ELDRED) What is -- what are we looking at in D-15?

A. This is the same. This is the same as the previous one where it's a double incision, double mast- -- double mastectomy where there's the incision in the inframammary crease below the breast and then incision around the nipple. And you can see the nipple has been resized, reshaped, and relocated.

Q. And in all three of these sets, D-13, D-14, and D-15, are we seeing before and after pictures?

A. That's correct. The before pictures are above and the after pictures are below.

Q. All right. Thanks. I'd like to move on -- what is facial feminization surgery?

A. So facial feminization surgery is performed on male to female transgender patients basically to make the -- give the face a more feminine procedure -- I'm sorry -- appearance. These procedures -- there are several procedures. They most often involve a surgery on the forehead, surgery on the nose, surgery on the jaw, surgery on the larynx.

Q. Are there potential complications of facial feminization surgery?

A. The potential complications are the same as any surgery, bleeding, infection, wound healing problems.

There's always -- in any type of structural surgery, there's always contour deformities. Some of the complications of rhinoplasties apply where there's both structural complications as well as cosmetic complications.

Q. Let's move on to bottom surgery. What are the kinds of bottom surgery?

A. So bottom surgery entails phalloplasty for a female to male or a vaginoplasty for a male to female.

Q. All right. What's a phalloplasty exactly?

A. So a phalloplasty is basically creation of a penis and whatever other external genitalia for a trans male patient.

Q. By trans male, you mean a female to male person?

A. That's correct.

Q. I think we're looking at D-16 now.

MR. SELDIN: Your Honor, we would just note our objection on the record to the extent these are Wikipedia articles.

THE COURT: Sure. Hold on. Are you going to ask to have them admitted, Mr. Eldred?

MR. ELDRED: No, Your Honor. I just want to use the pictures -- let me set a little more of a predicate.

Q. (BY MR. ELDRED) Did you send us pictures from Wikipedia to show examples of phalloplasty and vaginoplasty?

A. Yes.

Q. Even though they're Wikipedia, are they demonstrative of those types of procedures?

A. Yes.

Q. So I'd like to show you and the judge --

MR. ELDRED: I think it's D-16. Is that what it is?

THE COURT: It's actually D --

MR. ELDRED: And really we just want to look at pictures. We don't want to read anything.

THE COURT: I guess as a demonstrative that's fine, but your objection's noted.

MR. SELDIN: Thank you, Your Honor.

Q. (BY MR. ELDRED) And can you just -- again, don't talk about the article itself. We're just looking at the pictures. And describe what the pictures show and how that demonstrates the phalloplasty procedure.

A. So the photographs basically show what a phalloplasty looks like or at least in this particular instance of this photograph. Phalloplasty is performed most usually by taking a flap, which is a collection of tissue, from a distant area. And most commonly it's

taken from the radial forearm as a radial forearm flap. And that is used to form a penis where it's attached in the location. And obviously the female genitalia are removed.

Q. Can it also include a scrotum and testicles?

A. A scrotum can also be fashioned by using skin grafts and/or scrotal implants, and phalloplasty also can contain penile implant.

Q. And this again is probably a dumb question, but if a patient receives this procedure, will that patient have a functioning penis?

A. I think the jury is still out on that. The literature is not really clear. I -- they can have a functioning penis if they go through the steps of the penile implants. And I'm assuming by functioning you mean a sexual function.

Q. Okay. I apologize for this question, but would that include -- if someone receives a phalloplasty, can they ejaculate?

A. No. And also another important part of phalloplasty is surgery and relocation of the urethra where someone -- what's used to urinate. So from any transgender surgery, the urethra needs to be lengthened or shortened and/or repositioned.

Q. Okay. And does the phalloplasty surgery have

an effect on the female anatomy, the sexual anatomy of a female?

A. I'm not sure I understand the question.

Q. If a female to male gets a phalloplasty, can the patient still perform sexual function as a female?

A. The patient can't perform sexual function as a female, no, but the patient can sometimes achieve orgasm.

Q. Okay. What are potential complications of phalloplasty?

A. So again, it's the short-term complications of wound healing infection. With a phalloplasty there's also a donor site, so there's long-term complications of donor site -- donor site scarring. Any time there's a flap that's moved to another location, there's always a chance that that flap will not survive or that flap will only partially survive. Because of what I mentioned about the urethra and the urinary flow, there's potential long-term complications of what's known as urethral strictures or scar tissue in the urethra. There's also urinary complications such as urinary tract infections.

Q. All right. Let's look at D-17.

MR. SELDIN: Your Honor, we would have the same set of objections.

THE COURT: And this is on 17?

MR. SELDIN: Just noting for the record.

THE COURT: Understood. Thank you. So noted.

Q. (BY MR. ELDRED) And I'm sorry. I want to stick with the phalloplasty for just a little bit longer. How long is -- does the phalloplasty take? Is it a one -- is it -- I'll stick with that. How long does it take to complete a phalloplasty?

A. So phalloplasty is most likely a multistage procedure and usually somewhere between two and three stages.

Q. About how long in terms of months, weeks, years does it take to complete the procedure?

A. Usually the first stage is done, then the second stage is done at about six months after that, and the third stage may not be done until a year afterwards.

Q. So what is a vaginoplasty?

A. So a vaginoplasty is so-called bottom surgery for male to female. And a vaginoplasty is where the penile tissue and the scrotal tissue is used to create a vagina, also known as a neovagina.

Q. What's the difference between a vagina and a neovagina?

A. I guess a neovagina is one that's constructed

or reconstructed for that matter.

Q. And does D-17 -- again, this is a Wikipedia article. I don't want you to talk about the words or anything, but there are some photographs in D-17. Are those -- would those photographs help the judge understand what this procedure is?

A. Yes. These photographs just show basically the external appearance of a neovagina. They don't -- they don't show obviously the inside of the vagina or anything else like that.

Q. So this is an after picture?

A. That's correct.

Q. And I'm going to ask I think a dumb question again, but if a patient gets a vaginoplasty, can that patient get pregnant?

A. No.

Q. Why not?

A. Because the patient doesn't have a uterus.

Q. Does the patient have ovaries?

A. The patient does not have ovaries.

Q. How do you perform a vaginoplasty?

A. So the most common technique is what's called a penile inversion technique where the actual skin of the penis is removed and fashioned into a tube-like structure that is then inserted between the ureter and

the rectum to form a vagina. This is often supplemented with skin in the form of a skin graft taken from somewhere else.

Q. And are there potential complications in a vaginoplasty?

A. So the complications are -- for bottom surgery in general, the complications are more significant. There's the short-term complications, but for procedures like this, there's much more serious long-term complications. For vaginoplasty in particular, there's problems with loss of depth, loss of girth. There's problems with skin slough from the skin that's used to create the inside of the vagina. There's problems with a total loss of the vagina. There's what's called fistulas, which are connections between the vagina and the ureter and/or the rectum.

Q. And what's that?

A. That would be an abnormal connection between the tissue of the vagina and the tissue of the ureter, which is used for urination, or the rectum, which is used for defecation.

Q. And when you said I think the loss of depth and girth, can you explain that a little bit more?

A. Sure. This is -- this is other tissue that's used to create a vagina. So with time, that tissue will

contract, particularly a skin graft, and that tissue will lose its depth and will lose its girth. And that's why after a vaginoplasty the patients need to use a dilator to dilate the neovagina to keep it open, so to speak.

Q. I think that's it for the pictures. So let's move on to a new topic, informed consent. What is informed consent in the context of plastic surgery?

A. So informed consent is explaining the risks, benefits, alternatives, and also the limitations of a particular surgical procedure or intervention.

Q. And why is it important?

A. It's important that the patient understands the risks, what can go wrong, they understand what the benefits are, what can be achieved, and that they understand the limitations of what cannot be achieved and also what the alternatives to those treatments are.

Q. And in general, how do you obtain an informed consent to plastic surgery?

A. You would -- I obtain informed consent by explaining the pertinent risks, alternatives, and benefits, and limitations of a particular treatment.

Q. How do you obtain consent from a minor for plastic surgery?

A. So there's been a lot of testimony today about

consent. The minor -- the minor has to agree to the procedure, but legally it's the parents or the guardian that give the actual permission for the procedure.

Q. Okay. Are you familiar with WPATH?

A. Yes.

Q. Have you reviewed their guidelines for informed consent?

A. Yes.

Q. How long ago did you review them?

A. This week.

Q. Okay.

MR. ELDRED: I'd like to show what's already been admitted, the WPATH guidelines that we've been talking about a few times today.

THE COURT: P-26.

MR. ELDRED: Yes. Thank you. And if you can go to Page 63, please. Can you Zoom in on those four bullet points?

Q. (BY MR. ELDRED) And do you recognize what we're -- I'm sorry. Do you recognize what we just put up on the screen there?

A. Yes.

Q. What is that?

A. It's from the WPATH guidelines for gender-affirming treatment. And I don't know if this

section is particularly for surgery or treatments in general.

Q. And I don't want to beat a dead horse, but let's look at the first bullet point. It says: Can a young person think carefully into the future and consider the implications of a partially or fully irreversible intervention?

Do you think a minor can give informed consent based on that definition of informed consent?

A. No.

Q. Why not?

A. Because a minor doesn't have the emotional and cognitive ability to understand that these procedures -- and I didn't mention this before -- that these procedures are irreversible.

Q. How so?

A. How --

Q. How so are they irreversible?

A. They're irreversible.

Q. Yes. How are they irreversible?

A. They're -- they're -- they're not reversible. Once the breasts -- I'm sorry.

Q. That's too --

A. Once the breast -- once the breast tissue is removed with a mastectomy of any type, that breast

tissue doesn't come back. That's -- that's irreversible. Once the genitalia is changed, that cannot -- that cannot be changed back.

I would say that a breast augmentation is partially reversible because if it's a matter of just putting implants in, those implants can be removed, but then there's other issues with skin and scars and things like that that may not be reversible.

Q. All right. Thank you. The next bullet point reads: Does the young person have sufficient self-reflective capacity to consider the possibility that gender-related needs and priorities can develop over time and that gender-related priorities at a certain point in time might change?

Do you agree that's a good definition of informed consent for plastic surgery?

A. I -- I think it's a good definition for the gender-related part of plastic surgery, yes.

Q. Do you have any opinion about whether a gender-related -- I'm sorry -- about gender-related needs and priorities can change over time related to plastic surgery?

A. You see, I -- I don't want to testify out of my area of expertise. I'd like to stick to the surgery. So as far as the surgery goes, that's a -- that's a good

definition related to the surgery.

Q. All right. Well, we'll skip gender stuff. Let's go to number 4. Is the young person able to understand and manage the day-to-day short- and long-term aspects of a specific medical treatment? Is that a good definition of informed consent with respect to plastic surgery?

A. Yes.

Q. Can a young person -- can a young person give informed consent to plastic surgery?

A. No.

Q. Why not?

A. Particularly in this item in number 4 because they are unable to understand all the short- and long-term aspects of these treatments and particularly the more complicated procedures.

Q. All right. And can we go to Page 259 of this exhibit? And do you see the heading Surgery followed by A through F?

A. Yes.

Q. Are you familiar with this part of the WPATH guidance?

A. Yes.

Q. And I'm going to go to number C: Can a minor demonstrate the emotional and cognitive maturity

required to provide informed consent/assent for the treatment?

A. So that's an important aspect of informed consent, but I believe that minors cannot provide informed consent for these treatments.

Q. And I'm reading part C under surgery. These are kind of things that according to WPATH are kind of definitions of informed consent. Would you agree?

A. Yes.

Q. Okay. Can minors -- I'm looking at number E now. Can minors give informed consent to reproductive effects including potential loss of fertility and available options to preserve fertility?

A. So I don't believe that minors can give confirmed -- informed consent to issues of fertility, but certainly that's a vital aspect of the needed informed consent.

MR. ELDRED: I'll pass the witness.

THE COURT: Thank you, Mr. Eldred.

MR. ELDRED: Wait. I'm sorry, Judge. Wait.

THE COURT: Oh, no worries.

MR. ELDRED: I'm so sorry, Judge.

THE COURT: That's okay.

Q. (BY MR. ELDRED) Do plastic surgeons perform

breast augmentation surgeries on minors?

A. In general, no. In fact, the American Society of Plastic Surgeons recommends that we don't do a breast augmentation on patients under 18. And I believe that FDA breast implants are also -- I'm sorry -- not FDA breast implants, but breast augmentation is not approved by the FDA for under 18 years old --

Q. Do you know --

A. -- for saline implants, and I believe it's 20 or even 22 for silicone implants.

Q. And do you know why it's not?

A. It's for all the same reasons that we discussed, that minors don't have the emotional and cognitive abilities to understand all the aspects of breast augmentation surgery.

Q. All right.

MR. ELDRED: All right. Now I pass the witness, Judge.

THE COURT: All right. Thank you. Cross-examination?

CROSS-EXAMINATION

BY MR. SELDIN:

Q. Dr. Perrotti, you testified earlier that you have performed periolar -- perioareolar mastectomies on minors under 18 for treatment of gynecomastia; is that

correct?

THE REPORTER: Can you speak up?

MR. SELDIN: I'm sorry. I apologize.

Q. (BY MR. SELDIN) You have performed -- are you familiar with the term keyhole surgery?

A. Yes.

Q. Is that another term for perioareolar?

A. Yes.

Q. So -- have you performed keyhole -- you testified that you performed keyhole surgery on minors under 18 to treat gynecomastia; correct?

A. Yes.

Q. And about how many times have you performed that surgery?

A. I can't give you a number. I've been doing that procedure since I was a resident in 1997 and '98, so I don't know.

Q. In --

A. If I do several a year, if I do five or ten a year and I've been doing them for 25 years, then I've done hundreds.

Q. In persons under 18 or total?

A. Total.

Q. And about how many of those have been for minors under 18 years old?

A. I don't know. I will say that the ones that are under 18 are in that kind of 17- to 18-year age because we most often wait till the development of the gynecomastia is complete.

Q. But you have performed keyhole surgery on minors age 17 or younger in your career; correct?

A. Yes.

Q. Okay. Did you obtain informed consent from the parents in each of those cases?

A. If the minor -- if the minor was unable to give their own consent, then it was the parent or the guardian that gave consent, correct.

Q. So in each of those cases did you also obtain informed assent from the minor?

A. If the minor didn't want the surgery, I wouldn't do the surgery.

Q. So then the answer is yes, you obtained informed consent and assent in each case?

A. Yes.

Q. And is keyhole surgery -- keyhole surgery in minors is irreversible; correct?

A. It depends on what the surgery is for. If keyhole surgery is done for a mastectomy, let's say, for a transgender patient, that is essentially irreversible. If a surgery is done for gynecomastia, depending on the

reason or why that patient developed gynecomastia -- and remember, gynecomastia is a different -- it's kind of a different operation. It's a different pathology. Gynecomastia always contains breast tissue and fatty tissue. So it's -- it's irreversible, but it's certainly -- I don't know how to explain this. It certainly can recur, let's say. So if they're forming breast tissue for some reason, that can recur. And if they're forming fatty tissue, that can recur.

Q. So is it your testimony then that when you perform keyhole surgery in minors under 18 who are cisgender and not transgender, there's a possibility that you may have to do a second corrective surgery if gynecomastia occurs?

A. That's always a possibility, yes.

Q. Dr. Perrotti, have you ever performed facial feminization surgery on a transgender adolescent?

A. I have not.

Q. Okay. Have you performed facial feminization surgery on a transgender adult?

A. I have not.

Q. And have you ever performed what you refer to as bottom surgery on any individual?

A. I have not.

MR. SELDIN: Your Honor, if I could have a

moment.

Q. (BY MR. SELDIN) Dr. Perrotti, to your knowledge, phalloplasty and other forms of bottom surgery are extremely rare -- very rarely performed in minors; is that correct?

A. I would agree with that.

Q. And the same true for facial feminization surgery?

A. I don't know the specific answer to that. I would say that it's less uncommon or more common than genital surgery in minors.

Q. It's generally outside of your knowledge?

A. No, it's not outside of my knowledge. I can't give you an exact number.

MR. SELDIN: Thank you, Your Honor. Nothing further.

THE COURT: Thank you. Any other redirect?

MR. ELDRED: One question.

REDIRECT EXAMINATION

BY MR. ELDRED:

Q. Have you ever treated an adult for complications from prior gender-affirming surgery?

A. Yes.

MR. SELDIN: Objection, Your Honor. It's

outside the scope -- I apologize. Now that my mic is on, objection, Your Honor. That's outside the scope of cross.

MR. ELDRED: I believe he just asked about his experience doing these surgeries.

MR. SELDIN: In minors with gender dysphoria.

THE COURT: Right. Let me read your question again.

MR. ELDRED: I believe that's my only question, Judge.

THE COURT: Okay. So what is your question?

MR. ELDRED: Have you ever treated an adult for complications from prior gender-affirming surgery? I guess I could say from -- performed on a minor. Does that help?

MR. SELDIN: Your Honor --

THE COURT: Right. I think that's what would take it back into his scope.

A. I have treated complications of surgery in adults, but I can't say specifically whether the surgery was done when they were minors or not.

Q. (BY MR. ELDRED) All right. Thank you, Judge -- thank you, Your -- thank you, Doctor.

THE COURT: Any other further recross?
MR. SELDIN: Your Honor, no, thank you.
THE COURT: Okay. All right.
Dr. Perrotti, you're done on the witness stand. You're excused.
THE WITNESS: Thank you.
THE COURT: Take care. All right. Any additional witness for the State?
MR. GONZALEZ-PAGAN: Your Honor, if I may, can we address a little bit of a cleanup matter before moving on to fact witnesses to the extent that there are any?
THE COURT: Sure.
MR. GONZALEZ-PAGAN: Specifically --
MR. STONE: And, Your Honor, we've got two -- two very brief fact witnesses. We're going to try to go as fast as we can to get through them.
THE COURT: Okay.
MR. GONZALEZ-PAGAN: Your Honor, under Rule 902 as official publications, plaintiffs will be moving for P-57 and P-58 to be admitted into evidence, both publications by the Food and Drug Administration related to off-label use, which has come up a number of times during the testimony. And under Rule 90 -- 902.5, their official publications are self-authenticating.

MR. STONE: Which number are they again?
THE COURT: 57 and --
MR. GONZALEZ-PAGAN: 57 and 58.
MR. STONE: Oh, sorry. Okay. Your Honor, may I respond briefly?
THE COURT: Sure.
MR. STONE: For 57, this is a notice of request for comment. So our first objection to this is on relevance. This is just a call for public comment. It has no relevance to this particular case. It's -- oh, right. So what they're -- they're also conflating two different things. They're conflating, I believe, Your Honor, authentication on how you authenticate a document as opposed to its admissibility. And in this case, like -- I'm not disputing the authenticity of this document, but that doesn't -- just because it's authenticated doesn't make it admissible.
And again, in this case, at least with respect to 57, it's just a request for comment. There appears to be some highlighting in it in here, so it looks like they're trying to highlight something from a request for comment related to a separate FDA drug bulletin. So it looks like they're trying to get something in that's buried within this document without citing specifically to the original document. But in

any respect, Your Honor, we don't believe this is relevant, and we don't believe that it passes the hearsay exception, is subject to any kind of hearsay exception.

THE COURT: So that's 57; right?

MR. STONE: 57, Your Honor.

THE COURT: A response on 57, Mr. Gonzalez-Pagan?

MR. GONZALEZ-PAGAN: Yes, Your Honor. As public records -- this is published by the FDA. It says for the activities of the FDA. It passes -- there's a -- it is an exception to hearsay under 803.8. What is more, just because it's a notice for comment from the FDA, it still lays out the FDA's official position when it comes to off-label use. Your Honor can give it the weight that the Court wants, but it is -- it is an official governmental publication that the Court may admit into evidence.

MR. STONE: No, Your Honor, that is absolutely wrong. Under 803.8 it sets out the specific criteria for what qualifies as a public record, and there are elements of it. Number one, it has to -- the statement or record from the public office must, one, set out the office's activities; number two, a matter observed while under a legal duty to report, but not

including, in a criminal case, a matter observed by law enforcement personnel; or in a civil case or against the government in a criminal case, factual findings from a legally authorized investigation. That is not what -- that is not what this document is. It is absolutely not subject to 803.8, the public records exception.

THE COURT: Okay.

MR. GONZALEZ-PAGAN: Just --

THE COURT: Hold on. The objection to 57 is sustained. What about 56?

MR. STONE: 58.

THE COURT: I mean 56. Wasn't it 56?

MR. GONZALEZ-PAGAN: 57 and 58. Your Honor, I --

THE COURT: Oh, I'm sorry. I'm looking at the wrong one.

MR. GONZALEZ-PAGAN: I -- I apologize. 57 and 58.

THE COURT: Okay.

MR. GONZALEZ-PAGAN: With regards to 57, again, it sets out --

THE COURT: I've ruled, Mr. Gonzalez-Pagan. We're done on that one.

MR. GONZALEZ-PAGAN: Understood.

THE COURT: 58.

MR. GONZALEZ-PAGAN: 58 is an official guidance by the FDA administration. It again passes muster under the public records hearsay exception. It sets -- it's a record or a statement of a public office that sets out the office's activities. It is a disjunctive test. It is an "or," not an "and." And therefore, any publication by an agency or public office that sets out the office activities are acceptable like rule-making or the office activities with regards to guidance as to off-label use is a hearsay exception.

THE COURT: Mr. Stone?

MR. STONE: Yeah, absolutely. Your Honor, this is not the record or statement of a public office setting out the office's activities. I think that that's pretty obvious. This isn't -- this isn't a record or statement setting out the office's activities. So this isn't describing what the FDA does, all right? This is -- instead, this is an information sheet that appears to be --

THE COURT: Guidance.

MR. STONE: -- guidance issued for IRBs and from 1998.

THE COURT: All right. So on P-58, the objection is overruled. So P-58 is in. P-57 is not.

MR. GONZALEZ-PAGAN: Thank you,

Your Honor. In that case, plaintiffs would move that the Court take judicial notice of P-57 as an official governmental publication pertaining to regulations.

MR. STONE: It's a request for comment.

THE COURT: I -- hold on. I'm not going to take judicial notice of 57.

MR. GONZALEZ-PAGAN: Understood. Thank you, Your Honor.

THE COURT: Okay. So fact witnesses.

MR. STONE: Your Honor, are we going to have a hard stop at 5:00? Because it determines whether or not we can -- if we hard stop at 5:00, I think we can only call one of our remaining fact witnesses then.

THE COURT: Well, let -- tell me a little bit about how long you think you have with either of these fact witnesses.

MS. DYER: Your Honor, I only expect about ten minutes, but I'm unsure if plaintiffs intend to use any of their time on cross.

THE COURT: I think we can go ahead and do it. I mean, I have permission from Ms. Crain and Ms. Gould to stay a little after 5:00.

MS. DYER: I will do my best to be efficient.

THE COURT: But, you know, I didn't ask,

but I apologize to the deputies, because that means they have to stay after 5:00 too. So let's get going with that then.

MS. DYER: Okay. Then the first fact witness will be Emelie Schmidt.

THE COURT: All right. Ms. Schmidt, if you can step forward, or is she --

MS. DYER: She is in the room in the back based on the rule.

THE COURT: Got it. Hello, Ms. Schmidt, if you'll step forward, please, I'll swear you in and then you can take the stand. If you'll raise your right hand for me.

(Witness sworn)

THE COURT: You can step around there and up to this chair here. Go ahead.

EMELIE SCHMIDT,

having been first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MS. DYER:

Q. Good afternoon, Emelie. How's it going? First I will have you state your name for the record and spell it, please.

A. Okay. Emelie Anne Schmidt, E-m-e-l-i-e, A-n-n-e, S-c-h-m-i-d-t.

Q. And do you live in Texas, Emelie?
A. Yes, ma'am.
Q. Which county?
A. Harris.
Q. And do you live with anyone else or is it just by yourself?
A. I live with my husband, and then I have a renter on my first floor.
Q. Okay. And how long have you lived in Texas?
A. My whole life, so 24 years.
Q. I was about to ask how old you were, so perfect. And what is your biological sex?
A. Female.
Q. And sitting here today, do you consider yourself female or male?
A. Female.
Q. And describe to me your first experience with the transgender world.
A. I was around 14 years old. And I was always a tomboy growing up and I saw something on TLC. It was about trans youth, and it said if you're a tomboy you might actually be a boy. So I started looking on the TLC Facebook page and I commented on a few things, and that's where a few grown men who identified as women contacted me privately and invited me into their

Facebook groups.

Q. And how did those groups transform you over the next few years?

A. I posted that I was questioning and they affirmed my gender at the time -- I guess my delusion. They affirmed that I was male even though I'm not male. And they just flooded me with a bunch of love and support telling me that I'm handsome. And they told me that my parents were evil because they wouldn't let me start hormones or surgery. My parents are amazing, by the way. They're not evil. But they made me truly hate my parents even though they were wonderful. They also sent me messages describing how to make HRT at home.

Q. Can you explain to me what --

THE REPORTER: Say it again. What at home?

A. They taught me how to make hormone replacement therapy at home, testosterone.

Q. (BY MS. DYER) And did you end up telling your family -- you mentioned that, you know, they kind of made you hate your parents. Did you tell your parents that you were feeling this way?

A. I didn't feel comfortable telling them, but they eventually found out through someone at my school.

Q. And did you tell people at your school?

A. I did. They found out through a kid's mom at the school. My school never told my parents.

Q. But you did tell your school. Did you tell your teachers to call you by your preferred pronouns, name, et cetera?

A. Yes, ma'am.

Q. And they did that?

A. Yes. And they never notified my parents about any of this, but they called me Jacob and he/him in the classroom.

Q. And did you ever receive any -- I know you mentioned a minute ago that you were angry at your parents for not, but did you ever actually receive any medication or surgeries?

A. I did not.

Q. And why was that?

A. At the time my parents didn't have insurance, and my -- my mom said even if we had insurance she wouldn't have let me because she felt deep down that -- she knew I was a girl because I was a girl, you know. She said she would have supported me if she felt like this is who I really was, but she knew that I wasn't.

Q. And when did you start questioning your transgender status?

A. Around the time -- right after my 18th

birthday.

Q. And was there something that happened around that time that made you start questioning that or was it just like an ah-ha moment?

A. I started realizing that I didn't have any friends in real life. All my friends were online, and most of them were grown men online. And they were just encouraging me to hate myself and hate my body. They kept telling me my body was wrong and it needed fixing with hormones and surgeries. And I just realized none of my friends were in real life; I need to stop being online all the time. And what really opened my eyes was my mom took me on a trip to the beach, and she just started telling me, hey, it's okay to be a girl and like masculine things. It's okay to be a tomboy. And that's when I really understood I could just be a tomboy. I don't have to hate my body. I don't have to hate myself.

Q. And now looking back on that chapter of your life, how do you feel sitting here today?

A. I'm confident in my womanhood. I'm proud to be a woman. And I regret that I spent so long hating my femininity.

Q. And are you glad that you never received any hormone replacement, puberty hormone blockers, or

surgeries?

A. I am eternally grateful that I never received any of that treatment. I don't think I would be as successful as I am today if I got those treatments. I think if I got those treatments I would still be depressed and anxious. I was never more depressed and anxious as I was when I was surrounded by adults telling me to hate my body in the trans community. They -- yeah.

Q. And that was going to be my last question actually, was in terms of your mental health throughout this process, you know, can you walk me through how you were before you got involved in the community mental health-wise, how you were during, and then after as well?

A. I didn't have the best mental health just before I was trans. I had a lot of anxiety and depression just from my body growing up because I was uncomfortable during puberty. But the trans community latched onto these insecurities and they latched onto my depression and anxiety and made it worse. I was the most depressed, the most suicidal when I was in the trans community. Once I got out of that community, I was finally able to not be depressed and not be suicidal. I was finally able to work on myself and love

myself for who I am.

MS. DYER: I have nothing further, Your Honor.

THE COURT: Cross?

MS. LESKIN: Very briefly, Your Honor.

CROSS-EXAMINATION

BY MS. LESKIN:

Q. Hi, Ms. Schmidt. I just have a couple of questions for you. No doctor ever diagnosed you with general dysphoria; correct?

A. No, ma'am. It was all online and my school hiding it from my parents.

Q. Right. But you've never been diagnosed with gender dysphoria?

A. No, ma'am.

Q. And you never sought medical care for gender dysphoria?

A. No, ma'am.

Q. And your parents did not decide one way or the other to help you seek medical care for gender dysphoria?

A. No, ma'am. And I'm glad they didn't.

Q. Okay. Thank you.

THE COURT: Anything further, Ms. Dyer?

MS. DYER: Nothing further.

THE COURT: Ms. Schmidt, you're done on the witness stand. Thank you very much.

THE WITNESS: Thank you.

THE COURT: Next witness?

MS. DYER: Yes. The last witness the State will call is Soren Aldaco.

THE COURT: Aldaco?

MS. DYER: Uh-huh.

THE COURT: Okay. I just want to say it right. All right. Are they out there?

MS. DYER: Yes.

THE COURT: Okay. I just wanted to make sure.

All right. If you'll step forward, I'll swear you in.

THE WITNESS: Where should I step?

THE COURT: Here.

THE WITNESS: Okay.

THE COURT: If you'll raise your right hand.

(Witness sworn)

THE COURT: All right. You can make your way around there and up to this chair, please.

Go ahead.

SOREN ALDACO,

having been first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MS. DYER:

Q. Good afternoon, Soren. First things first. We're going to have you state your name and spell it for the record.

A. I'm Soren Aldaco, S-o-r-e-n, A-l-d-a-c-o.

Q. And you live in Texas -- or do you live in Texas? I'm sorry.

A. I do.

Q. Okay. What county do you live in?

A. I live in Tarrant. Or I -- well, I grew up in Tarrant. I live in Travis County.

Q. Okay. And have you lived in Texas your whole life?

A. Yeah.

Q. And how old are you?

A. I am 21 years old.

Q. Are you in school right now?

A. I am in school.

Q. What are you studying?

A. I study humanities, which is an honors program where we make our own major.

Q. And is this -- is it through a university?

A. Yeah, it's through UT. And I more specifically am interested in how we define normal and come to develop identities.

Q. Okay. And what is your biological sex?

A. Female.

Q. And today do you consider yourself to be male or female sitting here?

A. Female.

Q. Okay. And I'd like you to describe your first kind of introduction, experience, however you want to phrase it, with the transgender community and world.

A. Well, I always felt different from my peers, but I was first introduced to trans identity through the Internet via some friends who identified that way.

Q. Okay. And had you ever had -- had you been diagnosed with any other mental health conditions or anything else before you had been introduced to the trans community?

A. I was diagnosed with ADHD at age six, and then I acquired diagnoses after the trans identification.

Q. And around what age did the trans identification come?

A. Well, I sort of played with the idea of gender starting at 11, but I didn't really, like, solidly identify as transgender until after age 15 when a

psychiatrist started to medically -- or medicalize those thoughts.

Q. So tell me about that experience with the psychiatrist.

A. Well, I was -- I went to the hospital for a psychiatric episode at age 15. And when I was in there, they put my chosen name on the door but had my legal name on the records. And while speaking to the psychiatrist, he asked me about that incongruence between the name on my door and my records. And I told him that was just the name I went by, and he pushed for further explanation and I told him that was just the name I went by. And he pushed for further explanation and offered the idea that people didn't identify with their biological sex, told me that was like normal and I was safe to admit to him. And I told him -- asked him whether or not our conversation was confidential and essentially felt pressured to tell him that I was trans as he, you know, recommended.

Q. Had you ever called yourself trans before that time?

A. I had called myself a trans boy, but I also, like, was calling myself a girl in online video games at that time and was okay with people addressing me and viewing me as female.

Q. And is that when you -- when did you get your -- like, a gender dysphoria diagnosis if you got one?

A. I don't know if he diagnosed me with that at the time because I haven't seen my records, but I got my first gender dysphoria diagnosis while seeing a therapist, and it was only I believe after she had written me a letter for my mastectomy.

Q. Okay. So let's go back a little bit to when you were at the hospital for your psychiatric episode. What was kind of the timeline between that and when -- and these recommendations later down the line?

A. So that was at age 15 shortly before my 16th birthday. I began seeing a therapist for, like, developmental problems. I was diagnosed with autism, major depressive disorder, social rejection and exclusion, and general anxiety, and OCD is a subset of autism, that March I believe. And then at age 17 after attending a transgender youth support group for a couple of years, I was prescribed testosterone by a psychiatrist in that support group who prescribed hormones for many children and adults in that support group. And then age 18 I was written a letter by the therapist. And age 19, about a month after my 19th birthday, I had a mastectomy. And then less than six

months later I medically and ideologically detransitioned.

Q. Okay. And I want to go back to when you were prescribed the hormones. How did the hormones make you feel?

A. Well, I felt good right after I took them, like especially because they were like a steroid and made my body sort of feel like very engaged, almost like a high of sorts. But over time I started having a lot of joint pain. I would feel very hot on the hormones, like a lot of menopausal-like symptoms. I felt like a lot of brain fogs. The hormones would wane, and my natural hormone cycle would attempt to, you know, come back. And eventually, like, I just -- it felt, like, gross. Like, I mean, I was happy that I was being affirmed, but I think it was just that. Like, I was happy I was being affirmed, but the actual mode of affirmation was, like, very detrimental to my health overall. Like, I was on 11 different medications to manage the symptoms of those hormones, and I was also just like tired all the time and not engaging in any of my interests. I quit playing softball. I stopped playing cello. Like, I was just sort of obsessed with this identity even though my body was, like, falling apart.

Q. And tell me a little bit more about when you

had the double mastectomy.

A. So I had the mastectomy in June of 2021. And shortly after, like within three or four days, I noticed significant bruising underneath my bandages. And I called to talk to the emergency physician line, sent them photos, and they just sort of said, oh, bruising is normal, it can happen, which I sort of knew. I mean, it's a surgery; right? But it felt very wrong in my body.

At the post-op appointment when the nurse took off my sutures and my holsters that were holding my nipple grafts on, she said I've never seen bruising like that before but didn't go and get a physician. I continued to let them know that the bruising was getting worse. I sent them photos of bruising on my flanks that I had researched and found out was called Grey Turner's sign. And I kept telling them something was wrong.

And it culminated on June 23rd I believe when I called up to the same emergency physician line and got the same doctor I spoke to before. I sent him photos, and he told me I don't know what's wrong here, but at the time my nipple grafts were peeling off. I looked like I had breasts again. And I went to UT Southwestern where they cut my incisions back open under my arms and inserted drains. They had to put like a

Q-tip in and aggressively knock out blood clots. And the top surgeon or the, you know, plastic surgeon who did these mastectomies at the hospital actually refused to see me because he didn't want to manage those complications, so I was seen by the breast oncology team.

Q. Okay. And you mentioned that six months later you started to detransition. Did I hear that correctly?

A. Yeah, I stopped the hormones first because they made my body feel awful, but then shortly after I realized that after stopping the hormones I had no other choice but to be fine. Like, I had to keep going. And I realized, like, that actually wasn't bad for me. Like, I learned to be resilient throughout my life by becoming resilient to that. And then I realized that I had been sold, like, the lie that that was the only way forward when in fact it was not the only way forward, and it caused me a lot of other problems on top of the ones that I was already experiencing.

Q. And what kind of things do you still -- what kind of side effects do you still have today from those treatments?

A. Well, from those treatments I specifically have a lot of chest pain. Like, I was supposed to give a speech to my university welcoming the new faculty

yesterday, and I, like, had to take some time before I went up on stage because I was getting, like, random, like, zaps along my scar line and up through the tissue where they had to, you know, use the Q-tips and such.

I still experience, like, vaginal dysfunction, like in terms of, like, emptying my bladder, in terms of, like, engaging in sex. It's really painful. And I'm just generally disinterested. I have bumps on my clitoris.

And I also just, like, generally have some endocrinological issues. I was diagnosed with hypothyroidism after starting the testosterone. I also struggle with what I suspect could be like hypoglycemia, like, related to my hormone -- regulation of my other hormones. And then I also was diagnosed with idiopathic hypersomnia afterwards on top of chronic fatigue. So I'm just like tired all the time as if, like, you know, my hormones are still struggling to, like, you know, keep me going. That's what they do.

Q. In terms of your mental health, how do you feel today?

A. I feel relatively good. Like, I have emotions, which I didn't really experience on testosterone. Like, I was just very blocked off and disconnected with my body, which I suspect was part of the issue all along.

But now, like when I have negative emotions, I see them as part of my beautiful colorful human existence. Like, I have learned to be resilient and fortified, which is what I really honestly needed all along to realize that as I felt distressed, that it was just temporary, that it was momentary, that I also experienced a lot of joy in other ways. And that's kind of what I focus on now is the joy.

I used to look at my body in terms of, like, you know, thinking that I might be too fat or -- this morning I was a little bit upset at, like, how my jeans fit because they fit better when I was on testosterone; right? But that is part of the underlying issue that I'm getting at, that it was just the way that women -- in my case, you know, we are taught to hate ourselves from a really young age. I mean, I was exposed to pornography way too young, and I feel like that was part of what contributed to this idea that I needed to be thin. And that's what testosterone did to me, was it gave me control over my body.

Q. And looking back, how effective would you say were the hormone therapies at getting you to the place you -- the peace you have today? Do you think you could have gotten it if you had stayed on them?

A. No, because I just had a slew of other

problems. Like, I have way more peace just letting my body be what it is and figuring out the mental side of it now today than I ever did on testosterone.

Q. Do you wish you had never had taken hormones or had the surgery?

A. Yeah, I really do.

MS. DYER: Nothing further, Your Honor.

THE COURT: All right. Cross-examination?

CROSS-EXAMINATION

BY MS. LESKIN:

Q. Good afternoon, Ms. Aldaco. On July 21st of this year, you filed a lawsuit; correct?

A. I do think it was July 21st. I can't give you the exact date, but yes.

Q. Okay. And in that lawsuit, you named the doctor that you described, the mental health provider you saw while you were hospitalized; correct?

A. Yes.

Q. And you're suing that doctor for breaching the standard of care by, among other things, improperly assessing, diagnosing, and/or counseling you regarding your gender identity; right?

A. Yes.

Q. And that doctor did not prescribe any medication to you; correct?

A. Yes.
Q. You also in that lawsuit filed -- name the doctor who prescribed the testosterone to you; correct?
A. He wasn't a doctor, but yes.
Q. Okay. The medical professional who gave -- prescribed testosterone to you; correct?
A. Yes.
Q. And you are suing him for breaching the standard of care in prescribing you hormone treatment without performing a proper biopsychosocial evaluation and without parental consent; correct?
A. I'm not entirely sure. I don't know the exact verbiage.
Q. Sure.
MS. LESKIN: Can we pull up Exhibit P-75, please? And if we can go to Paragraph -- Paragraph 70 of that. Let's bring up the first page first.
Q. (BY MS. LESKIN) Do you recognize this document?
A. Yes.
Q. And this is the complaint you filed; correct?
A. Yes.
Q. Okay.
MS. LESKIN: So can we go to Paragraph 70, please? I'm sorry. I have the wrong paragraph.

Paragraph 76 and 77.

Q. (BY MS. LESKIN) And Paragraph 77 is Count 3, and that is a count against Del Scott Perry; correct?

A. Yes.

Q. And Mr. Perry was the medical professional who prescribed testosterone to you; right?

A. Yes.

Q. And in Paragraph 77, you list a number of items that you are alleging Mr. Perry was negligent and grossly negligent; correct?

A. Yes.

Q. And you also named Doc- -- the therapist who wrote your letter prior to your mastectomy; correct?

A. Yes.

Q. And you are suing that doctor for authoring and signing a deceptive letter containing numerous material falsehoods and recommending your mastectomy; correct?

A. She was not a doctor, but yes.

Q. And you're alleging that Ms. Wood breached the standard of care to you in providing that letter; correct?

A. I'm not sure the exact verbiage.

Q. Sure. Let's pull up Paragraph 89, please. And you're alleging that Dr. Wood breached that duty of care to you and thus committed negligence and gross

negligence in numerous ways, including but not limited to authoring and signing a deceptive letter; correct?

MS. DYER: Objection, Your Honor, relevance.

THE COURT: Overruled.

A. Duty of care, yes.

Q. (BY MS. LESKIN) And finally, you have named in this lawsuit the doctor who performed your mastectomy; correct?

A. Yes.

Q. And among other things, you are alleging that he violated the standard of care to you; correct?

A. Yes, I believe she violated her duty of care.

Q. And that the doctor breached the standard of care in failing to perform an adequate biopsychosocial evaluation in anticipation of the surgery; correct?

A. The duty of care, yes.

Q. Thank you.

THE COURT: Any further re- --

MR. GONZALEZ-PAGAN: Just a second.

MS. LESKIN: Oh, excuse me.

THE COURT: Okay.

MS. LESKIN: Sorry, Your Honor.

THE COURT: That's okay.

MS. LESKIN: If you'll give me one moment,

Your Honor. Your Honor, we would offer P-75 into evidence.

THE COURT: Any objection?

MS. DYER: Yes, objection. Why does her lawsuit have any relevance on this case? Her testimony speaks for itself.

THE COURT: Well, I think -- I guess the cross-examination -- I'll -- I'll take judicial notice of P-75. I don't think it needs to be in evidence.

MS. LESKIN: Thank you, Your Honor.

THE COURT: Okay. Any redirect?

MS. DYER: Just a couple of quick questions.

THE COURT: Sure.

REDIRECT EXAMINATION

BY MS. DYER:

Q. I'm sorry. I just have a couple more questions for you.

A. Sure.

Q. Are you a lawyer?

A. No.

Q. Did you write the lawsuit that was just taken judicial notice of?

A. No.

Q. And do you wish you had received psychotherapy

instead of hormones?

A. Proper psychotherapy, absolutely, yes.

MS. DYER: Nothing further.

THE COURT: Any other?

MS. LESKIN: No, Your Honor.

THE COURT: Okay. All right. Ms. Aldaco, you are done on the witness stand. You may be excused.

Mr. Stone, Ms. Dyer, Mr. Eldred, any other witness at this time?

MR. STONE: No further witnesses, Your Honor. The defendants rest our case-in-chief.

THE COURT: Okay. I need to give Ms. Crain a little bit of a break before we continue, so we can go off the record.

(Discussion off the record)

THE COURT: Okay. We're back on the record. It's 5:43. We have concluded evidence. The State has rested. We -- the Court can forego closing arguments at this time. And although I have not given the attorneys a final decision on exactly what I'm anticipating needs to be -- or is allowed to be filed, they will hear from me tomorrow morning on the plaintiffs' response to the plea to the jurisdiction that the State has filed and whatever briefing schedule relates to that.

Is there anything else we need to put on the record at this time?

MS. WOOTEN: No, Your Honor. Thank you.

MR. STONE: No, Your Honor. Thank you.

THE COURT: All right. Thank you. We can go off the record.

(Court adjourned)

REPORTER'S CERTIFICATE

THE STATE OF TEXAS)
COUNTY OF TRAVIS)

I, Chavela V. Crain, Official Court Reporter in and for the 53rd District Court of Travis County, State of Texas, do hereby certify that the above and foregoing contains a true and correct transcription of all portions of evidence and other proceedings requested in writing by counsel for the parties to be included in this volume of the Reporter's Record, in the above-styled and numbered cause, all of which occurred in open court or in chambers and were reported by me.

I further certify that this Reporter's Record of the proceedings truly and correctly reflects the exhibits, if any, offered in evidence by the respective parties.

WITNESS MY OFFICIAL HAND this the 1st day of September, 2023.

/s/ Chavela V. Crain
Chavela V. Crain
Texas CSR 3064, RMR, CRR
Expiration Date: 10/31/2024
Official Court Reporter
53rd District Court
Travis County, Texas
P.O. Box 1748
Austin, Texas 78767
(512) 854-9322 *