UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
TALLAHASSEE, FLORIDA

AUGUST DEKKER, et al.,	)	
	)	
Plaintiffs,	)	Case No: 4:22cv325
	)	
vs.	)	Tallahassee, Florida
	)	May 17, 2023
JASON WEIDA, et al.,	)	9 A.M.
	)	
Defendants.	)	
_____	)	

VOLUME IV
(Pages 712 through 962)

TRANSCRIPT OF FOURTH DAY OF BENCH TRIAL
BEFORE THE HONORABLE ROBERT L. HINKLE,
UNITED STATES DISTRICT JUDGE

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P R O C E E D I N G S

(Call to order; all parties present.)

THE COURT: Good morning. Please be seated.

MR. GONZALEZ-PAGAN: Good morning, Your Honor. Omar Gonzalez-Pagan for the plaintiffs. Ms. Rivaux will be conducting the examination.

THE COURT: Please call your next witness.

MS. RIVAUX: Good morning, Your Honor, we will be calling Dr. Edmiston.

DEPUTY CLERK: Please raise your right hand.

ELLIOT KALE EDMISTON, PLAINTIFFS' WITNESS, DULY SWORN

DEPUTY CLERK: Be seated.

Please, state your full name and spell your last name for the record.

THE WITNESS: My name is Elliot Kale Edmiston, E-l-l-i-o-t, K-a-l-e, E-d-m-i-s-t-o-n.

DIRECT EXAMINATION

BY MS. RIVAUX:

Q. Goo morning, Dr. Edmiston. Can you please state your profession.

A. I'm a neuroscientist and an associate professor of psychiatry.

Q. And can you please describe for the court your education and training.

A. Certainly, yes. I received a Bachelor's degree focused

in the cognitive science from Hampshire College. I then went on to the Yale School of Medicine for three years of additional training in a lab focused on mood disorders and adolescents.

I then attended Vanderbilt University, where I completed a Ph.D. in neuroscience. I went on then to China Medical University for a postdoctoral fellowship, returned to the United States, completed an additional postdoctoral fellowship at the University the Pittsburgh, and in 2019 I was promoted to assistant professor of psychiatry at the University of Pittsburgh.

Q. And what positions do you currently hold?

A. Currently I am an associate professor of psychiatry at UMass Chan Medical School.

Q. And what type of work do you do in your current role?

A. I run a research lab that focused on human subjects research in mood anxiety disorders, particularly in young adults, adolescents, and youth, and I'm interested in the neurobiology of mood and anxiety disorders as well as risk factors associated with them, like stress.

Q. Have you published any scholarly articles?

A. Yes.

Q. And are they peer-reviewed articles?

A. Yes. I've published approximately 50 peer-reviewed articles.

Q. And in addition to the works that you published, are there any other professional works that you've authored relating to transgender health issues?
A. Yes. I have published two book chapters related to transgender health. I was also a coauthor of the adult assessment chapter for the WPATH Standards of Care, Version 8; and I currently have two publications that are under revision related transgender health. One is an article discussing how stress affects the mental health of trans youth, and the other is an article about impulsivity in adolescent decision-making as it pertains to gender-affirming hormone care.
Q. Are you being compensated for your time here today?
A. Yes.
Q. And does your compensation in any way depend on the outcome of this litigation or your testimony?
A. No.
Q. And, Dr. Edmiston, did you provide a copy of your CV with your expert report in this case?
A. I did.
Q. And is that CV a present and accurate summary of your qualifications and professional activities?
A. Yes.
MS. RIVAUX: Dr. Edmiston's CV is Plaintiffs' Exhibit 357. It's among the stipulated exhibits, and I would

like to move that into evidence.

THE COURT: Plaintiffs' 357 is admitted.

(PLAINTIFFS' EXHIBIT NO. 357: Received in evidence.)

MS. RIVAUX: At this time I move to have Dr. Edmiston qualified as an expert on adolescent decision-making and the effect of gender-affirming care on the brain.

THE COURT: Questions at this time?

MR. BEATO: No, Your Honor.

THE COURT: You may continue, but before you do, let me ask a question before I forget it.

The last article I think you mentioned was adolescent decision-making as it pertains to transgender care. If I understood it right, that is under submission. Does that mean it's submitted for peer review but not yet peer-reviewed and published?

THE WITNESS: It's currently being peer-reviewed, so it's been submitted but not published yet, correct.

THE COURT: You may proceed.

BY MS. RIVAUX:

Q. And so, Dr. Edmiston, I would like to talk to you. The Court has heard a little bit about adolescent decision-making.

And in your field of work, are you familiar with a body of research pertaining to decision-making by adolescents?

A. Yes, I am.

Q. In adolescent decision-making, what does the research tell you about the importance of the context and the circumstances surrounding the decision-making?

A. The context with regard to impulsivity and adolescent decision-making is incredibly important. So we do know that adolescents in certain contexts tend to be more impulsive than adults, but the context is really important here.

So in a cold context, a context where there is time to make a decision, a context where the decision-making is being supported by adults, the research shows that adolescents are capable of adult-like deliberative decision-making.

Where we see the impulsivity come into play is in these hot contexts. So that would be a context where there is pressure to make a decision quickly or when the adolescent is surrounded by peers. So these would be things like driving recklessly or using substances or alcohol. Those would be the hot contexts where adolescents tend to be more impulsive.

Q. How does this research that you work with regarding adolescent decision-making relate to the context of adolescents making decisions regarding gender-affirming medical interventions?

A. So gender-affirming care, medical decision-making is not a hot context. It's a cold context. It's a context where decision-making unfolds over an extended period of time, and that decision-making is supported by caregivers and medical

professionals.

Q. Can you describe for the Court a little bit more about the type of research that's been done about adolescent decision-making in the medical context?

A. So there has been research as it relates to gender-affirming care, decision-making adolescence. There is a study by Bauer, et al., that demonstrates that on average, adolescents take about three years between when they realize that they are trans and when they come out to their parents. And so to me, that's quite a long bit of time. That's not an impulsive decision.

There's also been some qualitative research interviewing trans youth, their parents, and their medical providers about the decision-making process. That's a Daily 2019 article. And it shows that adolescents really value the input of adults when they are making these medical decisions, and that parents feel that the ultimate decision is really up to them.

Q. Can you explain a little bit --

THE COURT: Let me stop there just to keep the record. It's "really up to them."

THE WITNESS: I'm sorry. The parents feel that they have the authority to make the decision, the final decision.

THE COURT: The parents do?

THE WITNESS: The parents do, yes.

BY MS. RIVAUX:

Q. And this protracted time frame, what is the significance of that particularly in the context of gender-affirming care?
A. Well, it just demonstrates that it's not an impulsive decision. It's a decision that unfolds over an extended period of time. So, you know, on average, three years between realizing that one is trans and coming out to a parent; and then from there, the parents and the child have to have, you know, a conversation about what to do with that information, you know, and that could take months or even years depending on sort of where the parent is at.

And then from there, they have to navigate the healthcare system, you know, find a provider, make an appointment. And then from there, they are going to be evaluated for their readiness for treatment by the provider. So that can also take months or potentially years. So it's really an extended process.

Q. And the defendants in this case make a claim that adolescent brains are insufficiently developed to make medical decisions in the context of gender-affirming care or with their caregivers and professionals.

How do you respond to that claim?

A. I would say certainly that the adolescent brain is still developing, but the studies show that it's really in this hot context where we are seeing this sort of difference developmentally between adolescents and adults. So I don't

think the evidence supports that claim.
Q. Is there any scientific literature that supports the proposition that, when it comes to adolescents making healthcare decisions for treatment for gender dysphoria, that they are actually making an impulsive medical decision?
A. No.
Q. So I would like to turn -- the Court heard a lot of testimony about puberty blockers, GnRHa, and I would like to talk to you a little bit about that right now.
Are you familiar with the body of scientific literature that studied the effect of puberty blockers on the brain in adolescents?
A. I am. There's animal studies and also some human studies.
Q. And when we are talking about these studies, are these all studies in peer-reviewed scientific literature?
A. Yes.
Q. And before we turn -- because I do want to talk to you about the animal studies and the human studies, but before I turn to that, I want to ask you:
Based on your assessment of the literature, is there any basis to suggest that there's -- that you could conclude that the effects on the brain are harmful?
A. No.
Q. At the same time, can you say that GnRHa or puberty

blockers have no effect on the brain?
A. No. These are medications that have an effect on the brain, that have an effect on the body, and the effect that they have is the intended effect, that it reduces sex differences.
Q. And defendants have suggested that we need more studies in this field. Does that mean doctors should not prescribe puberty blockers based on your assessments of the scientific literature?
A. No. As a scientist, we tend to be very curious, and we always want to do more research. But the preponderance of the evidence suggests that this is a safe medication that should be used.
Q. And are you familiar with any literature that talks about the impact on the brains of adolescents of untreated gender dysphoria?
A. I'm sorry. Could you repeat that?
Q. Sure. I was asking if you're familiar with the body of scientific literature that discusses the effects on the brain of untreated gender dysphoria?
A. So we know from the literature that untreated gender dysphoria is associated with anxiety and depression, and that treated gender dysphoria is associated with an improvement in anxiety and depression symptoms and a reduction in suicidality.

We also know that, when anxiety and depression are left untreated, particularly during adolescence, a time of neural plasticity that this can be associated with detrimental effects on the brain. Specifically, the brain is flooded with stress hormones, and the stress hormones can damage the brain and also set these adolescents on a developmental trajectory where they are more likely to experience repeated depressive episodes.

So this is called the "kindling effect," and it's the idea that, with each successive depressive episode, you are more likely to experience episodes in the future, and that's because of the effects of this on the brain.

Q. I want to turn now if we can shift gears to talk about some of the specific studies. You mentioned that there were animal studies that looked at the effects of GnRHa on the brain.

Are you familiar with those studies?

A. Yes. There are some sheep studies, a rodent study, and also a nonhuman primate study.

Q. And when we talk about the animal studies, are there known limitations when assessing animal studies?

A. Certainly. All studies have limitations; and that's why, as a scientist, we look at the literature as a whole to draw conclusions.

In particular, animal studies have the limitation that --

you know, rodents don't really have the complex social identities that humans do, so we can't really model a trans identity in a rodent, because they don't have a sense of themselves as being a particular gender.

At the same time, we can't necessarily directly measure things like anxiety and depression in animals. You know, in a human study, the type of work that I do, we can just ask people directly about their mood and about their level of anxiety. But for animal studies, we have to observe their behavior and project humanlike traits onto animals. So that's why in animal studies, it is important to always that a behavior is anxiety-like, because it's not really clear that a mouse experiences anxiety the way that a human does.

Q. Let's talk more specifically about those animal studies, then.

Are you familiar -- you mentioned some sheep studies. Can you talk to the Court a little bit about what the sheep studies looked at and what they concluded?

A. Certainly. So there are a series of sheep studies from a single group, and they were interested in assessing the effects of GnRHa on spacial cognition. So in these studies, they had half of the sheep treated with the GnRHa and half were untreated, and then they built a maze for the sheep and had them navigate the maze, and timed how long it took them to complete navigating the maze as a measure of their spacial

cognition.

And those studies show that there is no effect of GnRHa on spacial cognition, and that there is no effect of GnRHa on learning. So they had -- in one study they had the sheep navigate the maze repeatedly in a short period of time, and they showed that all of the sheep were able to navigate the maze faster with each attempt.

There was one finding in one of the studies that looked at long-term memory for the maze, and they had the sheep complete the maze at 27 weeks and then again at 41 weeks. And at the 27-week mark, they found that there was one area of the maze where the GnRHa-treated sheep spent a little bit longer in that part of the maze.

They also found that the GnRHa-treated sheep were vocalizing more in that part of the maze. And so they weren't able to conclude necessarily that this was due to an effective GnRHa on cognition, that there were alternate explanations that were also possible as well.

Q. And you mentioned that they did this same experiment at the 27 weeks and again I think you said 41 weeks.

Was there any difference in the 27 and the 41 weeks?

A. Yes. The difference was no longer present at 41 weeks, so it resolved.

Q. You mentioned also a rodent study. Can you tell the Court about the rodent study and what they studied and what

the conclusions were of that study?
A. Yes. That was the Anacker study, and they were interested in assessing the effects of GnRHa on behavior in rodents. So in that study, they had male and female rodents and they treated half of them with GnRHa and half were left untreated; and then they ran a series of different behavioral assays that are very common in the rodent literature. And what they found was that GnRHa did exactly what we would expect it to do.

Specifically, that in the untreated male and female mice, there were sex differences in their behavior, and that those sex differences were reduced with GnRHa treatment. So, again, this medication that is intended to reduce sex differences reduced sex differences.

Q. And so can you explain a little bit what that means by "sex differences"? There are some -- some of the defendants have claimed that -- the experts have claimed that these are side effects. Can you explain a little bit more about what those sex differences are and what you -- how you respond to the claim of these are side effects?

A. Yeah, certainly. So, medications have effects, and the determination of what is an intended effect and what is a side effect is contextual. So in the case of GnRHa treatment for trans youth, the purpose of the medication is to minimize or reduce side effects or reduce sex differences. And so

when we see that in the rodent study, that's not a side effect. That's the intended effect of the medication.

Q. And the defendants have used this rodent study and some of the sheep study to suggest that GnRHa shouldn't be prescribed because of these side effects. How do you respond for what they claim to be side effects?

A. I would respond that these aren't side effects, and that the medication is working as expected and as intended.

Q. You mentioned also a primate study. Can you tell the Court a little bit about what was studied there and what the findings were?

A. Yeah. So that would be the Godfrey 2023 study. That study is very complex. But in that study, they took advantage of the fact that nonhuman primates form social hierarchies that are more akin to humans. So they live in groups, and there are some of the monkeys that are dominant and some monkeys that are subordinate that are essentially bullied by the more dominant monkeys.

And in this study they gave half of the monkeys GnRHa treatment and half were left untreated. They had them do an MRI scan, did a bunch of different sort of social behavioral assays, and then repeated an MRI scan later.

And the primary finding from this study is that for the socially-stressed bullied monkeys, GnRHa rescued them and reduced the effect of stress, the negative effects of stress

on the brain. So GnRHa protected them from the negative consequences of chronic social stress on brain development.

Q. You mentioned there were also human studies of GnRHa and the effects on the brain. Can you talk to the Court a little bit about what types of studies have been done on humans?

A. Yes. There are several human neuroimaging studies. So these are studies that use magnetic resonance imaging or MRI, and there are a couple of different techniques within MRI that we can use. So one is functional MRI, and this technique allows us to present an individual with a task; that they complete this task while in the scanner and were able to measure the relative concentration of oxygen in the blood to determine what parts of the brain are activated while they complete this task.

There is also structural measures that allow us to assess things like regional brain volumes or the integrity of white matter in the brain -- "white matter" being the fibers that connect different regions of the brain.

Q. And in any of the studies, was there any findings of a negative effect on cognition?

A. No.

Q. And in any of these human studies, was there a finding of any negative effect on executive function?

A. No.

Q. And just for a little further explanation, what exactly

is "executive function"?
A. So executive function is a subset of behaviors under sort of the umbrella of cognition. And executive function are the behaviors related to planning or goal-directed activity.
Q. And so let's talk a little bit about some of those human studies you mentioned.
Are you familiar with a study by Staphorsius in 2015?
A. Yes.
Q. Can you tell the Court about that study and what they found in that study?
A. So that is a functional MRI study. And in that study, they had individuals complete a Tower of London task in the scanner, which is a planning task, a task of an executive function. And they had a group of GnRHa-treated trans adolescents, untreated trans adolescents, and then cisgender boys and girls; and they showed that there was no effect of GnRHa on performance of this Tower of London task.
Q. Are you familiar with a study by Solman in 2016?
A. Yes. That's also an fMRI study. This was a study of emotional processing. And in that study, they compared again GnRHa-treated and untreated youth, and they found that there was no relationship between GnRHa treatment and brain activation during this emotional processing study.
Q. And are you familiar with the Van Heesewijk study in 2022?

A. Yes, the Van Heesewijk study is a structural study, and it uses a technique called "Diffusion Tensor Imaging" or DTI, and this allows us to measure the coherence of these white matter tracks that connect different parts of the brain. And so if the white matter track is more coherent, it forms more of a straightforward bundle, then we would say that the transfer of information from one region to another is more efficient.

And in this study, they found that the trans youth overall actually had more coherent white matter than the cis youth, and they found one region where there was a difference in the trans boys, but it was such that GnRHa treatment made that white matter bundle more like the cisgender boys. So again, that it was having the expected effect.

They also looked at correlations between duration of GnRHa treatment and white matter integrity, and they didn't find any relationship between GnRHa treatment and the outcome measure of white matter integrity.

Q. And for a layperson like me, can you explain the significance of these studies?

A. These studies suggest that GnRHa treatment doesn't have any negative effect on cognition, and that the few findings that are related to -- that showed differences in the brain show us that the medication is doing what we would expect; that it is making the brain more consistent with the gender

or reducing sex differences.

Q. A point of clarification. In the Solman 2016 study, was that a study involving transgender adolescents?

A. Yes.

Q. Are you aware of a study that looked at the effects of GnRHa on the brain in treatment for precocious puberty?

A. Yes. That would be the Wojniusz 2016 study, and that was a study of emotional regulation, looking at girls treated with GnRHa for central precocious puberty and controls who did not have that condition, were not treated.

And they had them perform an emotional regulation task. They showed that there was no difference in performance in emotional regulation. And while they performed this task, they also collected EKG data. The collected heart rate data and also heart rate variability data.

Heart rate variability is an indirect measure of parasympathetic nervous system function or rest-and-digest function. And they found that the GnRHa-treated girls showed optimal physiological regulation during this emotion task such that they had a lower heart rate, which would indicate that they were more relaxed, and a higher heart rate variability, which is a positive outcome. It indicates that they are relaxed, and that their parasympathetic nervous system is engaged and active, and that they are ready to respond flexibly to the environment. So this is an optimal

emotion regulation result associated with GnRHa.

Q. And defendants cite a study as a reason not to use GnRHa.

Is there any support for that conclusion?

A. No.

Q. Defendants also suggest that GnRHa should not be used because it could have an impact on IQ.

Is there any support in the scientific literature that suggests that there is an effect on IQ by using a GnRHa in adolescents?

A. No, there isn't.

Q. Many of the defendants' experts argue that GnRHa is experimental because there is insufficient research on long-term effects of GnRHa.

How do you respond to this claim?

A. So GnRHa is a medication that's been used safely for decades. So we know from the experience of clinicians and from the research literature that it's a safe medication that is not associated with long-term harm.

Q. Is the fact that there is a smaller body of literature render the treatment for gender dysphoria experimental?

A. No. As a scientist, we would never rely on any one study to draw conclusions, but we look at the research literature as a whole. And the research literature as a whole shows that this is a safe and efficacious medication.

Q. The defendants' experts also opine that there is

insufficient research suggesting that the gender-affirming hormones alleviates gender dysphoria.

Are there any studies that actually look at this issue on the brain?

A. There are two studies in trans adolescents that look at effects of testosterone on the brain. So two studies of transgender boys. Those are both fMRI studies that use negative emotional face paradigms, so they are presenting them with angry or fearful faces in the scanner. And one of those studies showed that activity in the brain with testosterone treatment became more typical of a cisgender boy. So, again, what we would expect.

The other study looked at anxiety and depression symptoms as well as suicidality and body image satisfaction. They found that with testosterone treatment, there was a reduction in anxiety symptoms, depressive symptoms, and suicidality; and that this was explained by an improvement in the body image in these boys.

They also showed that there was increased coupling between the prefrontal cortex and the amygdala while they were looking at these negative emotional faces.

So what we think of in terms of amygdala prefrontal coupling is that this is a marker of regulation of emotions, and they actually showed that there was greater coupling between these two regions in the testosterone-treated boys --

so that's a positive outcome -- and that the amount of coupling was correlated with the reduction in their anxiety symptoms. So that the individuals that had more coupling showed a greater reduction in their anxiety symptoms. So, again, a positive outcome.

Q. And do the limitations -- excuse me.

Can you talk a little bit about whether there are limitations to these studies?

A. There are always limitations. Every study has limitations. It's not really possible to address every potential concern. There is always limitations of resources of time. You know, I do human subjects neuroimaging, and it's a very expensive and -- it takes quite a bit of time to do it well. So there's always limitations. And that's why, again, we would not rely on any one study to draw our conclusions. We look at the literature as a whole.

Q. And the limitations you mentioned, do they render the care experimental?

A. No.

Q. You mentioned a little bit earlier about the harms to the untreated brain and the effects of -- I think you called it "the kindling effect."

A. Uh-huh.

Q. Can you talk a little bit more about that and explain a little bit more what that means and what the impact is for a

gender-dysphoric adolescent?

A. Right. So we know from the literature that adolescents with gender dysphoria have higher rates of depression and anxiety and suicidality. We also know that they are more likely to be bullied, and they have more chronic stress. And we know from the literature that these things are all associated with negative effects in the brain.

So the release of the stress hormone cortisol, for example, when that stress hormone is chronologically released and the brain is flooded with cortisol repeatedly, this actually shrinks the size of neurons and is associated with more depressive symptoms, more anxiety symptoms. And we know that over time, there is a cumulative negative effect of this process on the brain structure and function.

Q. And is there evidence in the scientific literature that withholding treatment would have a negative effect on brain development?

A. So we know that access to treatment is associated with an improvement in mental health and a reduction in mood anxiety symptoms, and we know that untreated depression and anxiety is associated with harm to the brain. So being able to access the treatment can circumvent some of those harms.

Q. Based on your review of the literature, is there any scientific basis to exclude coverage for GnRHa in adolescents to treat gender dysphoria?

A. No.
Q. Is there any basis to exclude coverage of gender-affirming hormones in adolescents to treat gender dysphoria?
A. No.
Q. Based on what you testified to today, is there any support for the claim that the provision of GnRHa is experimental?
A. No.
Q. Based on what you've testified today, is there any support for the provision of cross-sex hormones as experimental?
A. No.
Q. And one last question. Some of the studies that you talked about, the human studies in transgender adolescents, were those cited by any of the defendants in their expert reports if you can recall?
A. No, they were not cited.
Q. And do you know if they were cited in the GAPMS report?
A. They were not.

MS. RIVAUX: Thank you.

THE COURT: Cross-examine?

MR. BEATO: Yes, Your Honor.

Thank you, Your Honor.

CROSS-EXAMINATION

BY MR. BEATO:

Q. Good morning, Dr. Edmiston.

A. Good morning.

Q. Just a few questions.

Doctor, on direct you testified about adolescent decision-making, correct?

A. Yes.

MR. BEATO: I would like to pull up DX16.

BY MR. BEATO:

Q. And you should see it on your screen. We also have physical copies if you need it.

A. Okay.

Q. What is this document?

A. This is the WPATH Standards of Care, Version 8.

MR. BEATO: And I would like to go to WPATH 45, please.

BY MR. BEATO:

Q. Doctor, is this the adolescent chapter?

A. Yes.

Q. I would like to go to the next page, please, first paragraph under the bolded "For clarity," nine lines down starting with "However."

If you can just read the section starting with "however" and ending "different from that of older individuals."

A. You would like me to the read it out loud?

Q. No. You can read it to yourself, and just let me know when you are finished reading.
A. Okay.
Q. Do you agree with the section?
A. I agree with this section in terms of it's -- you know, that it's true in the specific context that I discussed in my direct.
Q. Understood.
I would like stick with the WPATH Standards of Care. Can we go to WPATH 63, please. Top right, paragraph 14 lines down, and hopefully we be blow that up, starting with "gender-diverse youth."
Gender-diverse youth should fully understand the reversible, partially reversible, and irreversible aspects of the treatment, as well as the limits of what is known about certain treatments, e.g., the impact of pubertal suppression of brain development.
Do you see that, Doctor?
A. Yes.
Q. And you'd agree that there is limited knowledge of the impact of pubertal suppression on brain development, correct?
A. I would say that there's sufficient evidence that this is a safe medication. It's been used for decades; and, you know, we know from the literature as a whole that it's safe and effective.

Q. Okay. Can we go to WPATH 67, please. Second paragraph under the bolded "consideration of ages," second sentence, starting with "There is."

There is, however, limited data on the optimal timing of gender-affirming interventions as well as the long-term physical, psychological, and neurodevelopmental outcomes in youth.

Do you see that, Doctor?

A. Yes.

Q. Do you agree that there is limited data on long-term neurodevelopmental outcomes in youth who receive gender-affirming interventions?

A. I would say that the data that we have supports the use of these medications.

Q. Same page, right column, first full paragraph, 18 lines down, starting with "Puberty is a time."

Puberty is a time of significant brain and cognitive development. The potential neurodevelopmental impact of extended pubertal suppression in gender-diverse youth has been specifically identified as an area in need of continued study.

Do you see that?

A. Yes.

Q. Do you agree with that statement?

A. I would say that, again, as a scientist, we always want

to do more studies. No scientist ever says, well, we've solved that question, we know everything there is to know. We always want to do more studies. I would also say that they qualify this as an extended pubertal suppression. So that is also worth noting.

Q. Understood. And, Doctor, you're aware of the Endocrine Society's clinical practice guidelines and treatments for gender dysphoria, correct?

A. Yes.

MR. BEATO: DX24, please.

By MR. BEATO:

Q. Doctor, what is this document?

A. These are Endocrine Society guidelines.

Q. And can we go to ES19, please. I believe that's ES23, ES19. First full paragraph:

Limited data are available regarding the effects of GnRH analogs on brain development. A single cross-sectional study demonstrated no compromise of executive function, but animal data suggests there may be an effect of GnRH analogs in cognitive function.

Do you see that, Doctor?

A. Yes.

Q. And do you agree with this section?

A. Well, I would qualify it, because this was a document that was written in 2017. So there has been quite a bit more

research since then. I would also say, this Citation 108, this was one of the sheep studies that I referenced, the one that found a cognitive difference -- or a potential cognitive difference. They weren't entirely sure how to explain it, that they found that the sheep were spending more time in this particular part of the maze at 27 weeks, but that difference went away over time. So I think that, you know, it's important in clinical care to cite all of the potential risks, and also to consider the potential benefits, so they are just being completely thorough.

Q. And, Doctor, you mentioned 108, that particular study, correct?

A. Yes.

Q. That would be Q?

A. Yes.

Q. The title is "Spatial memory is impaired by peripubertal GnRH agonist treatment in testosterone replacement in sheep"?

A. Yes.

Q. And, Doctor, you also talked about the mice studies, correct?

A. Right.

Q. That's the Anacker study?

A. The -- yeah, Anacker, yeah.

Q. And you would agree with me that the authors found that puberty blockers have profound effects on female behaviors

that are commonly interpreted as depression-like?
A. They found that the females with GnRHa treatment showed a reduction in the sex difference that didn't exist or existed before treatment.
You know, I would again highlight the fact that they used the term "depression-like." The literature that we have in humans shows that -- I very clearly repeatedly over and over again that this is treatment is associated with improvement in depression. So I find a human study of depression much more compelling than a mouse study.
Q. Understood. And you also agree that the authors found pronounce differences in locomotion and social preference in males and increases in neuroendocrine responses to mild stress?
A. Again, they did find these differences, but it's a matter of the comparison group. So they have four groups in this study. They have untreated male and female and treated male and female. So there are differences when you compare the treated female rodents to the untreated female rodents, but there are no differences between the untreated male and the treated female.
So because the purpose of this medication in this context is to reduce sex differences, the medication is doing exactly what it should be doing.
Q. And moving away from animal studies, are you aware of a

study by Schneider called "Brain maturation cognition and voice pattern in a gender-dysphoric case under puberty suppression"?

A. I'm not entirely sure. Do you have a copy that I could look at?

Q. Would it be help if I refresh your recollection?

A. Yes, sure.

MR. BEATO: Your Honor, may I approach?

THE COURT: You may.

THE WITNESS: Yes, I am familiar with this study.

BY MR. BEATO:

Q. And you are aware that this study observed an IQ decrease in a gender-dysphoric individual who took puberty blockers?

A. Yeah. So a couple of things about this study. So first off, it's a case study. So we would consider this the lowest quality of evidence in terms of study design. Case studies can be useful to illustrate a common clinical phenomenon for teaching purposes or to suggest an area for, you know, additional work. But they can't be used in isolation to make policy decisions or clinical guidelines. A case study really isn't generalizable to the broader population.

The other thing about this study is that the particular transgender girl that they studied already had a low IQ prior to starting GnRHa. So she is really not a representative case of the effects of GnRHa because she has an intellectual

disability.
Q. Understood. And just to highlight something you said. It's your belief that low-quality evidence should not be used to make policy decisions?
A. So, again, I think that all evidence should be taken into account and evaluated it as a whole. But a case study, to me, in insolation is not compelling evidence.
Q. And, Doctor, just to stick with that study for a second.
A. Uh-huh.
Q. The individual who had gender dysphoria, did she show an IQ decrease after receiving puberty blockers?
A. So I believe so, but let me check.
Q. Sure. Take your time.
A. So there is a difference in her IQ; but, again, we can't say that this is necessarily due to GnRHa because she had an IQ of 80 prior to initiation of GnRHa, which is a significant intellectual disability.
Q. And did it go down after receiving puberty blockers?
A. It did go down, but it's important to remember that's why we also have cross-sectional studies. So, for example, the Wojniusz 2016 study did not find any differences in IQ with GnRHa, and because they had a group of individuals, they are able to perform a statistical test to see if that difference is due to chance or if it's a real difference.
Because this is a study of only one person, we can't do

that kind of statistical testing. So the IQ varies to some extent with repeated testing, and so we can't tell from this case report if the amount of variation here is due to chance.

Q. And, Doctor, you also mentioned a series of MRI studies, correct?

THE COURT: Let me stop and ask a couple of questions about the one you just dealt with. Nobody asked what the IQ test showed after the treatment.

What did the case study show after the treatment?

THE WITNESS: So they showed that the IQ was -- the global IQ was 71 after treatment. So, you know, these are both borderline-to-low-average IQs before and after treatment.

THE COURT: That case study, is that peer-reviewed?

THE WITNESS: It is, yes.

THE COURT: I see IQ results not in studies, but in individual cases where intellectual functioning is important including, for example, in death penalty cases and other kinds of criminal cases. I see that kind of variation frequently. I certainly haven't made any study of the cases I happen to have gotten, which would just be a random assortment anyway.

THE WITNESS: Sure.

THE COURT: How unusual is it to have successive IQ tests with the amount of variation shown there?

THE WITNESS: I would say that that is very typical.

THE COURT: If you really wanted to see what was

going on, would you rely on the single test or is that a test you would repeat?

THE WITNESS: Do you mean in terms of determining the real IQ, you would repeat the test?

THE COURT: Yeah. If, for example, there were a lawsuit involving that change in IQ -- a change from 80 to 71 on test -- and the question was exposure to some chemical that led to a lawsuit claiming that that was what was caused by a chemical, is that the kind of thing where an expert in your field would look at the one test and the one test and say, this is a real change in IQ, or would you need to do more tests to find out whether there was really a change or whether this was just a variability between two tests?

THE WITNESS: I would certainly want to do more tests. So they used the WISC IQ test, and I would want to do more targeted neuropsychological assessment to really get into what components of cognitive function are, you know, there are very specific components of cognitive function. So I would want to do a full neuropsychological workup.

THE COURT: What, if any, conclusions would you draw about the effects of GnRHa based on that case study?

THE WITNESS: I wouldn't want to draw conclusions of the effects of GnRHa on the basis of a case study. I would use the Wojniusz 2016 study to draw conclusions because that actually looked at a group of individuals and compared them

statistically. That allows us to really get a sense of, you know, is this a real difference, is this a significant difference. And that study didn't find any significant difference.

MR. BEATO: Thank you, Your Honor.

BY MR. BEATO:

Q. Doctor, you also mentioned MRI studies, correct?

A. Yes.

MR. BEATO: Can we pull up PX351, please.

BY MR. BEATO:

Q. Doctor, is that one of the MRI studies?

A. Yes.

Q. And this study observed 22 individuals with gender dysphoria?

A. I can't exactly read it. Yes, it looks like 22.

Q. And this is not a longitudinal study?

A. It's a cross-sectional study.

MR. BEATO: Can we pull up PX352, please.

BY MR. BEATO:

Q. Doctor, this is another one of those MRI studies?

A. Yes.

Q. And --

A. I'm sorry. I was just going to say, this is the Solman study that I mentioned, yes.

Q. And this study observed 21 individuals with gender

dysphoria?
A. Yes, it did.
Q. This is not a longitudinal study?
A. No. It's a cross-sectional study, and cross-sectional studies are important. They have value in terms of our ability to draw conclusions. And, you know, again, that's why, as scientists, we use lots of different approaches and methods to assess a particular question from lots of different angles.
Q. Understood.
MR. BEATO: And can we pull up PX354, please.
BY MR. BEATO:
Q. Doctor, that's another one of the MRI studies?
A. Yes. That's the Van Heesewijk study, the DTI study.
Q. If we can look at the background section, fourth line:
Knowledge about the effects of puberty suppression on the developing brain of transgender youth is limited.
Do you see that, Doctor?
A. Yes.
Q. Do you agree with that statement?
A. I think that this is a common approach to structuring an introductory paragraph. So, you know, as a scientist, we are trained to sort of have the first sentence be what is the concern we're addressing, and the last sentence of the background section is always, this is what we don't know yet;

and that's why I did this study, and this study is going to help us understand what we don't know.

So this is saying -- this is giving a justification for the performance of this particular study.

Q. Understood. And this article came out in 2021, I believe?

A. I can't see, but -- yeah, uh-huh.

Q. Last few sets of questions.

So just so the record is clear, you are not a medical doctor?

A. That's true. I have a Ph.D. in neuroscience.

Q. You never diagnosed anyone with gender dysphoria?

A. No, I don't diagnose individuals with gender dysphoria.

Q. And, Doctor, is it true that to form your expert opinion in this case, you partly relied on your work as a contributing author of WPATH Standards of Care 8?

A. Yes.

Q. And you helped draft Chapter 5, the adult chapter?

A. I did, yes.

Q. What was the drafting process like?

A. So the drafting process, which is publicly available on the WPATH website, involves each team of chapter co-authors generating a list of questions. We send those out to an external review that does an extended peer review allowing us to see what evidence there is to answer those questions.

And then from there, the co-authors of the chapter draft statements, and we use the language of "recommend" or "suggest" that's based on the strength of the peer-reviewed literature with regard to that particular recommendation.

From there, then that -- those -- those statements are evaluated by all of the authors.

Q. Did the authors of Chapter 5 include any individuals who were not medical professionals?

A. Yes.

Q. Who were they?

A. Oh, there were several therapists, and the chapter lead is a medical doctor.

Q. To your knowledge, do all of the individuals who assisted in the drafting of Chapter 5 approve of gender transition treatments to treat gender dysphoria?

A. I think that we all base our opinions on the evidence. And so, you know, our recommendations are that people be evaluated for the appropriateness of the treatment, and this needs to be done on a case-by-case basis.

Q. And what feedback did you receive from the WPATH board of directors?

A. I'm sorry?

Q. I'm sorry. What feedback did you receive from the WPATH board of directors?

A. Feedback regarding?

Q. The drafting of Chapter 5.
A. So the particular statements are all voted on by all of -- by everyone, and then once all of the statements -- once there is a consensus, then the chapter co-authors draw -- start drafting the explanatory text that goes underneath those statements; and then we work very closely with the chapter editor to ensure that there is consistency in the document. So we receive feedback from the chapter editor.
Q. Did any of the authors of Chapter 5 not feel comfortable with the recommendation in the finalized Chapter 5?
A. All of the recommendations are based on consensus of all of the authors of not just the chapter but the entire document.
Q. So did individuals feel not comfortable with the particular finalized recommendation?
A. No. If someone felt uncomfortable with that finalized recommendation, then, you know, we would come to a consensus.
Q. And just to backtrack a little bit, the WPATH board had to approve the draft of Chapter 5, correct?
A. Yes, it's a consensus-based document.
Q. And were there any disagreements between the authors?
A. In drafting anything like this where we have diverse opinions, we have to have discussions and come to a consensus. So, yes, sometimes there were.

Q. Did you contribute to any other chapter in Standards of Care 8 aside from Chapter 5?

A. I was only a co-author on Chapter 5, but because it's a consensus-based document, we all contributed or many of us contributed in different ways to different chapters.

MR. BEATO: One moment, Your Honor.

No further questions.

THE COURT: Redirect?

MS. RIVAUX: No questions, Your Honor.

THE COURT: Dr. Edmiston, the lawyers haven't asked you or the other witnesses this, and that may be because the answer is "I don't know" or there's no scientific evidence of that, and if that's the answer, tell me that.

THE WITNESS: Of course.

THE COURT: But it seems to me that one of the questions that -- at least under the surface in some of the submissions, is something like this:

Let's posit just a 12-year old who is trans or who says, although my sex assigned at birth, my physical sexual characteristics make me a boy, in fact, I'm a girl; I identify as a girl.

It seems to me that some of the defense suggestion is, that's not really so. That's just something the person is deciding to do just as if one would decide to wear jeans or slacks or long pants or short pants on some day to go out in

public.

What, if anything, can you tell me about whether this is really a thing, whether there are people who not as a matter just of choice but as a matter of their identity, their personhood, actually identify with the opposite gender from the gender assigned at birth or whether this is really just something they decide to be?

THE WITNESS: Yeah. That's a great question, Your Honor. So I would say a couple of things.

I would say, first off, that transgender people have existed throughout history; that there is records of transgender people all over the world throughout history. And that the analogy of deciding whether to wear jeans or slacks, that the social consequences of changing one's gender or changing one's sex to be consistent with one's gender are enormous.

If you think about how much of the social world is structured by people's perception of your gender, you know, people risk losing support of their family and friends. We know that they are bullied and ridiculed. So the decision to come out and live as one's authentic self requires an enormous amount of bravery and conviction. You know, it's not a decision that anyone would just make on a whim, because it's a very challenging life.

THE COURT: I understand that. Aside from that kind

of reasoning, is there any scientific literature, any evidence based that bears on that question?

THE WITNESS: Yeah. There is literature showing that, when the cross-gender identification is persistent and consistent, that those people over time do -- you know, that they stay, that it's a consistent desire. It's not a thing that fluctuates over time, especially when you're talking about someone that is 12, maybe. It would be perhaps a little different if you have a three-year-old boy that likes to play with Barbies. That would be a different scenario, right?

So by the age of 12, if someone is consistently saying, "I'm the opposite gender," then there are longitudinal studies that show that that is a consistent desire.

We also know that the rate of regret -- we know from the scientific literature that the rate of regret for these sorts of interventions is very small.

So I think for some -- some studies have shown a 97 percent satisfaction rate with these sort of interventions, which is much, much higher than you would see for most other medical interventions.

THE COURT: Questions just to follow up on mine?

MS. RIVAUX: No questions, Your Honor.

MR. BEATO: One moment, Your Honor.

One question, Your Honor.

RECROSS-EXAMINATION

BY MR. BEATO:

Q. Is there any study anywhere that identifies something in the brain as the basis for a transgender identity?

A. Yes.

Q. What is that?

A. So there are a number of studies in adults that have looked at -- you know, the neuroimaging studies that have looked at differences in the brain between trans and cisgender individuals, and they found differences in the -- particularly in the somatic motor and sensory motor cortices, and these are regions in the brain that are responsible for one's sense of one's own body.

So there is actually quite a bit of literature. I actually wrote a peer-reviewed review of this literature. So there is quite a bit of literature.

MR. BEATO: No further questions.

THE COURT: Thank you, Dr. Edmiston. You may step down.

THE WITNESS: Thank you.

THE COURT: Please call your next witness.

MR. GONZALEZ-PAGAN: Thank you, Your Honor. Mr. Little will call our next witness, Ms. Hutton.

MR. LITTLE: Plaintiffs would call Kim Hutton to the stand.

DEPUTY CLERK: Please raise your right hand.

KIM HUTTON, PLAINTIFFS' WITNESS, DULY SWORN

DEPUTY CLERK: Be seated.

Please, state your full name and spell your last name for the record.

THE WITNESS: Kim Hutton, H-u-t-t-o-n.

DIRECT EXAMINATION

BY MR. LITTLE:

Q. Thanks for being with us, Ms. Hutton.

Can you tell us why you are here to testify today?

A. I'm here to testify about a conversation that I had with one of the witnesses for the State, Dr. Paul Hruz.

Q. Is there anything else you here to talk about with us today?

A. Just my experience as the mother of a transgender child.

Q. Okay. Before we get to that, can you briefly tell me your familiarity of this case, generally, a brief description of what you know?

A. I understand it has something to do with Medicaid coverage for transgender-related healthcare.

Q. Okay. And you came here from out of state today, correct?

A. I did.

Q. Where are you from?

A. The Greater St. Louis area, Missouri.

Q. So you mentioned you are here to testify for two

purposes. We are going to go to the second one first, regarding your family.

Would you mind just telling me a little bit about your family and we'll go from there?

A. Sure. So I am the mother of two sons. I have a 35-year-old son and a 20-year-old son who is transgender. My transgender son actually first expressed to me that he was a boy at the age of two and a half. I had him in out bathroom sink, as I did every day, ponytailing his long blonde hair, and he looked in the mirror. I was standing behind him ponytailing his hair, and he looked up in the mirror at my reflection and said, "I a boy."

I remember, like, tilting my head and thinking I must have heard him wrong, and I said, "What did you just say?"

And he said, "I a boy."

I said, "Oh, okay." And I finished his ponytail and I put him down and he ran off and played.

But I remember feeling very nervous about what he had said. I had been around children my entire life, babies, toddlers my whole life, and I never had a child tell me that they were the opposite gender. So I was pretty nervous.

That night my husband got home, and I told him what happened. And he is like, "Well, you know, they're two." And we talked about it and decided that, you know, they were confused or something, you know, didn't do anything about it,

really, and life went on.

For my child, they started expressing that they were a boy every day after they initially told me. And, you know, within six months, all of his baby dolls, even if they were in pink and dresses became boys. They were suddenly boys. And all of his stuff animals were boys, and they were given boy names. And, you know, it just became really clear that this was not going to, like, go away on its own.

And so I think he was about four and a half or five years old, and we kind of taken the approach of, like, "Oh, no, sweetheart, like, you're a girl; you have a body like mommy's," and just tried to gently redirect him. But he was very insistent that he was a boy.

And I think he was a four and a half or five years old when he had a complete breakdown one day and said, "Am I going to have breasts some day like you?

I said, "Well, some day, but that's a long ways away."

And he just melted into the floor sobbing and crying, and I couldn't understand what he was saying. So I scooped him up, and I'm like, "Hey, what is going on?"

And he's like, "When they come, can you take me to the doctor and can they cut them off?"

I soothed him as best I could, but, like, it was a very, very difficult time in our house. And I told my husband that we needed to try to find some outside help to figure out what

was going on. And there were no therapists in St. Louis that had treated a child like ours, you know, such a young child.

But I did find a therapist who treated adult transgender people, and so I made an appointment. And they told me to let him wear boy clothes in the house, but don't let him wear them outside of the house. And if he went to a birthday party, to make him take the blue balloon -- or the pink balloon, even if he wanted the blue balloon. She advised us that he would get picked on and bullied if he left our house expressing himself as a boy.

So it was kind of like asking him to live in two worlds. You know, he could dress the way he wanted in our home, but he had to look differently when he left our home.

And that advice only led to our child getting tremendously depressed. I just watched the sparkle and shine in his eyes just drain out.

So eventually, I said to my husband, you know, we need to find a different doctor, this is not working, and I called a therapist. I read something in the newspaper and found a doctor in California, and I called her and begged her to work with us over the phone, and she did.

And then over time, she connected me to a research doctor in Washington, D.C., who is studying children like mine. And I told him what was going on; and, you know, that my son wouldn't look in a mirror. Like, he wouldn't even look in a

mirror to brush his teeth.

And he -- the research doctor told me that that was one of the primary signs, that he would likely go on to be a transgender adult.

And so we spoke with that doctor several times, and then they eventually connected us to a therapist in St. Louis who had seen a child at one point in their career. She treated my husband and I. We were all therapy. There was a lot therapy in our house.

And my husband and I saw that therapist, and then she referred us to a child psychologist to meet with my son who at the time was between six and six and a half. They recommended that we get a complete psychiatric evaluation of our child, which we did.

And they wrote up a report, and they did diagnose him with -- at that time it was called "gender identity disorder," and they told us that, to make him live his life as a girl would be cruel and inhumane; that he knows who he is; and that we should let him wear boys' clothing, get him a boy haircut, give him a boy name, use boy pronouns, and find a school that would support him, which back then was going to be really difficult, but we did.

And with these small changes, like, my son was just happy again and, like, all of the life came back in his personality, and he was just, like, cheerful and happy and

engaging with his friends. And we put him in this new school.

And he could have gone in without anyone knowing that he was transgender, but he told them at first day at Community Circle that he was a boy, but he didn't have a boy body. And just the nature of the school allowed him to express himself, for people to know him for who he really was. And he had millions of friends, invited to every birthday party, and just -- his confidence just grew. And it was probably for the next even three years the happiest years of his life.

And so, yeah, I think it was around between nine and ten that puberty struck and breasts started developing, which was his biggest terror in life, was having breasts.

So at that time we sought an endocrinologist at St. Louis Children's Hospital, and we talked about the hormone blocker therapy. And I remember -- you know, I remember her saying things like, you know, we'll have to do lab work, blood work, I think every six months or something like that. And we'll do x-rays of his hands, and we'll watch for the growth plates to open -- or to stay open or closed, just kind of monitoring him while he was on this.

I also knew that they had used this type of treatment for children with precocious puberty for many, many years, decades I think I heard, before my child was on it. And so I felt like, you know, they've been using it in other ways on

children, you know, it seems like it's okay. And knowing how our child felt, we absolutely wanted it for him. He would have been devastated to have endured female puberty and to have breasts. And so for us it wasn't really even a question about doing it.

And once he had the blocker implanted, and the minimal development that had happened on his chest went away, he was happy again, full of life, and engaged with his friends and just did great.

Q. That's good to hear.

The facility where your son received puberty suppression hormones, did they have a gender clinic or a specialized gender facility?

A. They did not.

Q. How were the next few years like after beginning the puberty suppression?

A. They were great. I mean, his confidence just continued to soar. He's smart, his grades were excellent, his circle of friends was huge. He's well liked and just an all-around happy kid, and just really living a very regular boy life.

Q. And then at a certain point, did your son ever progress to any other kinds of gender-affirming care in addition to the suppression hormones?

A. He did. I think he was almost 15, right around 15, and he started with a very tiny dose of testosterone. And over

time, I think it was actually over a year, a year and a half to get to the full dose. And so he experienced the type of puberty I think that he wanted where he had facial hair. He had talked to us since he was three years old that he was going to have a beard when he grew up, you know.

So for him to get facial hair and things of that nature from the cross-hormone therapy just made his day. He was beyond ecstatic. He was delayed in puberty. Most of his peers, his guy friends had already gone through that. He was catching up to them and just -- he was beyond thrilled with everything that was happening.

Q. Where did your son receive testosterone from?

A. So he started on testosterone at Cardinal Glennon Children's Hospital, and then ultimately, when he was older, transferred to the St. Louis Transgender -- Washington University Transgender Center, Pediatric Transgender Center.

Q. Okay. So you talked a bit about the observations you had seen in your son since taking testosterone. How is your son doing day?

A. He is doing great. He just completed his freshman year in college. I'm so proud of him. He did really well. He's an A-B student. Again, he took off for school, and he created this whole new social circle. It's really large. When I talk to him on the phone, when he's away at school and he's walking across campus, countless people are yelling his

name and saying hello. I mean, it's wonderful.

He could have gone into a dormitory that was for anybody that was on the gender spectrum, and he's like, no, I'm just going to let them place me where they place me.

And so the guys that he roomed with in his dorm didn't know right away that he was transgender, but he told them about that within a few months. And everybody loves him, and they protect him and they stick up for him where needed. And he's just a great kid. He's so happy.

And it's been kind of rewarding as a parent because recently, because I'm sure he's growing up and maturing and he's looking across life, and he said, you know, mom, I will never be able to thank you and dad enough for loving me, supporting me, and getting me the medical care I needed to live this life. He goes, I don't even know what kind of person I would be today if I hadn't gotten the hormone blockers and the cross-hormone therapy. He said, I know friends who are transgender who didn't have access for a variety of reasons and didn't have loving and supportive parents, and he said, they're living a very difficult life.

And so it's kind of -- it's been really nice to get that appreciation from our son and recognition, I guess. But obviously, as parents, you just want to make sure that your children are healthy and happy, and that was our goal.

So, yeah, he's doing great.

Q. That's really wonderful to hear.

And we'll circle back to that before we end, but just spend a few minutes talking about the other matter you came here to testify about.

You mentioned you were familiar with one of the defendants' experts. Can you tell me a bit more about that?

A. Yes. So in 2010 I started this small not for profit called "Transparent," and it is a support group for parents who are raising a transgender child of any age. And as a part of that and then also raising my child, I was doing all kinds of reading and trying to find resources and help for children like mine in our community.

I ran across information on a Dr. Norman Spack, and I found out that he actually started a pediatric transgender center at Boston Children's Hospital. And I was like, oh, my gosh, there's a center, like there's a place that does, like, full care for children like mine, I couldn't even believe it.

So I called him. I didn't think he would take my call, but he did. I introduced myself, and I told him how we're really struggling in St. Louis. We didn't have a center like this; that it would be like my dream to someday have a center like that in St. Louis.

And I said, you know, our doctors are just starting to talk about this. They are not really educated on what our children need, and I said, you've got these standards of

care. Do you think you would ever consider coming to St. Louis and sharing what you know about treating transgender children with our medical community. He's like, sure. He said, I'm going to be in Kansas City -- this would have been October of 2013 -- and he goes, I'll just come in a couple of days early, and I'm happy to speak in your area.

So I arranged presentations at the Washington University School of Medicine and the St. Louis University Medical School. And when Dr. Spack gave his presentation at Washington University School of Medicine, Dr. Hruz was in the audience. And then after the presentation -- after the presentation, there was a small private meeting where doctors met with Dr. Spack privately, I'm sure, to ask him more detailed questions; and Dr. Hruz was a part of that small meeting. And so --

Q. Go on.

A. And so Dr. Spack came out of that meeting, and he reconnected with me, and he said, Dr. Hruz would like to meet with you. I'm like, oh, okay. I thought that would be a good thing, because I understood that Dr. Hruz had an important position within the endocrine department at Washington University School of Medicine. So I thought it would be a good thing. And Dr. Spack seemed concerned, and when I asked him about that, he said, he's a very, very religious person.

Q. Was he referring to Dr. Hruz?
A. To Dr. Hruz.
MR. PERKO: Objection, Your Honor. Under Rule 610 evidence of someone's religious beliefs is not admissible to support or --
THE COURT: Or oppose their credibility. Is that what the rule says?
MR. PERKO: Yes.
THE COURT: I won't consider it for that purpose.
BY MR. LITTLE:
Q. Go on.
A. So I -- he said he'll reach out to you, and he did. I got an email from Dr. Hruz. I think it was the same day, I think. It was right around -- it was very close to the presentation. I wrote him back and told him that I was happy to meet with him and we scheduled a lunch.
Q. Can I ask you what he said in his email?
MR. PERKO: Objection, Your Honor. Calls for hearsay.
MR. LITTLE: It's Dr. Hruz's email that we are referring to, not Dr. Spack.
THE COURT: Dr. Hruz is going to testify?
MR. PERKO: Yes.
THE COURT: He can be impeached with his statement, can he not?

MR. PERKO: Yes, sir.

THE COURT: I'll allow the testimony. If it turns out it's not properly impeaching testimony, we will double back and I won't consider it. He'll need to be confronted and given an opportunity to explain it, but that can be done when he testifies.

MR. PERKO: Thank you, Your Honor.

THE WITNESS: So his email said that he was very interested in meeting me because he had questions that he thought that I would be able to answer based on my experience raising a transgender child. He said that he had done some research, but that -- he had done some reading, but it wasn't exhaustive, and he just felt like he could learn some things from me. He said that he wouldn't try to debate me or change my views.

But there were a couple of terms in the email that caused me concern. He talked about morals and spiritual needs of the children, and I thought that was interesting because I didn't know how that really impacted the medical care that my child needed. But I made the meeting and we had lunch I think the same week of the presentation.

And when I got there, I sat down and I started to talk about my son, telling him about my son, and I was going to go on to tell him about my family's experience, but he stopped me pretty quick. And he said, I looked at the

transparent brochure, and I know that your goal is to normalize the transgender experience. And he said, your child is not normal, and they will never be normal. And he said, surgeries -- surgeries that attempt to change a person's gender are, like, against God's will or God's plan.

And I listened. There were other things that were said during this period of time. And I said, you know, men have top surgeries. If they develop breasts, men have top surgeries. He goes, well, that doesn't matter because men's breasts serve no purpose. Women's breasts lactate and provide nourishment for babies, so they could not have top surgeries.

And he went on to say, if you would read Pope John Paul's writings on gender, I would understand God's plan for gender. And I said, well, you know -- because he kept coming to this -- to religious, like, he even said the thing about reading Pope John Paul's writings probably five or six times in our conversations.

So because he kept going down that vein, I said, you know, the Bible also says that God created women from the man's rib, and I go, you know, maybe this whole transgender thing started right then, like mixing man's DNA over into women, and like maybe the transgender experience is actually God's design.

And he snapped at me and said, not all of the stories in the Bible are true or accurate. And I said, how do you --

MR. PERKO: Can I have a standing objection to --

THE COURT: You can have a standing objection to whatever Mr. Hruz said.

MR. PERKO: Thank you.

THE WITNESS: He said, not all the stories in the Bible are true or accurate. And I said, well, how do you decide what to believe and what to follow? And he said, your child is a girl, and they will never be a boy. And I said, do you know that children like mine have a 40 percent risk of suicide if they don't have the love and support of their parents? And he said, some children are born into this world to suffer and die.

And then he said, you think I don't ask myself why people die of cancer? And I said, well, people with cancer, you will give them every known medical treatment available to save their lives, and he said -- he stood up at that point and he said, there will never be a transgender center at St. Louis Children's Hospital. I will never allow it, but I'll pray for you, and I'll pray for your family. And I said, and I'll pray that you change your mind.

BY MR. LITTLE:

Q. Was there ever a transgender center opened at the children's hospital?

A. There was.

Q. When did that open?

A. 2017.
Q. You mentioned a few aspects of the meeting. At any point did Dr. Hruz express to you an interest in discussing the science behind gender-affirming care?
A. No.
Q. Did it seem to you that his mind was already made up on that topic?
A. Oh, yeah. Yes.
Q. What do you think his purpose was in meeting with you?
A. I think he wanted me to stop asking about a transgender center. I think he wanted to make it clear. He had his --
THE COURT: Let me just say, if you have particular objections -- this testimony is obviously objectionable. If you have objections other than the 610 objection you made earlier, then you need to make it.
MR. PERKO: Yes, Your Honor.
THE COURT: But, otherwise, I'm just going to listen. I can tell all of you, I really don't care what Ms. Hutton thinks Mr. Hruz' purpose was. It is admissible what Mr. Hruz said. The rest of this, we can just give her an open mike and let her talk, but --
MR. PERKO: Yes, Your Honor. Objection as to speculation.
THE COURT: Sustained.
MR. LITTLE: It's the last question on that line of

inquiry.
BY MR. LITTLE:
Q. Okay. That was all I had to ask regarding Dr. Hruz. I just have one final question for you.
Oh, right. Did Dr. Hruz ever examine your son or your son's medical records?
A. Never. No.
Q. Was it your impression that Dr. Hruz was uninterested in learning about your family's experience?
MR. PERKO: Objection, speculation.
THE COURT: Sustained.
BY MR. LITTLE:
Q. Okay. One final question unrelated to the meeting with Dr. Hruz.
You already talked about the benefits you've observed from your son receiving gender-affirming care. Is there anything else you want to add for the record about your experience as a mother raising a transgender child and what you've observed through that experience?
A. Just, I would say that the fact that my son expressed that at the age of two and a half for -- and across his entire life, he has never once ever identified as female, it makes me believe that he was absolutely born this way.
I think it's a -- his brain is wired in this way. It's who he is. He's never once identified as female ever. And

he's living an incredibly successful life. He's productive, he's happy, he's funny, he's smart. It's -- for our family, it was absolutely the right decision to make, and even my son is confirming that, like, continues to confirm that as he continues to grow.

MR. LITTLE: Thank you so much for sharing with us today.

THE COURT: Cross-examine?

MR. PERKO: Thank you, Your Honor.

CROSS-EXAMINATION

BY MR. PERKO:

Q. Just briefly, Ms. Hutton. You mentioned that a gender clinic did open at Washington University in 2017; is that correct?

A. Yes.

Q. Now, that clinic --

THE COURT: I'm sorry. I thought it was at the children's hospital, and maybe that's associated with WashU. So before you ask your question, let me just straighten it out.

Are those affiliated entities?

THE WITNESS: They are affiliated. St. Louis Children's Hospital is affiliated with Washington University School of Medicine.

THE COURT: Got it.

BY MR. PERKO:

Q. That's the clinic I'm speaking of.

That clinic is currently under investigation by the Missouri Attorney General's Office based on allegations of improper treatment practices; isn't that correct?

A. That's correct.

Q. And those allegations were made by a case manager who worked at the clinic?

A. Yes.

MR. PERKO: That's all I have, Your Honor.

THE COURT: Redirect?

REDIRECT EXAMINATION

BY MR. LITTLE:

Q. Ms. Hutton, are you familiar with the findings of the investigation at the children's hospital?

A. I did read a report that they were all unfounded and unsubstantiated. I did read something about that.

Q. Are you aware, a rule promulgated in the state that was recently going to be enforced by the Attorney General in the state? Are you aware of that rule?

A. I'm aware of that rule, and I heard yesterday that that has been dropped.

MR. LITTLE: No further questions.

THE COURT: Thank you, Ms. Hutton. You may step down.

Tell me where we stand. We'll probably take the morning break. Give me the lineup for the day.

MR. GONZALEZ-PAGAN: We have our next witness prepared. He would be the one joining the Zoom. So if we can take our morning break now.

THE COURT: That's good. We will start back at 10:50 by that clock. And you can have the connection made by then, that will be good. Thank you. We're in recess.

(*A recess was taken at 10:32 a.m.*)

(*The proceedings resumed at 10:50 a.m.)*

THE COURT: Please be seated.

MR. GONZALEZ-PAGAN: Your Honor, the plaintiffs would call Dr. Aron Janssen.

THE COURT: Dr. Janssen, let me start by asking you a question about logistics. Are you there in a room by yourself?

THE WITNESS: I am.

THE COURT: If anyone comes into the room, if you would just let us know, we'll deal with it; but, otherwise, we will assume for the whole time you are there by yourself.

Please raise your right hand.

ARON CHRISTOPHER JANSSEN, PLAINTIFFS' WITNESS, DULY SWORN

THE COURT: Please state your name for the record.

THE WITNESS: My full name is Aron Christopher Janssen, J-a-n-s-s-e-n.

THE COURT: Thank you. You may proceed.

DIRECT EXAMINATION

BY MR. GONZALEZ-PAGAN:

Q. Dr. Janssen, what is your profession?

A. I'm a child adolescent and adult psychiatrist.

Q. Where are you currently employed?

A. I am currently the vice chair of clinical affairs of the Ann & Robert H. Lurie Children's Hospital of Chicago and an associate professor of psychiatry at Northwestern University.

THE COURT: We're not hearing you terribly well. If you would speak up nice and loudly for us, you may be able to get closer to your microphone. Thank you.

THE WITNESS: Got it. Will do.

THE COURT: Much better. Thank you.

BY MR. GONZALEZ-PAGAN:

Q. Dr. Janssen, in this capacities, what is your role within Lurie Children's Hospital and Northwestern?

A. My job is comprised of clinical care, and the clinical care I provide is primarily with youth and young adults with gender dysphoria. In addition, I do administrative work, research, teaching, systems-based advocacy.

THE COURT: Say the last thing again.

THE WITNESS: Systems-based advocacy, building services for patients with mental health concerns.

BY MR. GONZALEZ-PAGAN:

Q. And prior to your role at Lurie Children's Hospital, where did you work?
A. Prior to Lurie Children's, I was on faculty at New York University.
Q. And what was your role there?
A. I was the founder and director of gender and sexuality service and the co-director at the pediatric consultation liaison service.
Q. Could you please describe your practice at present?
A. At present?
Q. Yes.
A. Presently, my clinical work is almost exclusively with transgender and gender-diverse young people and young adults, and I have a particular niche in the world of co-occurring mental health issues among this population.
THE COURT: Dr. Janssen, I may have made this worse rather than better when I told you to get closer to your microphone. We're getting some echo. Let's start farther away from the microphone but still speaking up loudly.
BY MR. GONZALEZ-PAGAN:
Q. Dr. Janssen, about how many gender-diverse children and transgender adolescents and adults have you worked with throughout your career?
A. I have worked with over 500 patients.
Q. And you mentioned that most of your practice deals with

gender-diverse children and gender adolescents.

About what percentage of your practice is dedicated to that population?

A. Approximately 95 percent of my practice is dedicated to that population.

Q. Is there any particular conditions that you treat in your practice working with this population?

A. In working with this population, I treat the whole gamut of co-occurring psychiatric disorders, and my area of focus that I have published on is with co-occurring mental health issues among transgender and gender-diverse youth and young adults.

Q. Do you make any diagnoses or provide treatment for gender dysphoria?

A. I routinely make diagnoses and provide treatment for gender dysphoria.

Q. Are there any clinical guidance that you utilize in your work?

A. I use the WPATH Standards of Care, the World Professional Association of Transgender Health Standards of Care, as guidelines for my practice, in addition to the standard review of all updated scientific literature on the topic and my previous history and training.

Q. How long have you been providing care to gender-diverse children and transgender adolescents and adults?

A. For approximately 15 years.
Q. You said that you spent --
A. I began on faculty in 2011, so since that time. But I did work with transgender and gender-diverse young people and adults in my training a well.
Q. Thank you. You mentioned that you spend some of your time doing also research.
What are the specific areas of study that you research?
A. The specific areas I study are transgender mental health, so co-occurring mental health issues with gender dysphoria, suicide prevention, and system development.
Q. Have you published any research or scholarly articles related to the treatment of gender dysphoria?
A. Yes, I have.
Q. How many articles?
A. On last count I have published, I think it's about 24 peer-reviewed articles on gender dysphoria.
Q. And have those been in peer-reviewed journals?
A. Yes.
Q. And you mentioned that you utilize the Standards of Care from the WPATH.
Did you have any role in the promulgation or development of the Standards of Care, Version 8?
A. I was involved in writing two of the chapters, the chapter on children and the chapter on adult mental health.

Q. Are you member of the WPATH?
A. I am.
Q. Are you on the board of WPATH?
A. No.
Q. Are you a member of any other medical organizations?
A. I'm a member of the American Academy of Child and Adolescent Psychiatry.
Q. Did you submit a curriculum vitae as an attachment to your report in this case?
A. I did.
Q. And does that curriculum vitae accurately reflect your professional background and experience?
A. It does.

MR. GONZALEZ-PAGAN: Your Honor, Dr. Janssen's curriculum vitae is one of the stipulated exhibits, Plaintiffs' Exhibit 364.

THE COURT: Plaintiffs' 364 is admitted into evidence.

(PLAINTIFFS' EXHIBIT NO. 364: Received in evidence.)

MR. GONZALEZ-PAGAN: Your Honor, at this time I will ask that Dr. Janssen as a psychiatrist and researcher be qualified as an expert on the study, assessment, diagnosis, and treatment of gender dysphoria.

THE COURT: Questions at this time?

MR. PERKO: No questions, Your Honor.

THE COURT: You may continue.

BY MR. GONZALEZ-PAGAN:

Q. Dr. Janssen, there has been testimony in this case already about the nature of gender dysphoria and gender identity, but I want to ask specifically a little bit about your clinic experience and understanding of the recommendations and guidelines with regard to this diagnosis.

What is your understanding of the diagnosis or assessment of children or adolescents with gender dysphoria?

A. Well, first, it's important to note that there are two different diagnoses in the DSM-5. So there's gender dysphoria in children and then gender dysphoria in adolescents and adults.

For both, gender dysphoria refers to the incongruence between the sex assigned at birth and one's gender identity and significant distress in multiple areas of functioning that result from that incongruence.

Q. And are the diagnostic criteria for children and adolescents different?

A. The diagnostic criteria for children require more elements in order to make the diagnosis.

Q. And you mentioned that these are diagnoses that are contained within the DSM-5.

Is the DSM-5 the Diagnostic and Statistical Manual of mental disorder published by the American Psychiatric

Association?
A. That is correct.
Q. And is it something that you routinely utilize in your work?
A. It is.
Q. Are there any medical interventions associated with the diagnosis of gender dysphoria in children prior to the onset of puberty?
A. There are no medical interventions for gender dysphoria in children.
Q. Some of the State's designated experts and even the State suggest that allowing a child to socially transition puts them on a path to needing interventions in the future or that it makes them more likely to persist in their transgender identity.
What is your response to that?
A. There's no evidence to support that claim. The best data we have about persistence in social transition is that it is likely the kids who have the most intense amount of gender dysphoria who are both likeliest to socially transition as well as likeliest to persist.
Q. And what is your understanding of what "gender identity" is?
A. Gender identity is a complex construct, but that at the end of the day it's about how one identifies their own sense

of gender.
Q. Is gender identity a sex-related characteristic?
A. It is one of the multiple sex-related characteristics.
Q. And once an adolescent hits the onset of puberty, is it likely that they would desist from their gender identity?
A. The data on persistence and desistance is specific to a diagnosis of gender dysphoria. The best data we have suggests that children who meet criteria for the diagnosis of gender dysphoria in childhood, when heading to Tanner Stage 2 of puberty, so the initial stages of puberty. For those children who persist in that diagnosis, that diagnosis is highly likely, more than 95 to 99 percent likely, to persist through adulthood.
Q. We have been discussing young people that have experienced gender dysphoria or were diagnosed with gender dysphoria in childhood and then go on to receive medical care after the onset of puberty.
What about young people who present for treatment after they have initiated puberty? Is that a different phenomenon or is their gender identity more likely to persist?
A. There are multiple developmental processes, and when we talk to transgender adults and ask them about their early experiences, we hear a myriad of trajectories in terms of when folks recognize their identity.
By and large, even the people who are presenting

postpuberty had some sense of differentness around gender identity prior to that period. And there is no indication that we have from the scientific literature that those individuals are any less likely to persist after that.

THE COURT: Let me make sure I understood the answer clearly. You said "prior to that period." I want to make sure I know what "that period" was that you were describing. That may require you to go back and remember exactly how you said.

THE WITNESS: Yeah.

THE COURT: That may be asking a lot. Tell me again what you said about people who first present after -- I take it, it was after puberty, when they're telling you when they first recognized this, tell me again.

THE WITNESS: Sure. Most individuals can point to a period of time in childhood in which they recognized there was a difference in their gender identity, but it was not something disclosed at the time or clearly articulated. It is not any less likely that those individuals are going to not persist or persist, like they are just as likely to persist as those individuals who clearly articulated in early childhood.

Does that answer the question?

THE COURT: It does, and now I have one more question about that. You said people recognize something in childhood. And when you say "childhood" there, are you referring to

prepuberty?

THE WITNESS: Correct. There are many people who present for initial care postpuberty or even in adulthood or later adulthood who nevertheless have some recognition of difference prior to puberty. There are others who present with distress related to puberty. So that is another common trajectory that is not atypical in this population.

BY MR. GONZALEZ-PAGAN:

Q. Thank you, Dr. Janssen.

You've been discussing some this multiple or different pathways by which a person comes to understand their gender identity and present for care for gender dysphoria.

Can a person develop gender dysphoria based on social influences?

A. Social influences cannot create gender dysphoria just like they do not create other medical diagnoses or psychiatric diagnoses.

Q. Some of the State's designated experts have spent a great deal of time discussing a theory that an increase in the number of transgender boys in late adolescence presenting to gender clinics for treatment for gender dysphoria is a result of peer pressure or social contagion.

What is your response to that?

A. I have a few different responses to that.

First, it is a normal developmental process for

adolescents to seek out peers with shared experiences. This is not unique to transgender and gender-diverse young people. We see this with all types of minoritized youth where they seek out affinity groups with those that share their experiences.

So it is my experience working in this population that transgender youth seek out those social connections. It's not the social connections that leads to the identity, but it's the experience of the incongruence and the identity that leads to seeking out these social groups.

Q. Dr. Janssen, you've worked at two major institutions in two large states in different parts of the country.

Do you have an awareness of or keep up with the practices of other child and adolescent psychiatrists or other mental health professionals outside these institutions?

A. I've had the privilege of presenting and participating in conferences and events all over the country and the world, and in every event that I have been in, I have had opportunities to speak with practitioners and colleagues. And I've also had the opportunity to collaborate with a number of national and international colleagues in the work that I have done.

Q. One of the State's designated experts asserts that psychiatrists believe that social media has influenced the rise in gender dysphoria.

What is your response to that?
A. Well, first, there is no evidence to suggest that social media has led to an increase in identification as transgender among our youth.
The second is that there is no evidence to suggest that this is a widely-held belief of most child psychiatrists. In fact, in the spaces that I've worked in where I have a lot of opportunity to engage with and collaborate with child psychiatrists, I always have a robust discussion with folks after I've given a talk, and there's never been this significant groundswell of concern that this etiology that folks express concern.
Q. The State's designated expert also references conversations that he has had to argue that most psychiatrists admit that they not only believe that social media has contributed to a rise in gender dysphoria, but also that they will not speak in public on the subject because of how sensitive it is.
How does that accord with your experience?
A. I have had the pleasure of working in ACAP in a number of different committees including the sexual orientation and gender identity committee. As I mentioned, I have had opportunities to present on gender dysphoria in multiple fora. I have never had any concern about people raising opinions that differ from prevailing opinions of the time,

and we welcome robust debate and discussion about best practices and improvements and evidence-based care for these youth.

Q. You mentioned ACAP. By this, do you refer to the American Academy for Child and Adolescent Psychiatrists?

A. That's correct.

Q. Dr. Janssen, what is your understanding of what causes gender dysphoria?

A. Gender dysphoria is likely to be caused by a multifactorial etiology. We have some data that suggests there's a genetic component to this, and that monozygotic twins are more likely to share the diagnosis of gender dysphoria than dysototic twins versus siblings. There is some data on structural changes that we see within the brain, but we don't have a single entity that causes gender dysphoria, and like many psychiatric illnesses, it is likely to be quite multifactorial.

Q. Does the fact that someone's understanding of their gender identity change over time mean that their gender identity has changed?

A. It does not. It is a common process for individuals to evolve, and how they understand, how they label and how they express their gender identity does not mean that gender identity has changed.

Q. Some of the State's designated experts point to a shift

in the ratios of the patients that have been presenting for care as evidence that gender dysphoria is socially influenced or that we're dealing with a different phenomenon.

What is your response to that?

A. If we look at prevalence data, what we see in adulthood is that there's generally a 1-to-1 ratio of individuals assigned male at birth and assigned female at birth who identify as transgender or who have a diagnosis of gender dysphoria. Throughout the time in this field, we have seen wide variations in differences of sex ratio in childhood. When years ago it was a 5-to-1 ratio in some clinics of assigned males at birth presenting comparatively to assigned females at birth, we would anticipate that there would be some changes --

Q. Dr. Janssen, you sort of -- we lost you a little bit. You sort of disappeared a little bit in the last sentence. If you can just speak loudly and restate what you were stating.

A. Sure. What we saw is 20 years ago the sex ratios were quite different with significantly more assigned males at birth presenting for care than assigned females. That rate of adults who identify as transgender has not changed. So while social influence may impact who is seeking out care or how that distress is experience, it's not an influence in defining how people are identified.

And the other important note is that care was widely unavailable prior to the last 10 to 15 years, and so we would anticipate an increase in rates of seeking care in the context of that care being available.

THE COURT: Before you move on to something else.

Doctor, I'm not sure I heard properly or followed the description of 20 years ago, the 5-to-1 ratio, and what the ratio is now, and what point you were making with all of that. Back up and walk me through it again.

THE WITNESS: Sure. So, if we look at just who is showing up to clinics, it's going to be a sample of kids that's not always representative of the national population of individuals who are transgender, and that there are factors that are going to influence which kids present to which kind of care at what time. It doesn't mean that that is creating gender dysphoria more for boys than it was for girls 20 years ago or more recently now, that it's creating gender dysphoria more for assigned females at birth than assigned males at birth. It just means there's a lot of variability and that social context influences who is seeking care.

THE COURT: So what was the situation 20 years ago? Tell me what you know about the ratio of trans boys and trans girls. And I guess I should get you to tell me whether we are talking about the whole trans population or just boys and girls or all males and females.

Tell me what the ratio was between those presenting for care 20 years ago, and those who had the condition 20 years ago, if that's something you know, and then bring that forward to today and tell me what the same situation is today.

THE WITNESS: Sure. So 20 years ago, what we saw in the major pediatric gender clinics was that it was a much significantly more likely scenario for a kid assigned male at birth, so somebody who identifies as female but was born with assigned male gender, to present for care in the opposite.

What we are seeing now is that it is more likely to see folks who are assigned female at birth than folks assigned male at birth.

The challenge is the structure of those clinics, who had access to care and what was the social context of the time. Throughout that period, 20 years ago and today, we haven't seen changes in the sex ratio difference in transgender adults, and so what we're looking at is really a difference in who is presenting for care as opposed to a difference in the characteristics of the population.

THE COURT: How do you know that difference isn't related to fluidity in identification?

THE WITNESS: My answer for that would be on an individual level. A part of our assessment is recognizing what is and isn't fluid, how symptoms persist over time, the amount of distress that that leads in the social context in

which that assessment occurs. It's inherent to the practice of mental health that we are assessing social context as a part of a diagnostic evaluation, and that's not the experience that I've had or that my colleagues who do this work has had that there is a difference in etiology or a difference in mechanism or fluidity that's leading to these changes.

THE COURT: So when you referred a minute ago to the adult trans population by gender, was that based on people presenting for treatment or some kind of study in the population at large?

THE WITNESS: Those are population-based studies.

THE COURT: So if I understand what you told me, the population-based studies showed the same results 20 years ago as today, but the treatment patterns for children were different 20 years ago than today.

THE WITNESS: Correct. And treatment availability was different 20 years ago from today. And so there were a number of folks who would not present for care because there was no treatment available. As treatment becomes available, you have people presenting for care.

THE COURT: So the conclusion you draw from all of that is that what I would call social factors including the availability of treatment is what explains the difference in the ratio of children presenting for treatment, but not that there was any change in the 20 years in the number of trans

individuals. Is that --

THE WITNESS: Correct.

THE COURT: Got it. All right. You may continue.

MR. GONZALEZ-PAGAN: Thank you, Your Honor.

BY MR. GONZALEZ-PAGAN:

Q. Thank you, Dr. Janssen.

One argument that has been made is that providing medical care for adolescents diagnosed with gender dysphoria essentially ensures that they will persist in their transgender identity.

What is your response to that?

A. There's no evidence to support that assertion. We are not making recommendations for individuals to pursue medical treatment until they have met very clear criteria and there has been a thorough assessment of appropriateness and medical necessity of that intervention.

Q. Similarly, an argument has been made that allowing a minor, whether a child or adolescent, to socially transition ensures that they will persist in their transgender identity.

What is your response to that?

A. That is a claim that there is no evidence to support, and the preponderance of the evidence actually says the opposite. When we followed kids that socially transitioned, those that accessed care versus those that did not access care, have no difference in the persistence rates among those groups.

So it's not that your medical care leads to persistence. That persistence is going to persist. If you have a transgender gender identity that will persist regardless whether or not you have access to care.

Q. You've talked a little bit about the assessment done of adolescents before obtaining medical treatment.

What does the assessment for an adolescent for gender dysphoria entail?

A. Sure. The primary components of an assessment are, one, a full diagnostic evaluation. What we want to understand is that the presence, the diagnosis of gender dysphoria has been persistent, and that the diagnostic criteria are met.

This diagnosis is made not just with an interview with the patient themselves but also looking at other criteria, other informants.

The second is any co-occurring mental health and psychiatric disorders, how they may or may not influence the diagnosis of gender dysphoria.

The third is making sure we have a very clear understanding, both the patient themselves and whoever the caregiver or the parents may be of the specific risks, benefits, and alternatives, which include both the known and unknown risks of whatever that intervention is.

The fourth is recognizing the social context in which the treatment happens.

So that's all the components of an evaluation in this context.

Q. Dr. Janssen, the State's designated expert point to the rates of other psychiatric diagnoses among people presenting with gender dysphoria as a reason to not provide gender-affirming medical treatment because presumably this diagnoses make identifying someone who is really transgender more difficult.

What is your response to that?

A. A child who presents to a psychiatric clinic with a diagnosis of ADHD is more likely to have a co-occurring mental health diagnosis than somebody presenting with gender dysphoria. And yet we are able to make a diagnosis of ADHD plus any other co-occurring diagnoses and make treatment plans that are based upon the diagnoses -- all of the diagnoses that an individual presents with.

So if an adolescent presents with gender dysphoria and co-occurring mental health conditions, we are making all of those diagnoses and coming up with a comprehensive treatment plan to address each of those individually.

Q. Do the clinical practice guidelines and standards of care make any recommendations of how to deal with the presence of co-occurring conditions?

A. They do. It's important that co-occurring conditions are treated. And if co-occurring conditions impair the

individual's capacity to understand the interventions in question, we have to treat those conditions before any medical care for gender dysphoria would be initiated.

Q. Is there any evidence that addressing a co-occurring condition on its own leads to the resolution of a person's gender dysphoria?

A. No. There is no evidence that treating co-occurring mental health conditions resolves gender dysphoria.

Q. And why not?

A. It's a different diagnosis. In the same way that we wouldn't expect that treating anxiety is going to get rid of ADHD. Treating anxiety is not going to get rid of gender dysphoria.

It is a separate diagnostic entity with different etiologic factors. We would hope that as you treat co-occurring mental health conditions that quality of life improves, but we would not anticipate any impact on the gender dysphoria that is present.

Q. We talked a little bit about the assessment of the diagnosis of gender dysphoria. Backing up, I'm sorry.

Does the presence of co-occurring conditions among transgender people with gender dysphoria surprise you?

A. It's in no way surprising. There are a number of reasons:

Number 1, one out of five individuals are going to have a

diagnosable mental illness that requires care prior to graduating from high school. Transgender folks aren't different from the population --

Q. Dr. Janssen, if you can restart and just enunciate and be a little bit louder.

A. Of course. Sorry about that.

In the general population in the United States, one out of five individuals will have a diagnosable mental illness by the time they graduate high school that requires care.

So we would anticipate transgender folks in addition to that are also subjected to what we call minority stress. There is a theory that says that the daily stigma and experiences of bias influence mental health outcomes and lead to increased rates of things such as depression and anxiety.

So many kids are struggling with mental health right now. Transgender kids have the additional burden of managing stigma and bias and often family rejection.

Q. Can you tell me a little bit about the role of the medical health professional in deciding whether to -- whether a patient should undergo gender-affirming medical care?

A. Of course. The process of the mental health professional is to do that evaluation that I articulated the components of earlier to assess the readiness and appropriateness of an individual to proceed with medical care or surgical care.

Q. In your practice, have you provided letters of assessment

in support of medical interventions?
A. Yes, I have.
Q. Have these letters been for deprivation of puberty-delaying medications?
A. Yes.
Q. What about hormones?
A. Yes.
Q. And surgery?
A. Yes.
Q. Specifically, with regards to puberty-delaying medications, when discussing the risks and benefits of the medical intervention with the patient and their parent or guardian, as part of deciding whether to provide an assessment letter recommending that medical intervention, what is the process that you undergo with the patient and their parent or guardian?
A. The process involves a comprehensive assessment or evaluation. Again, we want to understand:
Is there a diagnosis of gender dysphoria that is present that has been persistent over time.
Does it lead to distress in multiple areas of functioning?
Are there any co-occurring mental health conditions that would cloud that diagnosis or make it inappropriate to proceed with medical care?

And is that medical care necessary?

And if it is, can the child understand and articulate to the best of their ability the risks, benefits, alternatives of that intervention, and can the parents provide consent for that intervention?

So it's a very comprehensive evaluation that involves discussions with multiple components and multiple individuals to look at how these symptoms present across multiple social contexts.

Q. And that would be similar with regards to hormones and surgery?

A. Presumably, the adolescents and young adults who are seeking out hormones and surgery are older, so the process by which you elicit that information will be different, but it is analogous in terms of the components of that assessment.

Q. In your experience, is this a process that mental health providers qualified to do assessment and diagnosis for gender dysphoria follow as well?

A. It is the standard of care, and it is my experience that practitioners follow this, yes.

Q. You mentioned that as part of the informed consent process that you engage in with your patients that you have to be aware of the risk and benefits of the treatment and that you also do some research in this arena.

Are you familiar with the body of research with regards

to the efficacy of gender-affirming medical intervention to treat gender dysphoria?

A. Yes, I am.

Q. In your opinion, what does the body of research tell us about the efficacy of the puberty-delaying medications to treat gender dysphoria?

A. Well, what we see is an improvement in the quality of life, mental health outcomes, and some relief of symptoms related to gender dysphoria.

Q. How does this accord with your clinical experience?

A. It's a little drier when talking about it from the data perspective comparatively to the profound positive impact we see when kids get access to this care.

One thing that is frequently not discussed in the delivery of gender-affirming care is the risks of not intervening and how terrifying pubertal development is for transgender youth with gender dysphoria.

And the relief that kids and young people experience when they are able to have puberty-blocking medications initiative initiated is quite profound.

Q. In your opinion what does the body of research tell us about the efficacy of hormones to treat gender dysphoria?

A. We see improved body congruence, improved quality of life, improvement in mental health symptoms, and improvement in gender dysphoria symptoms.

Q. And how does that accord with your clinical experience?
A. Again, I see a tremendous benefit from these interventions. You have individuals who blossom and are able to express and live their lives according to their experienced gender, and you see so much joy and improvement in functioning when kids get access to this care.
Q. In your opinion, what does the body of research tell us about the efficacy of surgery to treat gender dysphoria?
A. The preponderance of evidence that it is safe, it's effective, improves quality of life, improves mental health outcomes. And for some people, it's actually curative of the gender dysphoria. We see significant improvements in gender dysphoria symptoms.
Q. And how does this accord with your clinical experience?
A. Similarly, I see patients who are able to live their lives more freely, more openly, and with more satisfaction and significant improved mental health.
Q. And you stated that you work with the spectrum both from children, adolescents, young adults and adults in providing care.
When we're talking about adolescents, what are the surgeries we are talking about?
A. Primarily, we're talking about top surgery. "Chest masculinization" is another name to describe it.
Q. When we're talking about adults, people over 18, do you

have experience with patients who have obtained surgery as well?
A. I do, yes.
Q. And can you tell us a little bit about that experience?
A. Sure. So, in addition to the chest masculinization, patients can opt for vaginoplasty, phalloplasty, facial feminization surgery, et cetera, and I work with patients who have had all of those procedures.
Q. And what have you observed in your patients that have had those procedures?
A. The patients for whom those procedures are medically indicated and medically necessary see tremendous benefit, both in their symptoms as well as their quality of life and functioning.
Q. Let me ask you this:
Is there any evidence that psychotherapy alone is sufficient to resolve a person's gender dysphoria?
A. There is no evidence to suggest that. In individuals for whom medical care is necessary, there's no substitute for that medical care, and there is no role for psychotherapy in eliminating those gender dysphoria symptoms in those patients.
Q. The State's designated experts have testified about how the provision of puberty-delaying medications is purportedly a one-way road to further medical interventions.

I think you've covered some of this ground, but what is your response to that assertion?
A. That assertion is not backed up by the evidence. When we look at children who have socially transitioned, their rates of persistence of that identity are independent of whether or not they have access to puberty-blocking medications.
Q. Is there any evidence that puberty-delaying medications access some type of switch by which children go on to persist in a transgender identity?
A. No.
Q. Some of the State's experts argue that mental health professionals believe that a patient who suffers gender dysphoria based -- let me restart that.
Some of the State's experts argue that mental health professionals believe that a patient suffers gender dysphoria simply by relying on the patient's self-report and taking it at face value without any scrutiny.
What is your response to that?
A. I think that opinion belies what mental health care is and how we provide that care. In our training of all mental health professionals, we recognize that the patient's individual history in psychiatry just like in other aspects of medicine is but one component of the diagnostic evaluation. We are looking at exam findings. We are looking at other historical elements. We are looking at other

informants to describe experiences across multiple contexts to get the most accurate diagnosis that we can make.

Q. One of the State's experts criticizes the American Academy of Child and Adolescent Psychiatry for taking, what is according to him, inconsistent positions regarding the capacity of minors. Specifically, he points to an *amicus* brief filed by the Academy arguing that an adolescent's mental capacity should be taken into account when the adolescent is being adjudicated for criminal sentencing, but then supporting the provision of gender-affirming medical interventions for adolescents in the same age range.

What is your response to that?

A. This is a bit of an apples-to-oranges comparison. In one case, we are talking about an individual being exposed to legal consequences that will follow that patient throughout their life in an incident that happens in the moment; whereas, with gender-affirming care, a part of our assessment is understanding the maturity level, a cognitive step -- of these actions. And these are not --

THE COURT: You froze on us there, so --

THE WITNESS: Sorry.

THE COURT: Back up.

THE WITNESS: I saw my connection was unstable for a moment. I apologize. I can restart, if that works.

BY MR. GONZALEZ-PAGAN:

Q. If you don't mind restarting, that would be great.
A. Sure. So, as I was saying, it's a bit of an apples-to-oranges comparison. In the one case we have individuals who are participating in an alleged act that is going to have lifelong legal consequences for them.

For gender dysphoria care, it is inherent to our assessment that we are evaluating an individual's cognitive capacity, capacity to understand, ability to think through potential consequences. And these are discussions and assessments that occur longitudinally over time, and that these are decisions that children and family are making over a long period and not in a moment. So it's a very different process.

Q. Dr. Janssen, does the presence of clinical depression or other psychiatric co-occurring conditions affect the capacity of an individual to providing informed consent or assent to medical care?
A. Capacity is a time- and decision-specific evaluation. And so there is no one blanket to say yes or no. However, it would be highly unlikely, very, very rare for depression or most psychiatric diagnoses to lead to an incapacity to consent to this care. Even among our most severely mentally ill patients with chronic psychotic disorders, a vast majority of those individuals retain capacity to consent to specific medical care.

Q. Dr. Janssen, some of the State's designated experts criticize medical organizations for taking positions in support of gender-affirming medical care and state that the taking of these positions delegitimizes and politicizes medical care.

What is your response to that?

A. It is common for medical and professional organizations to make statements in support of what is the best and most evidence-based interventions for any particular condition. It would be not atypical and very appropriate for an academy to support this evidence-based care.

Q. Some of the State's designated experts say that these organizations' positions lack legitimacy because they have been discouraging or silencing diverse or opposing viewpoints.

What is your response to that?

A. In all of the organizational meetings and conferences that I have been present for, I have never seen a stifling of academic debate about best practices in this population.

Q. One of the State's designated experts opines that, even transgender adults and the parents and caregivers of transgender adolescents are unable to provide informed consent because there is no full accounting of all the potential risks associated with gender-affirming medical interventions.

What is your response to that?
A. One of the things that I value most about my profession of medicine is that we are constantly learning new information. There is not a single medicine, not a single procedure, not a single surgery, not a single intervention for which every risk or potential risk is known. It is a part of our informed consent process that we talk about what is known but also what is not known. If we were to hold up this standard that unless we knew every single potential risk, there would not be a single medicine, a single procedure or a single surgery we would ever be able to get consent.
Q. Dr. Janssen, I would like to talk about the harms that people may experience for not having access to care.
Can you tell me a little bit about what effect the lack of access to gender-affirming medical interventions has on transgender people with gender dysphoria?
A. Sure. I would put this in two different buckets.
The first is the lack of access to care itself. And so we have treatments that are effective and safe for gender dysphoria; and if you don't treat the gender dysphoria, the gender dysphoria will get worse, and that will lead to increasing, to health consequences; and, unfortunately, we see things such as increased rates of suicidal ideation and attempted suicide.

The second bucket is the changes in the physical habitus. As individuals who are transgender and have gender dysphoria do not have access to care, their bodies are going to proceed through puberty in a way that's unaligned with their identity. That creates a tremendous amount of distress.

And finally, lacking access to care in and of itself creates like a pathology among youth. Kids who have experienced and young adults who have experienced discrimination or in states in which laws have been passed that bar access to care, we see increased rates of suicide attempts, we see increased searches for suicide online. So there is a number of consequences that are quite profound when kids lack access and young adults lack access to this care.

Q. Dr. Janssen, did you have an opportunity to review the regulation at issue in this case?

A. I did.

Q. And did you have an opportunity to review the GAPMS report in support of that regulation?

A. Yes.

Q. Did the GAPMS report take into account any of those harms you just discussed?

A. It did not.

Q. Dr. Janssen, in your opinion is the provision of gender-affirming medical intervention to treat gender

dysphoria experimental?

A. It is not experimental. It has a robust evidence base and is safe and effective.

MR. GONZALEZ-PAGAN: Thank you, Dr. Janssen.

No further questions, Your Honor.

THE COURT: Cross-examine?

MR. PERKO: Yes, Your Honor.

CROSS-EXAMINATION

BY MR. PERKO:

Q. I guess it's still morning, Dr. Janssen. Good morning. I just have a few questions.

A. Good morning to you.

Q. I just have a few questions for you.

Dr. Janssen, you're a psychiatrist, correct?

A. That is correct.

Q. You're not an endocrinologist?

A. Correct.

Q. And you're not a surgeon?

A. Not a surgeon.

Q. And the opinions you just expressed are based at least in part on your experience as a clinician. Is that fair to say?

A. In part, yes.

Q. And that would include personal observations?

A. Correct.

Q. It also include discussions with colleagues?

A. Correct.
Q. Moving on: You have been a member of WPATH since 2011; is that correct?
A. That's correct.
Q. And you served on the revision committees for the child and adult mental health chapters of Version 8 of the WPATH Standards of Care?
A. I did.
Q. And the adult chapter is Chapter Number 5; is that correct?
A. I believe the adult chapter is actually 18, but I don't have it in front of me, so I don't know the specific number. But it's the last chapter.
Q. And the chapter on children is Number 7?
A. Number 7 is correct.
Q. For those two chapters, did the authors include any individual who is not a medical profession?
A. In the child chapter, yes.
Q. And what was that author's field?
A. She was the parent of a transgender child and also ran a charity in the United Kingdom supporting transgender youth.
Q. To your knowledge, do all the individuals who assisted in drafting Chapter 18 approve of gender transition treatments to treat gender dysphoria?
A. Yes.

Q. Would the same be true for all the individuals who assisted in drafting Chapter Number 7?
A. Medical transition and surgical transition is not an indicated treatment for gender dysphoria in children, so it was not relevant to that specific chapter.
Q. Fair enough.
Now, these both chapters had to be ultimately approved by the board of directors of WPATH; is that correct?
A. It was approved through a Delphi process of all of the co-authors and involved the board, yes.
Q. Now, moving on. Doctor, you diagnose people with gender dysphoria, correct?
A. I do.
Q. And you counsel people before they are prescribed puberty blockers?
A. It depends upon the context in which we are engaging in care, but counseling is an important part of any informed consent decision. So if I'm involved in any way in the process of assessing readiness for a puberty-blocking medication or any other medical or surgical intervention, counseling is inherent to that process.
Q. And so you engage in counseling for patients if they are prescribed cross-sex hormones?
A. Yes.
Q. And surgeries also?

A. Yes.
Q. Now, your conversations on these issues, you discuss the risk and benefits of the treatments?
A. We do.
Q. And that conversation usually lasts more than 20 minutes, doesn't it?
A. It does. I think for many of the youth that I work with, I have been lucky enough to have a longitudinal relationship with many of the patients that I work with, so these discussions are happening over months to years as opposed to in a single session or two.
Q. And you said that you write letters in support of a person's decision to have surgery for gender dysphoria.
Did I understand that correctly?
A. You did.
Q. Now, Doctor, you've had years of training and experience to recommend surgeries, right?
A. Yes.
Q. And more than ten hours?
A. Yes.
MR. PERKO: I have nothing further, Your Honor.
THE COURT: Redirect?
MR. GONZALEZ-PAGAN: Just one question, Your Honor.

REDIRECT EXAMINATION

BY MR. GONZALEZ-PAGAN:

Q. Dr. Janssen, you were asked if there was a non-health professional involved in the drafting of the chapters that you were a co-author for with regard to Standards of Care 8.

Do you recall that line of questioning?

A. Yes.

Q. Is it inappropriate for a non-health stakeholder to be involved in the drafting of practiced guidelines?

A. No. It's actually a tremendous value. We want to have stakeholder experiences as a part of these processes to understand the real-world impact of the recommendations that are made and the insights from people who are actually experiencing the disorder around which we are making guidelines. And this, again, is not atypical to transgender health. This is relative standard of practice among many medical illnesses.

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

THE COURT: Dr. Janssen, I have a question just to make sure I understand correctly what you are saying.

You said, I think when Mr. Perko was asking you questions, that medical and surgical intervention isn't indicated for children. This goes back to what you and I were talking about earlier. By "children" there you mean prepuberty.

THE WITNESS: Correct. And that is the -- the child

chapter was specific to prepubertal.

THE COURT: Questions just to follow up on mine?

MR. PERKO: No questions.

MR. GONZALEZ-PAGAN: No questions, Your Honor.

THE COURT: Thank you, Dr. Janssen. We are going to disconnect your transmission at this point. Thank you.

THE WITNESS: Thank you. I'm sorry I couldn't be in person.

THE COURT: Tell me where we stand on the plaintiffs' side.

MR. GONZALEZ-PAGAN: Apologies, Your Honor.

Your Honor, we are primarily done with witnesses. There is an open question about records custodian from the defendants -- from the agency. We're in conversations about that. I know that they are trying to get one for today. It's been on our list. We alerted them yesterday about it, but --

THE COURT: What do we need a records custodian for? If it's just to authenticate things, let's find out whether there's an authentication objection.

MR. GONZALEZ-PAGAN: My understanding is there is no authentication objections to the exhibits.

THE COURT: So why do we need -- if you just got exhibits to offer, offer the exhibits, and I'll find out if there is an objection.

MR. GONZALEZ-PAGAN: Your Honor, our understanding

was there was no authenticity objections to the exhibits, but then when we were going through the list, they included a lack of foundation for them. Based on our understanding, covers authenticity, and so we are still working on that. That said, we also do have a number of exhibits that we are going to moving to admit into evidence.

THE COURT: Okay. Move them.

MR. GONZALEZ-PAGAN: But I don't know if my friend would like to address this point about the records custodian.

MR. JAZIL: Your Honor, we were asked to provide a records custodian after 5:00 p.m. yesterday. I haven't been able to locate one for today.

THE COURT: Well, offer the exhibits. I'll hear any objections, and then we'll deal with what the objections are.

MR. GONZALEZ-PAGAN: Thank you, Your Honor.

Your Honor, there are a couple of buckets, if you will. I will be handling some, and some of my colleagues will be handling others.

THE COURT: All right.

MR. GONZALEZ-PAGAN: Specifically, Your Honor, I first wanted to clear up -- I wanted to clear up one particular admission of an exhibit. The GAPMS report, the Court admitted both the GAPMS report as plaintiffs' exhibit which didn't contain the attachments last week, as well as the a defendants' version which included the attachments --

THE COURT: Got it.

MR. GONZALEZ-PAGAN: -- for the purposes of completeness as I understand it. We just wanted to clear up that the attachments were not being admitted for the truth of the matter asserted. We consider them to be hearsay within hearsay, and none of those experts have been called to testify, nor are they published peer-reviewed articles. They were just unpublished reports attached to the GAPMS report.

THE COURT: Well, they're certainly admissible to show what was done and the contemporaneous explanation of what was done. That's correct, isn't it?

MR. GONZALEZ-PAGAN: The fact that they were done, yes, Your Honor. I wouldn't consider these to enter -- we would posit that they shouldn't be entered to the truth of what the report states. I don't see how they are any different from any scholarly article that is actually peer-reviewed and cited within the GAPMS report for that matter.

THE COURT: Mr. Jazil?

MR. JAZIL: Your Honor, number one, it is a reflection of what the agency did.

THE COURT: I'll admit them for that purpose, surely.

MR. JAZIL: And if the point is that they are not expert opinions in and of themselves because no one has testified to that, Your Honor, we will be putting experts on

our own, to the extent that they rely on the particular GAPMS report and an attachment to the GAPMS report.

THE COURT: All true. If you put on witnesses, then they will testify. And if there is an objection to their testimony, we will deal with it when they testify. But I certainly anticipate that you will have experts who are allowed to testify and will give opinions that will be admitted into evidence.

If they issued a report and it said in an attachment the average height of individuals from England is 6 feet 5 inches, I would admit it to show what the agency did and what explanation was provided at the time. That may be a nonhearsay purpose; and, in any event, that would probably come in under 803(8) as a report of what the agency did, the report of its activities.

I would not admit that as substantive evidence that the average height of people in England is 6 feet 5 inches. It's just not. And the fact that the agency attaches some report where somebody makes an untrue, uncorroborated statement that would not itself be admissible doesn't make it admissible to show the truth of the matter. For that purpose, it seems to me it's inadmissible hearsay.

Is that analysis correct?

MR. JAZIL: Agree, Your Honor.

MR. GONZALEZ-PAGAN: That's --

THE COURT: The attachments are admitted as evidence of the office's activity under 803(8), and as relevant for a nonhearsay purpose; that is, to show what the agency did and the explanation it provided at the time.

MR. GONZALEZ-PAGAN: Thank you, Your Honor.

My colleagues, Ms. DeBriere and Ms. Dunn will handle the next update and admission of exhibits.

THE COURT: All right.

MS. DeBRIERE: Good morning, Your Honor, and thank you.

So I'll just be handling the exhibits that defendants have objected to, going line by line through each. Starting with Plaintiffs' Trial Exhibit 24, and I believe Ms. Gonzalez will help me by pulling them up for Your Honor.

THE COURT: All right.

MS. DeBRIERE: Plaintiffs' Trial Exhibit 24 is AHCA's automated prior authorization and bypass list. My understanding, Your Honor, is that defendants object to this exhibit on the basis of the lack of foundation, which speaks to my co-counsel's earlier reference to the authenticity and potential need for a records custodian as well as relevance.

I'm happy, Your Honor, to argue relevance, and then we can address the need for the records custodian.

So relevance, Your Honor, is related to AHCA's automated prior authorization and bypass list, speaks to those

drugs that AHCA covers without any demonstration of the need for medical necessity, and this is going to speak to our comparability argument, showing that certain drugs, they don't require any criteria in order to authorize.

THE COURT: What's wrong with that?

MR. JAZIL: Nothing, Your Honor. I just wanted someone to explain the relevance to me.

THE COURT: All right. Plaintiffs' Exhibit 24 is admitted.

(PLAINTIFFS' EXHIBIT NO. 24: Received in evidence.)

MS. DeBRIERE: The next exhibit is Plaintiffs' Trial Exhibit 21, which is Florida Administrative Code Rule 59G-1.010.

THE COURT: You can admit that, but you don't need to. It's like putting a statute or a rule in evidence. I would -- that's something I look at every day, so if you want to put it in evidence, that's fine. Plaintiffs' 21.

(PLAINTIFFS' EXHIBIT NO. 21: Received in evidence.)

MS. DeBRIERE: Thank you, Your Honor. Related to that is Florida Medicaid definitions policy at Plaintiffs' Trial Exhibit 22. That is incorporated by reference by 59G-1.010.

THE COURT: Same thing, I think, it doesn't hurt to have it handy. If it's incorporated by reference, I'm sure I could find it, but sometimes those things are better admitted

into evidence so that I don't have to search for it and make sure I have the right one. The problem with Googling things is, of course, you can sometimes 15-year old documents that aren't what you were looking for.

Is there a problem with Plaintiffs' Exhibit 22?

MR. JAZIL: No, Your Honor.

THE COURT: Plaintiffs' Exhibit 22 is admitted.

(PLAINTIFFS' EXHIBIT NO. 22: Received in evidence.)

MS. DeBRIERE: Your Honor, the next exhibit is Plaintiffs' Trial Exhibit 74. Objections include lack of foundation, relevance, and hearsay.

And, Your Honor, this is a public record produced by the Office of Substance Abuse and Mental Health, which is a division of the Health and Human Services; and, of course, that division regularly engages in the activity of releasing publications related to advancing behavioral health in the U.S., which would include this document.

Relevance speaks, of course, Your Honor, to the title of the document, and that's HHS's position on the actions to support LGBTQ, plus youth, including of course supporting individuals who are transgender.

THE COURT: Give me just a minute.

Mr. Jazil, do you object?

MR. JAZIL: Yes, I do. It's a 111-page report. I don't know what sections of are or aren't relevant to this

case. The report includes a section on the state of the evidence, et cetera. So, first, Your Honor, I'm not entirely clear what it is we are admitting this for, what sections of it we believe are relevant, and whether or not the materials in it would be --

THE COURT: Well, how about this -- it's a question. If I understand it correctly, there is evidence that the way the State got involved in this at all is something like this:

The State paid for this care under its Medicaid plan for years. There is a GAPMS report back when the State started doing this that approved it. Then the federal government issued some guidance that apparently -- I guess the plaintiffs would say raised the hackles of the people in the state, and in reaction to that, they triggered a new GAPMS report and we came up with a new rule.

I don't know the timing. So the answer may be this wasn't it. Why isn't this admissible at least to show the activities of the federal government to which the State reacted?

MR. JAZIL: Your Honor, I don't know if that's the reason why it's going to be introduced into evidence. I believe this report is from 2023. I also don't know whether or not the state of the evidence cited in it is being offered for the truth of the matter asserted.

THE COURT: Well, that's a different question. Then

my next question about it is:

You have made a big deal out of the alleged position of European countries. In fact, I just got in your memo in the related case where you continue to say that Florida is just like the European countries.

And just parenthetically I'll tell you, I scratch my head every time because I think it's just not. So you seem to adopt the theory that anything you say three times or 300 times is true, and it's not.

But part of what you have hammered again and again and again is the position taken by European countries.

This is the position taken by the United States. If you can continue to push what the European countries say, why can't they show what the United States said?

MR. JAZIL: Understood, Your Honor. If this is being admitted to show the United States' position, that is one thing. If it's being used to show the state of the evidence, that's another thing. So perhaps the caveat that your Your Honor has the GAPMS report.

THE COURT: I think that's exactly right. Part of the discussion here is what's the standard in the profession, and so we have had witnesses talking about all of the literature and dealing with things. So the peer-reviewed literature is certainly, to me, a lot more reliable than the position that some government has taken.

But the positions that governments have taken are part of assessing the overall lay of the land and what's going on out there. And so we had a witness -- and you may have witnesses, I take it, there have been changes not only in Europe, there have been changes in the United States among various states, and I think this admissible to show the activities of the federal government. I'll admit it for that purpose.

I'm certainly not going to make a finding on a medical issue, for example, based on some statement that is made in a government publication without backup that is not supported by experts or other testimony in the record. I do think for that purpose this is hearsay.

If it was actually a finding, that would be different. I take it, just having looked briefly at this, these are not findings you are admitting for that purpose, but just to show the activity of the office. You are nodding "yes."

MS. DeBRIERE: That's correct, Your Honor.

THE COURT: So it's admitted for that purpose.

What's next?

(PLAINTIFFS' EXHIBIT NO. 74: Received in evidence.)

MS. DeBRIERE: The next exhibit is Plaintiffs' Trial Exhibit 27, which is AHCA's prior authorization criteria for coverage of testosterone. The objections are authentication,

lack of foundation, and relevance. So, Your Honor, I can argue relevance which is --

THE COURT: Mr. Jazil, isn't that admissible? Agencies can change positions. That's certainly okay. There has been development through the decades on what has to be shown to support an agency's change of position. But at least they should be able to show that the agency has changed position.

MR. JAZIL: Your Honor, this isn't a document that we produced. It has a plaintiffs' Bates label.

MS. DeBRIERE: I can help clarify, Mr. Jazil. So on our stipulated exhibits list, we provided two online links, one to AHCA's preferred drug -- PDL, preferred drug list, as well as AHCA's drug criteria. AHCA's drug criteria has a list of drugs. This testosterone document is one of those criteria. It is the documents that live on your website, and since you've stipulated to the admissibility of any documents that are on that website, you know --

THE COURT: All right. This goes back to something I said a minute ago. Not everything you find on the internet is actually authentic. But if it's on your website, it probably is. You just -- if you need to check out and find out if it really is; although, I would have hoped that got done during the pretrial process, but --

MR. JAZIL: Your Honor, I will take my friend's word

at face value. If she says it's off our website, it's off our website, I'll withdraw the authentication objection.

THE COURT: All right. Look, you have folks there that are really good at checking on this kind of thing. So if you go back and find out this isn't really it, then you bring it back up and we'll straighten it out.

MR. JAZIL: Yes, Your Honor. As I understand it before, my friend is objecting that the relevant issues are overcome because they go to the comparability claims, and so --

THE COURT: Relevance is the low standard. Plaintiffs' 27 is admitted.

(PLAINTIFFS' EXHIBIT NO. 27: Received in evidence.)

MS. DeBRIERE: Your Honor, the next exhibit is Plaintiffs' Trial Exhibit 28. These are the agency's responses to plaintiffs' questions dated March 1, 2023. These -- the objection, Your Honor, is relevance. These were responses provided to us after the first round of the 30(b)(6) deposition in which the designee could not answer all of the questions for the topics which we noticed him for.

MR. JAZIL: Your Honor, I had the relevance objection based off of my perspective that under *Rush*, the process doesn't matter, but --

THE COURT: That's overruled. And what makes bench trials easier than jury trials is, if it's irrelevant, it

won't matter. Plaintiff's 28 is admitted.

(PLAINTIFFS' EXHIBIT NO. 28: Received in evidence.)

MS. DeBRIERE: Your Honor, the next exhibit is Plaintiffs' Trial Exhibit 67. This is a document from the Food and Drug Administration entitled "Understanding unapproved use of approved drugs off label."

Your Honor, the objections are lack of foundation, relevance, and hearsay. I can speak to hearsay inasmuch as this is a public document taken off of the FDA's website. I'm happy to provide the Court the URL.

As to relevance, there has been a lot of reliance in the GAPMS memo on the drugs not being FDA approved for indications, which is off-label a short form for not having a FDA-approved use for a particular indication of a drug. So this is just further description of what and when it's appropriate to authorize drugs for an off-label use.

MR. JAZIL: Your Honor, this is, as I understand, a Q&A off an FDA website. It's not the same as an FDA rule. It is not the same as an FDA guidance document. To the extent it's being used to establish that off-label use is appropriate under certain circumstances, I don't think that is an appropriate use of this.

THE COURT: I will admit this under 803(8). This is another one of those. I mean, no matter how many times you and your experts say it, the fact that a use is not the use

that was approved by the FDA at the outset when the drug came to market does not indicate that use of the drug is unsafe. It just doesn't. It's the kind of thing that advocates take to a legislative hearing I think in hoping that the legislators just won't understand, or that you take to a rule hearing in the hope that, well, it's just something you can put on the scale so that you can explain some decision made on some other basis.

However that might be -- and from that comment, you can tell that when you put your experts on to hammer on this not approved by the FDA, they are going to have some explaining to do, and I'll listen carefully to the explanation.

But aside from that, I do think that this is at least what the FDA says about this, and it's admissible.

Plaintiffs' 67 is admitted.

(PLAINTIFFS' EXHIBIT NO. 67: Received in evidence.)

MS. DeBRIERE: Your Honor, the next exhibit is Plaintiffs' Trial Exhibit 62. This is the CMS EPSDT, a guide for states regarding the coverage of the EPSDT Medicaid benefit. It's a public document. I would -- also add from the Centers for Medicaid and Medicare Services. I would also point out that this document has been previously cited in other courts within the Eleventh Circuit, including *CR v. Noggle*, which is at 559 F.Supp.3d 1323.

THE COURT: Mr. Jazil, anything different about this? This is the government's activities and what CMS says about how this works?

MR. JAZIL: No, Your Honor. Your previous rulings are clear to me.

THE COURT: This is admitted under 803(8).

(PLAINTIFFS' EXHIBIT NO. 62: Received in evidence.)

MS. DeBRIERE: Your Honor, the next exhibit is Plaintiffs' Trial Exhibit 63. This is a CMS informational bulletin regarding beneficiary protections and Medicaid drug coverage. This again is a public document, and as to relevance --

THE COURT: Same thing. Plaintiffs' 63 is admitted.

(PLAINTIFFS' EXHIBIT NO. 63: Received in evidence.)

MS. DeBRIERE: Thank you, Your Honor.

Plaintiffs' Trial Exhibit 295, the objection here, Your Honor, is lack of foundation. This was a document produced to plaintiffs in response to a subpoena to the Executive Office of the Governor. And so there is no relevance objection, so I will just speak to the lack of foundation.

THE COURT: Is there a foundation problem?

MR. JAZIL: Your Honor, I'll confess this does come from the Executive Office of the Governor, but to me foundation is more than just authenticity. And I don't know

what we are doing with this document. Is it just going to be introduced into evidence and --

THE COURT: Well, look, here's an important issue in the case: motivation, animus. I think it matters whether this rule started and was adopted by medical professionals exercising their medical judgment, or whether it started in the governor's office with nonmedical personnel who basically sent word down to the doctors, here's what you're to decide.

Now, I don't know what the answer to that is. And, of course, it could start with the governor's office and get pushed down to doctors who then make a good medical decision. So where it started doesn't tell you how the decision was made, but it's certainly relevant how this works. And I have seen this before, although I can't read it on the screen.

The chance that this document is going to affect the decision is pretty remote. It doesn't concern me that somebody in the governor's office is keeping up with how this process works. I probably would be surprised if they weren't. They probably ought to be keeping up with everything that goes on in the state, and I think they probably do. So I don't think this is going to make much difference. But the fact that it's there and they are keeping up with it is at least relevant.

As I said before, relevance is a very low standard. Is the chance that the governor initiated this greater than it

would be without this evidence, that's the 401 test, yeah, it does show that at least somebody in his office was paying attention.

MR. JAZIL: Your Honor, my objections are borne in part from, are we going to have a witness talk about these things or am I going to be, you know, confronted with these in summation, where there is a story told with some of this?

THE COURT: Well, you may be confronted with it in summation, but if they don't know who did it or what they did with it or when it came up, they are going to better spend their time on something else.

MR. JAZIL: Understood, Your Honor.

THE COURT: Because this isn't going to tell me much. On the other hand, you're probably going to have a witness from AHCA.

MR. JAZIL: Yes, Your Honor.

THE COURT: They might even ask that witness questions about it or maybe you will. This is admissible.

MR. JAZIL: Understood, Your Honor.

THE COURT: Plaintiffs' 295 is admitted.

(PLAINTIFFS' EXHIBIT NO. 295: Received in evidence.)

MS. DeBRIERE: Your Honor, the next exhibit is Plaintiffs' Trial Exhibit 296. This is similar, Your Honor, to 295. The objection is lack of foundation.

THE COURT: Same thing, same ruling. 296 is

admitted.

(PLAINTIFFS' EXHIBIT NO. 296: Received in evidence.)

MS. DeBRIERE: The next exhibit is Plaintiffs' Trial Exhibit 330. The objections are lack of foundation, relevance, and hearsay.

Your Honor, this is a draft memo of a GAPMS for specially-modified foods. This came from AHCA. It was produced to us in discovery. The relevance, Your Honor, is showing what information was previously relied on in the GAPMS process to determine whether the service was experimental.

MR. JAZIL: Your Honor, there is also a hearsay objection. I don't know if this was ever finalized or not. As I understood the exception for public records, it's an agency position. This is a draft that's unsigned.

THE COURT: Is this just a draft?

MS. DeBRIERE: It is just a draft, Your Honor, and it is unsigned.

THE COURT: How does it show what they relied on if we don't know they relied on it?

MS. DeBRIERE: As much as it's not finalized, I think the collection and organization of the information in the GAPMS memo shows that the agency uses that type of information to eventually reach a conclusion.

THE COURT: Only if they used it. I mean, if this is somebody internally there that wrote some memo and it got

tossed to the curb, it doesn't show that that's the kind of thing they used. It may indicate the kind of thing that they don't use, right?

MS. DeBRIERE: Yes, Your Honor.

THE COURT: That one is excluded, unless you can show that this actually corresponds with something that was done or --

MS. DeBRIERE: Your Honor, the next exhibit is Plaintiffs' Trial Exhibit 331. This is a final signed version of a GAPMS related to scleral contact lenses. Same argument, Your Honor. This is the type of information that the agency relies on in determining whether a service is experimental.

MR. JAZIL: Your Honor, my only objection was relevance.

THE COURT: Overruled. Plaintiffs' 331 is admitted.

(PLAINTIFFS' EXHIBIT NO. 331: Received in evidence.)

MS. DeBRIERE: Your Honor, Plaintiffs' Trial Exhibit 332. This is another GAPMS memo.

THE COURT: Same thing?

MS. DeBRIERE: Signed and finalized.

MR. JAZIL: Yes, Your Honor, same objection, relevance.

THE COURT: 332 is admitted.

(PLAINTIFFS' EXHIBIT NO. 332: Received in evidence.)

MS. DeBRIERE: And Plaintiffs' Trial Exhibit 333.

Same arguments, Your Honor.

MR. JAZIL: Yes, Your Honor.

THE COURT: Same ruling, Plaintiffs' 333 is admitted.

(PLAINTIFFS' EXHIBIT NO. 333: Received in evidence.)

MS. DeBRIERE: Next exhibit, Your Honor is Plaintiffs' Trial Exhibit 291. Your Honor, the objection to this is relevance. This is an email from Jason Weida, Secretary Weida, to Devona Pickle and Andre Van Mol regarding the payment to Dr. Van Mol by AHCA for participating in the GAPMS process. And so it goes to show, Your Honor, the process that was used in drafting the GAPMS and adopting the final Challenged Exclusion.

THE COURT: I don't see the attachment. Was there an attached itemized charge?

MS. DeBRIERE: It should be there now, Your Honor.

THE COURT: Why isn't this admissible to show who drafted the document?

MR. JAZIL: Your Honor, I just had a relevance objection to it, but --

THE COURT: Isn't that -- Dr. Van Mol wrote the document. Isn't that relevant? Is that what the background document is, master background document? Do we know what that is?

MR. JAZIL: Your Honor, I believe this is referring to just the invoices.

THE COURT: Well, the hours he's charging for, the first item on the list is *Research and drafting of master background document*.

MR. JAZIL: I believe that's a bibliography he provided. I had a relevance objection to this, Your Honor. As I understand my friend's point, this goes to the process, and we've just been consistently making objections to the process.

THE COURT: All right. So that objection is overruled in any event. So Plaintiffs' 291 is admitted.

(PLAINTIFFS' EXHIBIT NO. 291: Received in evidence.)

MS. DeBRIERE: Your Honor, the next exhibit is Plaintiffs' Trial Exhibit 292. This is a very similar document to the one we just reviewed. It's regarding invoices from Romina Brignardello-Petersen to AHCA regarding payment for her participation and adoption --

THE COURT: Scroll that down. What does the list say? Nothing. Look, here's what happens with these kind of invoices, you are welcome to ask any expert how much they have been paid.

MR. JAZIL: Your Honor, 292(a) is the accompanying document which is the attachment.

THE COURT: Is this the same thing?

MR. JAZIL: We have a relevance objection.

MS. DeBRIERE: I'm sorry. It did not make it on my

list. I apologize.

MR. JAZIL: 292 and 292(a), we have the relevance objections.

THE COURT: But same, based on process?

MR. JAZIL: Yes, Your Honor.

THE COURT: Overruled. So 292 and 292(a) are admitted.

(PLAINTIFFS' EXHIBIT NOS. 292 and 292(a): Received in evidence.)

MS. DeBRIERE: Plaintiffs' Trial Exhibit 313 is our next one. The objection here is relevance. This is a discussion, Your Honor, between AHCA employees regarding a policy transmittal and later a provider alert, speaking to continuity of coverage once the Challenged Exclusion was put into place as to whether they should notify individuals that they would be entitled to a continuity of care protections until the final implementation of the exclusion. And that, Your Honor, demonstrates that they were previously providing care.

MR. JAZIL: Your Honor, I had a relevance objection. I didn't understand what it was being used for.

THE COURT: Plaintiffs' 313 is admitted.

(PLAINTIFFS' EXHIBIT NO. 313: Received in evidence.)

MS. DeBRIERE: Next exhibit is Plaintiffs' Trial Exhibit 313(a). I probably should have spoken to these

together.

THE COURT: Same ruling, 313(a) is admitted.

(PLAINTIFFS' EXHIBIT NO. 313(a): Received in evidence.)

MS. DeBRIERE: Plaintiffs' Trial Exhibit 314, which is -- the objection is based on relevance, and, again, is just further email conversation between AHCA employees about the provider alert.

THE COURT: Same issue?

MR. JAZIL: Yes, Your Honor.

THE COURT: Same ruling, 314 is admitted.

(PLAINTIFFS' EXHIBIT NO. 314: Received in evidence.)

MS. DeBRIERE: Plaintiffs' Trial Exhibit 315, this is the draft policy transmittal, Your Honor, that the emails are discussing, and the objection is relevance.

THE COURT: 315 is admitted.

(PLAINTIFFS' EXHIBIT NO. 315: Received in evidence.)

MS. DeBRIERE: And then Plaintiffs' Trial Exhibit 316, objection is relevance. It's a sign-off form regarding the provider alert.

THE COURT: Same issue, same ruling, 316 is admitted.

(PLAINTIFFS' EXHIBIT NO. 316: Received in evidence.)

MS. DeBRIERE: Next exhibit is Plaintiffs' Trial Exhibit 254. The objections are foundation and hearsay. Your Honor, because these are statements made by employees of defendant, they are party admissions and not hearsay under

801(d)(2). We do have the foundation issue which is why we raised the records custodian.

THE COURT: This is 254?

MS. DeBRIERE: Yes, Your Honor.

THE COURT: And what's the objection?

MR. JAZIL: I don't know what the role these people play to the agency and whether or not they had authority to talk about these issues in the manner they are talking about.

THE COURT: So when somebody sends a memo and says, "Please work on creating criteria for approval of agents used to suppress puberty and transgender children," you think that's not within the scope of their work?

MR. JAZIL: Your Honor, I can't tell from the emails. I apologize, Your Honor. I read these a while ago, but I can't tell readily whether that is, in fact, the case.

MS. DeBRIERE: Your Honor, I will note that we have deposition testimony identifying Arlene Elliott as a program administrator in the pharmacy section for AHCA.

THE COURT: Well, is it in evidence? Maybe you don't need it. Just authenticate the document. But the hearsay objection is overruled. If that's all we are dealing with, 254 is admitted.

(PLAINTIFFS' EXHIBIT NO. 254: Received in evidence.)

MS. DeBRIERE: Your Honor, there are going to be similar arguments for the remaining exhibits, beginning with

Plaintiffs' Trial Exhibit 255.

THE COURT: You have a series that are all internal memos?

MS. DeBRIERE: Emails, yes, Your Honor. And the objections are the same for all of them, foundation and hearsay. So we would state that it's not hearsay because it's a party admission.

THE COURT: Read the numbers out.

MS. DeBRIERE: 255, 263, 276, and 346.

THE COURT: The ruling is going to follow the same pattern. If you get to those and one of those, you have reason to assert that it's not within the course and scope and that I can't find it within the course and scope based on the document itself, if there is a specific issue, you can bring it back.

MR. JAZIL: Yes, Your Honor.

THE COURT: But those are the admitted --

(PLAINTIFFS' EXHIBIT NOS. 255, 263, 276, 346: Received in evidence.)

THE COURT: -- subject to any reconsideration you bring back to me based on the specific document.

MR. JAZIL: Yes, Your Honor.

THE COURT: If we don't speak to it further, they are part of the record, they are admitted.

MS. DeBRIERE: Your Honor, that concludes my portion.

THE COURT: All right. Are there some with no objection?

MS. DUNN: There's one other outstanding issue with regard to the exhibits. During the testimony of Jeff English, Plaintiffs' Exhibit 302 was discussed extensively, and I believe that the Court indicated that it would be admitted as a party admission, but the transcript for that day does not reflect that it was, in fact, admitted into evidence.

THE COURT: Long experience teaches me to believe that, when I remember what happened and the transcript says something different, the transcript is always right.

MS. DUNN: It was probably an oversight on our part.

THE COURT: That's the email chain.

MS. DUNN: Yes.

THE COURT: 302 is admitted.

(PLAINTIFFS' EXHIBIT NO. 302: Received in evidence.)

THE COURT: Other exhibits? What else?

MS. DUNN: Yes, Your Honor, in our pretrial disclosures that were filed we indicated a number of a deposition disclosures that we would be moving into evidence. I have those copies of the depositions with those designations highlighted. I have a copy for defendants as well. If I can approach --

THE COURT: Yes.

MS. DUNN: -- the Court?

THE COURT: I look forward to reading them.

MS. DUNN: I'd ask the Court to move those into evidence as well.

MR. JAZIL: Your Honor, I believe there is a caveat with Mr. Brackett and Ms. Dalton that these designations would come in if they did not testify live. They will be testifying.

THE COURT: They both work for the department?

MR. JAZIL: Yes, Your Honor.

MS. DUNN: Ms. Dalton is the bureau chief for the Bureau of Medicaid Policy, and Mr. Brackett was the agency's 30(b)(6) representative.

THE COURT: Well, you can admit the 30(b)(6) and probably Ms. Dalton's deposition. Let me tell you my experience, frankly, I learned the hard way as a young lawyer. When there is a witness testifying live, the chance that the deposition testimony is going to make any difference or be credited differently from the live testimony is pretty slim.

Probably when the witness testifies live and you cross-examine, including with anything inconsistent in the deposition, I'll have what I need. If you nonetheless want to admit these, I think you are entitled to it. Under the deposition rule, a deposition of an opposing party, you can always put in the substantive evidence.

So I will expect to admit these and treat them as

part of the record. These are people who are equivalent of the defendant within the meaning of that rule, are they not, Mr. Jazil?

MR. JAZIL: They are. I never made a cross-designations because of the caveat that they were being --

THE COURT: And as long as what you want to say gets said from the witness stand, it won't matter whether it was cross-designated in the deposition as well, and this -- what's said in here, I'll admit it. These are parts of the depositions of Mr. Brackett, Ms. Dalton, and Mr. Donovan. And the actual notebooks, I'll keep with the record.

MS. DUNN: We can also file those transcripts on the electronic case record.

THE COURT: That would be good. Do that as well, and then I will --

MS. DUNN: Those are full copies of the transcripts. Just the designated portions are highlighted.

THE COURT: Figure out whether you can file those electronically and the highlighting works. Figure out how to do that. It makes it much easier if we don't have to mail the -- or ship the hard-copy transcripts to the Circuit. It's harder for them to find it.

Frankly, when it gets to the Circuit, there will be three judges and three sets of law clerks, and if all of them

can get to this electronically, it's much better than trying to find the one set of pretty white notebooks that are somewhere in Atlanta.

MS. DUNN: Absolutely, Your Honor.

THE COURT: What else?

MR. GONZALEZ-PAGAN: Thank you, Your Honor. That would conclude the presentation of evidence from the plaintiffs.

THE COURT: The plaintiffs rest?

MR. GONZALEZ-PAGAN: Yes, Your Honor, with the caveat that -- I believe, it is my understanding that 254 has been signed this morning. So there will be a motion to amend that will be filed in short order to include Section 3 of --

THE COURT: 254 is the bill that we talked about last week.

MR. GONZALEZ-PAGAN: Correct, Your Honor.

THE COURT: It has been signed this morning?

MR. GONZALEZ-PAGAN: That is my understanding, Your Honor.

THE COURT: All right. I'll give thought to it over lunch to what that means or doesn't mean. I don't think it affects the substance. At least the core substance of the case is the not affected, right?

MR. JAZIL: My perspective, I still need to get some guidance from my client. I heard it being signed by

Ms. Chriss during the break. From my perspective, if my friends for the plaintiffs in this case are challenging Section 3 that deals with the Medicaid provision, it should not affect the core issue as framed by *Rush*. Section 3 would still have to pass the, as I understand it, the *Rush* test as the Court laid out.

There are separate claims on the equal protection, et cetera. And, again, I understood my friend's colloquy with the Court earlier, they will be moving to amend to include a challenge to the Section 3, they rested their case, there is no new discovery, and that would be the motion.

Your Honor, I'm asking the Court and my friends for some guidance, because during the break I will go out and try to figure things out.

THE COURT: You want to amend the challenge of the statute.

MR. GONZALEZ-PAGAN: That is correct.

THE COURT: It does seem to me that that -- before I finish that sentence, I should say this:

Sometimes when I reach a conclusion in 10 or 15 seconds, it turns out not to be correct. Sometimes when I reach a conclusion after 15 months, it turns out not to be correct, but it's better than in 10 or 15 seconds.

Just having heard it, it does seem to me that this renders moot the challenge to the rule. The adoption of the

rule may still be relevant on the question of animus, motivation, and whatever in an attenuated way, a different decision-maker, different process. So it could be relevant. But a challenge to the rule itself now is probably moot; is it not?

MR. GONZALEZ-PAGAN: Your Honor, if I may. We would argue that the Affordable Care Act claim for which we have asserted nominal damages, and there have been instances that have come out in testimony about past discrimination, including the rejection of prior authorization to Plaintiff Brit Rothstein. The passage and enactment of 254 would not render that part of the case moot in any way.

Out of an abundance of caution either way, I think our intent is to proceed to amend to include only Section 3 of 254. It is my understanding that my colleagues and friends working on the *Doe v. Ladapo* case are asserting claims as to the rest of the aspects of 254.

THE COURT: And Section 3 is just the --

MR. GONZALEZ-PAGAN: State funding and specifically as to Medicaid, Your Honor.

THE COURT: Well, it may be right. If there is a nominal damages claim, the defendant is just the --

MR. GONZALEZ-PAGAN: In this case, it would be the same parties. And we would argue, I believe which is what my friend was asking about, that the presentation of the evidence

in terms of substance is truly the same, and so that would be how we would be proceeding to the Court.

THE COURT: You don't plan to have any evidence about the legislative process?

MR. GONZALEZ-PAGAN: Your Honor, from our position, we -- I think we can discuss that. But many of the aspects that have to do with the legislative process, we would argue the Court is empowered to make findings as to those aspects without the need for trial testimony, they're judicial legislative fact-finding.

I would just argue that we need -- our case is not completely moot. It just means we need to challenge both 254 and the rule. The judgment needs to apply to both.

THE COURT: You think you can get nominal damages against a state official in his official capacity?

MR. GONZALEZ-PAGAN: Yes, Your Honor. In fact, I argued that before the Fourth Circuit, and I can confirm that sovereign immunity has been waived at least as to the Fourth Circuit and cert was denied.

THE COURT: If you were in the Eighth Circuit, you would have an easier case. But you are in the Eleventh Circuit, so I get it. If I have dealt with a nominal damages claim against a state official, I have forgotten it, so I will go back and give it some thought.

But, in any event, do you have a written amended

complaint?

MR. GONZALEZ-PAGAN: We will be filing it probably later this evening, Your Honor. We are working on it.

THE COURT: But it's not going to surprise Mr. Jazil?

MR. GONZALEZ-PAGAN: I do not intend it to do so, and we are happy to share it with our friends before filing it as well.

MR. JAZIL: Your Honor, just a couple of other points of clarification. Because the state statute is being challenged, perhaps my friends can also notify the Attorney General's Office.

Second, Your Honor, again, as I understand it, the Section 3 deals with public post-secondary institutions, group healthcare plans and the managed care plans, and it's under Chapter 49. My understanding is this is still challenged, the managed care plans, AHCA. My friend is nodding in the affirmative.

MR. GONZALEZ-PAGAN: That is correct.

THE COURT: And notice to the Attorney General, at least in the local rule -- and I looked back -- isn't that required when there is not an official capacity state official as a defendant?

MR. JAZIL: Your Honor, I think as I'm coming up to speed with the signing of the legislation, I can't remember whether it's in the local rule or whether it's a Florida

statute that requires the Attorney General to be notified. I apologize, Your Honor.

THE COURT: All right. We can deal with those.

You are ready to go ahead with the presentation of evidence?

MR. JAZIL: Yes, Your Honor.

THE COURT: All right. Let's take an hour for lunch. That makes it 1:45 we'll start back. Good luck with the weather and the lunch break. I will see you back here in an hour and two minutes.

(*A luncheon recess was taken at 12:44 p.m.*)

AFTERNOON SESSION
(1:45 P.M.)

THE COURT: Please be seated. Mr. Perko, please call your first witness.

MR. PERKO: Your Honor, the defendants call Dr. Paul Hruz.

DEPUTY CLERK: Please raise your right hand.

PAUL WILLIAM HRUZ, DEFENSE WITNESS, DULY SWORN

DEPUTY CLERK: Be seated.

Please, state your full name and spell your last name for the record.

THE WITNESS: Paul William Hruz, H-r-u-z.

DIRECT EXAMINATION

BY MR. PERKO:

Q. Dr. Hruz, what positions do you currently hold?
A. I am currently an associate professor of pediatrics and associate professor of cellular biology and physiology at Washington University in St. Louis.
Q. Do you also hold any clinical positions?
A. I am also serving as the associate fellowship program director, a position that I previously held as the director.
Q. Could you please summarize your educational background?
A. I received a Bachelor of Science degree in chemistry at Marquette University. I then received my Ph.D. in biochemistry and my M.D. at the Medical College of Wisconsin. I completed my residency training in general pediatrics at the University of Washington in Seattle, and my fellowship training in pediatric endocrinology at Washington University.
Q. Are you a member of any medical organizations?
A. Yes. I am currently a member of the American Diabetes Association, the Pediatric Endocrine Society, and the Endocrine Society.
Q. Do you hold any professional certifications?
A. I am board certified in pediatrics and pediatric endocrinology, and I also have a certification in healthcare ethics.
Q. Have you ever served as a peer reviewer for any journal or grant-funding agency?
A. Throughout my 25-year career, I have routinely served as

a peer reviewer for a variety of journals, the same top-tier journals that I submit my own papers for publication, and I have also served as a reviewer on several grant review study sections including for the American Diabetes Association and for the National Institute of Health.

Q. Can you please summarize your professional experience since obtaining your degrees?

A. In my role as a pediatric endocrinologist and physician scientist, I devote my time to several different areas. This includes direct patient care, research, and the education of residents, medical students and clinical fellows.

Throughout my career, I have also taken on roles in leadership as I served as the chief of our division of pediatric endocrinology and diabetes at Washington University.

Q. Could you please explain what role research plays in your work?

A. In my research roles, for two decades, I have run a basic science research laboratory that for over a decade focused on questions related to adverse metabolic effects of various drug exposures and have transitioned into investigation of new drug discovery.

Within that context, I became very much involved in understanding the regulatory process, what is necessitated in evaluating the safety and efficacy of various medications

that are used in the treatment of various diseases.
Q. And is gender dysphoria one of those disorders?
A. I began investigating gender dysphoria about a decade ago, as the proposition was made at my institution to begin a gender center there. That necessitated me in my role as chief of our division to systematically look at the quality and nature of the evidence that was being put forward to justify the creation of that center.
Q. Dr. Hruz, what are some of the pediatric endocrine disorders that you treat?
A. As a pediatric endocrinologist, I treat a variety of hormone diseases, diseases that are caused either by a deficiency in the production or action of hormones. And by that, I mean substances that are made and secreted from one part of the body that act in a different part of the body. This includes treatment of disorders of metabolism, like diabetes mellitus, pituitary abnormalities, disorders of thyroid function, disorders of growth and development, disorders of sexual development, and puberty disorders, also includes diseases relating to abnormal menstrual function.
Q. And what's your understanding of gender dysphoria?
A. Gender dysphoria is a diagnostic term that refers to a condition in which one experiences a sense of their gender identity that is discordant with their biological sex. This diagnostic category became in use with the publication of the

Fifth Edition of the Diagnostic and Statistical Manual that is used in the field of psychiatry superseding the previous diagnosis of gender identity disorder.

Q. How does the diagnosis of gender dysphoria differ from the diagnoses for the other pediatric endocrine disorders that you treat?

A. In all of the endocrine disorders that I encounter in my practice, with the exception of gender dysphoria, there are objective, biological, radiologic or clinical features that allow for an objective diagnosis assessment of a response to treatment. This is in contrast with gender dysphoria where, to my knowledge, there is not a single biological or radiologic or objective test that can be used in the way that endocrinologists use to treat other diseases.

Q. Thank you, Doctor. I need to back up. I forgot one question.

Did you submit a curriculum vitae attached to your expert report in this case?

A. Yes, I did.

Q. And does it accurately summarize your professional experience and education?

A. Yes, it does.

Q. Does it contain a list of your publications?

A. It does.

MR. PERKO: Your Honor, I believe it's on the

stipulated exhibit list as Exhibit DX29. Ask it to be admitted.

THE COURT: DX29 is admitted.

(DEFENDANTS' EXHIBIT NO. 29: Received in evidence.)

BY MR. PERKO:

Q. Now, Dr. Hruz, I would like to talk to you a little bit now about treatments for gender dysphoria.

What are the various treatment approaches for gender dysphoria?

A. Well, there have been various terms that have been used, but they can generally be categorized into three different approaches to alleviate the suffering that people experience from this sex-discordant gender identity.

MS. RIVAUX: I'd like to object. I don't know if he is being qualified on all of these topics.

THE COURT: What are you tendering him as an expert in?

MR. PERKO: I will tender him as an expert in endocrinology, pediatric endocrinology.

THE COURT: Do you have questions at this tome?

MS. RIVAUX: If the topic is solely pediatric endocrinology, I don't have any questions. If it goes beyond the scope of that qualification, then, yes, I would have some questions.

THE COURT: This is your time to voir dire if you

wish to voir dire on credentials. Otherwise, you can object to questions as they come up and you can cross-examine.

Do you wish to ask questions now?

MS. RIVAUX: I'll object as they come along.

THE COURT: All right.

BY MR. PERKO:

Q. Let me ask that question again, Doctor.

What are the various treatment approaches for gender dysphoria?

A. As I had begun to explain, there are three categories of intervention to alleviate the suffering that individuals experience because of sex-discordant gender identity. They can be grouped into a reparative approach, a watch-and-wait or expectant approach, or the affirmative approach.

Q. What is the reparative approach?

A. All of the three approaches all differ with respect to the scientific premise and the goal of the intervention. The reparative approach is based upon the premise --

THE COURT: Wait just a minute.

MS. RIVAUX: I'm going to object, Your Honor. This is outside the scope of pediatric endocrinology.

MR. PERKO: I don't believe it is, Your Honor. It talks about hormonal treatments.

THE COURT: Doctor, how many patients have you treated for gender dysphoria?

THE WITNESS: As will be stated in my testimony, in my review of the literature, I have concluded that the risk versus relative benefit --

THE COURT: Let me stop you. If you can just answer my question: How many patients have you treated for gender dysphoria?

THE WITNESS: I have not because of ethical concerns about the safety and efficacy of that treatment.

THE COURT: How is he going to testify about treating patients when he's never treated one?

MR. PERKO: He's familiar with the literature, Your Honor.

THE COURT: If he read about cardiology, could he come and testify about cardiology?

MR. PERKO: Well, Your Honor, this is specifically related to the subject of endocrinology.

THE COURT: If you want to ask him questions about his expertise on pediatric endocrinology, you may certainly do it. But if all he's going to testify about is something unrelated to endocrinology, that he's never done, I'm not sure I understand the basis on which you think he can testify.

MR. PERKO: He's going to be testifying about puberty blockers and cross-sex hormones, Your Honor. It's established, he has got experience in prescribing those treatments. He has kept up with literature to determine

whether it's appropriate to prescribe those treatments for gender dysphoria.

THE COURT: I'm going to hear the testimony, because, frankly, it would be appropriate to have a proffer, in any event. It's probably more useful to have the proffer in question-and-answer form and to hear the cross-examination. And we can discuss ultimately whether the testimony is inadmissible, admissible, and entitled to very little weight, or admissible and entitled to great deal of weight and persuasive.

So at this point I will overrule the objection, and we can address those subjects later as part of argument.

MS. RIVAUX: Your Honor, if I can ask for one clarification. Some of the topics that he started testifying about are outside even the scope of pediatric endocrinology. For example, he was just mentioning the reparative model of treatment. That is outside the scope of pediatric endocrinology.

So while I understand -- I just want to make sure and whether you want me to object as the questions come up or how to handle it.

THE COURT: I don't need objections as it comes up. You can have a standing objection to his testimony about treatment of patients of the kind he has never provided.

MS. RIVAUX: Thank you, Your Honor.

BY MR. PERKO:

Q. Dr. Hruz, you mentioned the affirmative approach. Can you explain what that is?

A. The affirmative approach is the approach that actually involves the participation of the pediatric endocrinologist. That is based on a vastly different scientific premise than the other two approaches and necessitates or involves the use of puberty blockers and cross-sex hormones, which are medications that are used to treat pediatric endocrine disorders.

Q. Let's talk about the type of hormonal treatment you provide in your practice.

Have you ever prescribed puberty blockers in your practice?

A. Yes, I do.

Q. What conditions do you prescribe them for?

A. As a pediatric endocrinologist, this class of medication is routinely used in the treatment of central precocious puberty.

Q. Any other conditions that you've prescribed it for?

A. Other than its new use now in gender dysphoria, not in the setting of pediatric endocrinology, no.

Q. One of the medical treatments or interventions for gender dysphoria is cross-sex hormones.

Could you explain what cross-sex hormones are?

A. The term "cross-sex hormones" refers to the administration of androgens, namely testosterone, to biological females to allow them to appear masculinized, or estrogen to a biological male to lead to feminization, so the appearance of secondary sexual characteristics corresponding to the desired sexual identity.

Q. Backing up to puberty blockers. What are the risks associated with using puberty blockers to treat gender dysphoria?

A. There are significant risks that are unique to the application of the use of puberty blockers, the GnRH agonists, in somebody that is going through normally-timed puberty.

As opposed to the use in central precocious puberty, where one is intending to suppress the signals from the pituitary gland to the gonad at a time where it's occurring abnormally, the intention of using this in the treatment of gender dysphoria is to disrupt that signaling at a time when it would normally be occurring.

The consequences of this are severalfold. The well-documented concern is the effect of preventing somebody going through puberty at a time when maximal bone density is being accrued. This occurs during the teenage years in response to the sex steroid hormones that are produced by puberty; that the maximal bone density that one achieves by

the early 20s is going to be all that one has to carry them out through the rest of their life. So one of the concerns of giving this class of drugs to block normally-timed puberty is to prevent one from accruing maximal bone density.

There are unknowns about the -- it is very well established in the endocrinologic literature that sex steroid hormones are important in brain maturation. There are both organizational and activational effects of sex steroid hormones. By that I mean, differences in structure and neuronal signaling within the brain.

It is an unexplored -- virtually unexplored area as what the consequences are of disrupting that process. Only some of the questions related to that have even been asked in a formal way in scientific investigation.

And lastly -- not lastly, but in addition to that, there are other concerns as well. But the most important is the question as to whether this intervention itself influences the trajectory for the individual; meaning, that it's often presented by the endocrinologist that this is merely a pause button that allows one time to more explore their gender identity.

There are many who question that premise based upon the observation that nearly 100 percent -- the published studies show anywhere from 97 to 100 percent of the individuals who receive puberty blockers will proceed on to get cross-sex

hormones. So, objectively looking at that, one can question whether that really is serving that purpose as a pause button.

Another concern I will add is that, when it is stated that it is safe and fully reversible, the reversibility refers specifically to the reengagement of the signals from the pituitary gland to the gonad when you remove the drug, and that does occur.

What is very frequently missed is that in the process of interrupting normally-timed puberty, which is a temporally dependant process that occurs at the same time as the cycle social component known at adolescence, is disassociated; meaning that, when one allows -- if one were to withdrawal the puberty blocker and allow that gonadal access to reactivate, one cannot buy back the time that -- where that puberty was blocked.

And there are many questions that are not answered as to whether that disruption has any lasting effects on that individual that went through that intervention.

Q. We talked a little bit about cross-sex hormones.

Do you prescribe -- first of all, is testosterone an estrogen?

A. Testosterone is an androgen.

Q. But that is considered a cross-sex hormone?

A. If testosterone is given to a biological female, that

would be a cross-sex hormone use.
Q. Do you ever prescribe testosterone to adolescents in your clinical practice?
A. Yes, I do prescribe testosterone to males that have disorders in pubertal maturation, that have hypogonadism, which means inability for the testes to function normally, either by a primary defect in the development or functioning of the testes or by having an abnormality at the level of the pituitary gland signaling to that testicle.
Q. And do you monitor the testosterone levels of patients that you treat?
A. It is essential in the treatment of testosterone for gonadal disorders to be very vigilant in assessing hormone levels, recognizing that, one, that you have the response that is expected in producing the levels of that androgen, and also to make sure that you're not achieving toxic levels because of the significant risks of adverse effects related to that.
Q. What are the risks associated with using testosterone to treat gender dysphoria?
A. Well, in addition to the general risks of using testosterone where it could be administered to in excess even to male, which can lead to elevations in blood pressure, changes in lipid levels, causing -- inducing abnormal metabolism that increases the risk of cardiovascular disease.

It can also lead to elevations in red blood cell counts, a condition known as polycythemia.

But giving testosterone to a female is not equivalent to giving that same hormone to a male. And the reason for that is that there are clear biological differences in every nuclear cell of the body between males and females.

These are due to programmed epigenetic effects, modifications to the DNA that lead to differential expression of various genes. In fact, it is known that there are over 6,500 sex differentially expressed genes throughout the body. This is recognized by our National Institute of Health and requiring that when one is developing a new drug, that one studies both males and females, recognizing that the response to treatment and adverse effects may be different depending on the sex of that individual.

So also it's recognized by the Endocrine Society in a position statement that they published several years ago, where talking about sex as a biological variable, acknowledging the essential importance of recognizing that there are program differences between males and females.

So, therefore, there are greater attendant risks when you give testosterone to a female above and beyond that which you would see in giving that same hormone to a male.

Q. And, Dr. Hruz, we've heard some testimony about use of estrogen for treatment for gender dysphoria.

What are the potential risks of using estrogen for the treatment of gender dysphoria?

A. So, again, the same point that applies to the treatment of estrogen when given to a biological male; meaning, that you are giving a hormone at levels that are not native to the biological sex of that individual. The risk factors associated with giving estrogen, even to a female, include increased risk of clotting, changes in blood pressure.

The effects that actually have been shown to occur in males that are given estrogen as part of a gender affirmation can increase risk of a thromboembolic stroke three to fivefold.

And just to be clear about that, meaning a stroke that can lead to permanent neurologic damage or even death.

Q. Dr. Hruz, you said you are a member of the Endocrine Society. Did I get that right?

A. That's correct.

Q. And are you familiar with the Endocrine Society's clinical guidelines?

A. I am very familiar with a series of guidelines that have been produced by the Endocrine Society, yes.

Q. Do you utilize any of those guidelines?

A. Clinical practice guidelines like those that are published by the Endocrine Society are quite valuable to clinicians that are involved in the care of patients. And as

I teach all of my residents and fellows, clinical practice guidelines are only as good as the evidence by which they are based upon.

They cannot be interpreted as definitive. There is a very longstanding history of clinical practice guidelines not only for the Endocrine Society but in other fields as well, that I'm required to be up to date on, where the guidelines themselves change.

So they need to be utilized as they are intended to be able to synthesize a relatively large amount of data to be able to make tentative recommendations about the approach to care in the context of -- by which a patient is being encountered in the clinic with all of the variables associated with that, with recognition of the quality of evidence that is present in the production of those guidelines.

Q. Are you familiar with the Endocrine Society's guidelines for the treatment of gender dysphoria?

A. I am very familiar with the Endocrine Society guidelines for the treatment of gender dysphoria, the first guidelines that came out in 2009 and the revision that came out in 2017.

Q. Are you familiar with the grading or recommendations assessment development and evaluation or GRADE?

A. Yes, I'm very familiar with that.

Q. Could you briefly describe that?

A. The GRADE system is a systematic way of rating the quality of evidence that is present within clinical practice guidelines. They rate the quality of evidence from very low, low, moderate, or high levels of evidence. And the weight that one puts upon those recommendations and the predictive value by which those recommendations may or may not change over time, depending on the production of new evidence, is reflected in that grading system. By definition, studies that are of very low quality mean that it is very likely that the recommendations will change as new information becomes available.

Q. Does the Endocrine Society use the GRADE system in developing its clinic guidelines?

A. Yes. The Endocrine Society does make use of the GRADE system, yes.

Q. What is the quality of evidence supporting the Endocrine Society's guidelines for the treatment of gender dysphoria?

A. It's important to recognize that nearly all of the recommendations that are made in the Endocrine Society guidelines for the treatment of gender dysphoria are based upon low and very low quality evidence.

Q. Are you familiar with the World Professional Association for Transgender Health, or WPATH?

A. Yes, I am.

Q. What is it?

A. It is an organization that began as a scientific organization to help establish effective interventions for those that have this experience of sex-discordant gender identity. This organization has put forward their own set of clinical practice recommendations or guidelines that they currently have referred to as, quote, Standards of Care unquote. They are currently in the eighth iteration of those practice guidelines.

Q. And are you familiar with the WPATH Standards of Care, Version 8?

A. Yes, I am very familiar.

Q. What the evidence base for those standards?

A. So new to the SOC 8 document was an attempt to be able to incorporate a review of the literature that was present in making their recommendations for the care, which had been notably absent in prior iterations of that document.

With respect to my area of endocrinology and where it's very important in the treatment using the affirmative approach, in that document they acknowledge that there's very little evidence that helps guide the decisions that are being made. In fact, they claimed they were not able to do a systematic review based upon the level of evidence.

Q. Let's turn to treatment of gender dysphoria internationally.

Do clinicians and academics like yourself keep up with

developments in other countries?

A. It's very important for us as clinicians to be aware of what is going on around in other countries. Many times the introduction of new medications or new treatment approaches come from other countries, and changes in care, we need to be aware of that as we continue to evolve our practice.

THE COURT: Why would you keep up with the treatment of gender dysphoria in other countries if you don't treat anybody for gender dysphoria?

THE WITNESS: Because I'm a physician scientist, and I approach this with the goal of being able to achieve the best benefit for the patients. When I began and I made my decision, my conclusion that the available scientific evidence regarding risk and purported benefit did not justify engagement of myself as a pediatric endocrinologist in that condition, it did not mean that I was not willing to continue to look for the emergence of new evidence that would change that opinion.

Therefore, it's essential for me to maintain that perspective of being aware of what new research is being produced and the discussion that is going on nationally and internationally to be able to maintain that goal of providing -- or assessing whether there is a role for a pediatric endocrinologist in this condition.

THE COURT: So you're open to being persuaded and to

beginning to treat gender dysphoria with medicines.

THE WITNESS: In fact, I'm not only willing, I have actually openly had conversations with many of my colleagues about the need for conducting high-quality research trials and am very much in support of that being done.

THE COURT: I understand that you personally would treat gender dysphoria patients including with medications to affirm their gender identity if you were satisfied that the evidence was sufficient?

THE WITNESS: That's my role as a physician.

THE COURT: So that's yes or no.

THE WITNESS: Yes.

THE COURT: That answer is yes?

THE WITNESS: Yes.

THE COURT: You may continue.

MR. PERKO: Thank you, Your Honor.

BY MR. PERKO:

Q. Have there been any developments with regard to gender dysphoria care in Sweden?

A. So, yes, there have been significant developments. I'm aware of dating back to about May of 2021 when the Karolinska Hospital reversed course and decided that they would not offer puberty blockers and cross-sex hormone therapy to gender dysphoric youth outside of a clinical trial. This was followed up by a more formal policy statement in December of

2022, acknowledging the basis by which that decision was made. And that was essentially the same conclusion that I had made in my review of the literature, that there was not sufficient evidence that was present to justify the use of those medications for that condition, but acknowledged that there was a need to obtain more information.

Q. Was that analysis performed by the Swedish National Board of Health and Welfare for the care of --

A. Yes.

Q. And did the Swedish National Board of Health and Welfare prepare a summary of its conclusions?

A. Yes. I'm aware I think it was in December of 2022.

MR. PERKO: If I can pull up Exhibit DX8, please.

BY MR. PERKO:

Q. And you have a copy with you, Doctor. Ask if you recognize this document?

A. Yes, I do.

Q. Is this a fair and accurate copy of the summary issued by the Swedish National Board of Health?

A. Yes. This is the summary that I referred to that I've previously read, yes.

MS. RIVAUX: I object, Your Honor, on hearsay grounds.

THE COURT: The ruling here would be the same as what we talked about before lunch when you were objecting to their

documents, would it not, Mr. Perko?

MR. PERKO: Yes, Your Honor.

THE COURT: Same ruling. You can put this in to show the activity but not to show the truth of the assertions in it.

MS. RIVAUX: Your Honor, two more points. I believe this is document is a translation, and there is no certification of translation as well as proper authentication of where this document came from.

THE COURT: Well, he can --

MS. RIVAUX: And it's incomplete.

THE COURT: That's three things.

First, I much prefer English to Swedish, or whatever the original is in, but somebody needs to tell us where it came from and that it's accurate.

Then what was your last point?

MS. RIVAUX: That it was incomplete.

THE COURT: That's another problem, I guess. If it's not complete, you can certainly put in the rest of it under Rule 106.

MS. RIVAUX: The exhibit itself doesn't even have the attachments to it.

MR. PERKO: Excuse me, Your Honor. Your Honor, I don't believe there are any attachments to this document that I'm aware of.

THE COURT: Well, let's do this:

First, let's find out if Dr. Hruz knows where this came from and what the translation is and so forth. I don't know if he gave this to you or you got it somewhere else. It's like the one we had in the plaintiffs' case where the witness first said, oh, yes, I know what this is, and then started looking at it and said, no, that's not what I thought it was. Let's find out.

BY MR. PERKO:

Q. Dr. Hruz, where did you get this document?

A. This is searchable on the internet. You are able to find it from the --

THE COURT: That won't do it.

THE WITNESS: -- government website.

THE COURT: Do you know where this one came from?

THE WITNESS: Yes. This is the published policy statement that is available that, at least in my effort to stay abreast of the developments that are happening internationally, this is what I was able to find.

BY MR. PERKO:

Q. And was it on the website for the Swedish National Board of Health and Welfare?

A. I'm pretty sure it was.

Q. Has this been translated or was this originally released in English?

A. I did not translate this. This is the document as I read it.

MR. PERKO: Your Honor, I move the exhibit into evidence.

THE COURT: So he's pretty sure he got it off the internet.

MR. PERKO: I believe he said --

THE COURT: He's pretty sure it's their website.

Let me ask this to the plaintiffs:

Do you have any reason to believe this is not what it purports to be?

MS. RIVAUX: I just don't know, Your Honor, what website it came from or where it came from, so it's hard to tell.

THE COURT: This is going to be a ruling similar to one I mentioned before the lunch break when you were introducing documents.

I'm going to admit this. The standard to authenticate a document in the circuit is pretty low. The case I always cite is the *Siddiqui* case, S-i-d-d-i-q-u-i. There are others. It just needs to be evidence sufficient to support a finding that it is what it purports to be. It's probably not a precise articulation of the rule, but that's the gist of it.

When all you have so far is a witness saying he's

pretty sure this is where this came from, that is about as thin a showing as you could make. On the other hand, this is the kind of thing that shouldn't generate a lot of controversy, especially with lawyers this good on both sides with information that's publicly available.

I'm going to admit this, but just like I told Mr. Jazil about the other documents, you look into it. You've got a dozen or so people sitting there at your counsel table on that side. If this isn't what they say it is, then I'll change the ruling.

MR. PERKO: Thank you, Your Honor.

MS. RIVAUX: Your Honor, if I can just clarify if your ruling is also only to admit it for the position of the government as opposed to any of the hearsay statements?

THE COURT: Yes. This is to show the activity of that organization and the activity -- and what gets done is itself relevant just because, in part, the analysis of whether to pay for this kind of care deals with the consensus in the community or the standard in the community. And so what different folks are doing, how this is being treated in different places, is itself relevant.

So right or wrong, if, for example, it turned out that a hundred percent of the cardiologists in the United States were treating blockages with stints, it would be relevant that a hundred percent were treating blockages with

stints even if it was a bad decision. And so that wouldn't be proof that stints are the best way to treat it, but it would be some proof of the standard of care. So exactly the same ruling as I made on the plaintiffs' documents before the break.

MS. RIVAUX: Thank you, Your Honor.

MR. PERKO: Thank you, Your Honor.

(DEFENDANTS' EXHIBIT NO. 8: Received in evidence.)

BY MR. PERKO:

Q. Dr. Hruz, are you familiar with a recent article published out of Sweden by Ludvigsson, et al., entitled, "A systematic review of hormone treatment for children with gender dysphoria and recommendations for research"?

A. Yes. That was the systematic review that was published in the journal "Acta Paediatrica," a peer-reviewed journal which essentially has the same -- it was a systematic review that came to identical conclusions as presented in this government document that the relative risk versus benefit does not currently justify the use of hormones and puberty blockers in these children, and documents generally the low quality of evidence that is present in this field.

Q. Can you explain what a systematic review is?

A. A systematic review is a formal way of looking at the literature using very strict criteria to be able to include studies that fit the goals of that assessment.

It is considered one of the highest levels of information that can be used as we try to synthesize the available literature on a particular question or topic, and it is very important to be able to consider when a systematic review has been done, the conclusions that have been reached from that.

Q. Dr. Hruz, have there been any developments with regard to gender dysphoria treatment in Finland?

A. Similar to what has happened in Sweden, Finland also did their own review of the literature and they published the PALKO/COHERE report, and essentially came to the same conclusion about the low quality of evidence and led to policy changes in that country, prioritizing psychological interventions in the treatment of gender dysphoria and recognizing that, when affirmative interventions, including puberty blockers and cross-sex hormones are offered, that it needed to be done within the setting of a research trial.

Q. I would like to pull up Exhibit DX9 and have you take a look at it, Doctor.

MS. RIVAUX: Your Honor, I have the same objection to this document as I did to the prior document.

THE COURT: What is DX9, Mr. Perko?

MR. PERKO: DX9.

THE COURT: What is it? It's the same thing out of Finland, comparable --

MR. PERKO: I'll have the witness clarify if you

want.

THE COURT: Well, you can tell me. If it's the same objection and the same kind of document, it's going to be the same ruling.

MR. PERKO: It's the same type of document.

THE COURT: Same ruling.

(DEFENDANTS' EXHIBIT NO. 9: Received in evidence.)

MS. RIVAUX: Thank you, Your Honor.

BY MR. PERKO:

Q. Can I get you to identify what this document is?

A. These are the specific recommendations of the council for choices in healthcare that was put forward by Finland.

Q. Is that a complete and accurate copy of those recommendations?

A. It appears to be a complete document, yes.

Q. Have there been any developments in the United Kingdom with respect to treatment of gender dysphoria?

A. Yes. There have been several developments within the United Kingdom and specifically related to my area of pediatric endocrinology in the United Kingdom.

They did systematic reviews of the literature. As I mentioned for the other countries, these were contained relative to puberty blockers and cross-sex hormones in two separate reviews by the National Institute of Clinical Excellence, NICE, trials that formed the basis for the

National Health Service to appoint an individual by the name of Hilary Cass to perform an independent review of the services that were provided in that country at the Tavistock Center, which until recently was the only place in that country where gender-affirming services were offered to youth that had sex discordant gender identity.

On the basis of the interim report from the Cass review, major changes had been made to delivery of healthcare within that country. Within that Cass review, they acknowledged the same concerns about the low quality of evidence and many other concerns related to the presentation of children and the care that is being -- that had been delivered in their previous model.

Q. Let me show you what has been marked as Exhibit DX10.

Can you identify that document?

A. This is a the copy of the Cass review that I was referring to.

MS. RIVAUX: Your Honor, I have the same objection to this one, but in addition this one is an interim report. It's not a final report.

MR. PERKO: It is an interim report, Your Honor, but it's what Hilary Cass put out.

THE COURT: Doctor, I'm not sure I fully understood. Who is Dr. Cass?

THE WITNESS: She is a pediatrician who was appointed

by the National Health Service to conduct this review of gender services in the United Kingdom.

THE COURT: So she was working for the government?

THE WITNESS: National Health Center, yes.

THE COURT: Same ruling.

(DEFENDANTS' EXHIBIT NO. 10: Received in evidence.)

MS. RIVAUX: Thank you, Your Honor.

MR. PERKO: Thank you, Your Honor.

BY MR. PERKO:

Q. If I can show you Exhibit DX11 and ask what that document is.

A. This is a copy of that NICE review, and the one specifically relating to use of puberty blockers.

Q. And is this a complete and accurate copy of the NICE review?

A. Yes, it appears to be.

MS. RIVAUX: Your Honor, the same objection. I hate to stand up, I'm just preserving the record.

THE COURT: Same ruling.

(DEFENDANTS' EXHIBIT NO. 11: Received in evidence.)

BY MR. PERKO:

Q. And if you can look at DX12, and what is that?

A. This is the second systematic review by NICE, and this is the one specifically referring to cross-sex hormones.

MS. RIVAUX: Again, same objection.

THE COURT: Same ruling.

(DEFENDANTS' EXHIBIT NO. 12: Received in evidence.)

BY MR. PERKO:

Q. This is a complete and accurate copy of the NICE review, second NICE review?

A. Yes.

Q. Have there been any developments in France with respect to the treatment for gender dysphoria?

A. So France has come out with a -- their academy -- the French Academy of Sciences came out with a statement that was somewhat more nuanced than the other three countries that we've already discussed.

Yet, in their assessment of the current state of knowledge related to the care of individuals with sex discordant gender identity with affirming hormones, they specifically acknowledged the conclusions made by Sweden. They recognize that the utmost of caution needs to be made in the care of these individuals. And like these other countries have concluded, that there needs to be a prioritization of psychological care as we recognize the low quality of evidence present.

Q. Let me show you what has been marked as Exhibit DX13, and ask if you recognize it.

MS. RIVAUX: Your Honor, this one I have a bit of a different objection. This one is a press release. It's not a

government report of any kind.

MR. PERKO: It's reflective of what the government did, Your Honor. It's a statement of the government.

MS. RIVAUX: Your Honor, this is not the government.

THE COURT: Dr. Hruz, what is the French National Academy of Medicine?

THE WITNESS: It's a medical organization that makes decisions about the healthcare that is delivered in that country or makes guidelines and recommendations for them.

THE COURT: That's two different things. Is it --

THE WITNESS: So it's -- -

THE COURT: Wait until I through talking. The court reporter has to take us down, and it's much easier if we speak one at a time.

Does this organization make rulings that have the force of law, or is it an organization that does analysis and makes recommendations?

THE WITNESS: It would be equivalent to the American Academy of Pediatrics here in the United States.

THE COURT: So we put in the WPATH statement. What's wrong with this one?

MS. RIVAUX: Well, if they'll agree to all of the position statements that we've submitted, then we would agree to this one.

THE COURT: I'll admit it for the same purpose as the

other statements. This is a position taken by a medical organization. It's a little further removed because it's in France, and it's not the United States, but it's part of the body of evidence that could inform analysis of the Standard of Care.

MR. PERKO: Thank you, Your Honor.

(DEFENDANTS' EXHIBIT NO. 13: Received in evidence.)

BY MR. PERKO:

Q. Is this a complete and accurate copy of the document that it purports to be?

A. This is the same document that I read, yes.

Q. Have there been any developments in New Zealand and Austria with respect to the treatment of gender dysphoria?

A. Yes. The Royal Australian and New Zealand College of Psychiatry did come out with a statement very similar to these other documents that we've already discussed.

What's notable in this document is that the statement by that College of Psychiatry deviated sharply with their earlier recommendations that were made in 2015, acknowledging in this document that there are conflicting viewpoints on the best way to treat gender dysphoria, and when I first read this document, it reinforced my conclusion that what the WPATH claims as Standards of Care, which means that there are a universal consensus about treatment, does not exist.

This clearly highlights the fact that this is an area

that remains highly contentious and with differing viewpoints and recognition of the low quality of evidence that currently exist with respect to using the affirmative model.

Q. If I can show you Exhibit DX14 and ask if you recognize this document?

A. This is indeed the document that I read.

Q. What is it?

A. This is the statement by the Royal Australian and New Zealand College of Psychiatrists.

MS. RIVAUX: Same objections, Your Honor.

THE COURT: Same ruling.

BY MR. PERKO:

Q. And is it a fair and accurate copy of that statement?

A. Yes.

Q. Switching gears a little bit, Doctor, I would like to talk a little bit about the scientific literature in the area of gender dysphoria.

First, can you please explain the types of studies that are used in medical research?

A. Well, it's very important to this question of quality of evidence to recognize why there is a gradation of quality of evidence.

The lowest tier is generally anecdotal in case reports. And then moving on to observational types of studies and with higher quality of evidence, the standard of randomized

controlled trials, and then the metaanalysis or the symptomatic synthesizing of various randomized controlled trials.

Each of those levels differ with the confidence with which one can have in making conclusions based upon the evidence. In relevance to the assessment of the affirmative model using cross-sex hormones and puberty blockers for gender dysphoria, it's very important to recognize that observational cross-sectional retrospective studies that do not include a controlled groups are not capable of establishing a causal relationship between intervention and response.

At best, these types of studies, the case reports at best can usually lead to hypotheses generation, the recognition that further research needs to be done, and the design and conduct of subsequent research studies. An observational study, a cross-sectional study can establish an association, but it cannot establish the causal relationship between the intervention and response.

Q. Now, the plaintiffs' experts so far in this trial have quoted a few papers from the literature. I would like to go through them with you.

First of all, what is a "longitudinal study"?

A. A longitudinal study is where you follow patients over time. So you have a period of time, and then you look at a

follow up. And that is in contrast to a cross-sectional study where you gather data at one particular point in time.

Q. Are you familiar with the 2011 longitudinal study that was conducted by de Vries et al., that measured mental health outcomes after receiving puberty blockers?

A. Yes, I'm very familiar with that. This is really the basis for what is referred to as "the Dutch protocol."

Q. What is your assessment of that study?

A. So this study recruited 70 patients consecutively that entered into the gender clinic in that country and followed them at two time points: one at the beginning of receiving puberty blockers, and the second follow point was just before receiving cross-sex hormones.

The study itself did not have a control group. Again, very, very important in trying to assess whether any study outcomes are due to the intervention itself or another factor.

It stated very clearly in that report that all of the patients in that study received psychological support. Therefore, it's not possible to conclude that any differences were not due to that psychological support that was received.

The patients were patients that are vastly different to the ones being referred in large numbers to clinics here in the United States; meaning, that they were predominantly males identifying as females, and nearly -- I believe all of

them with the prepubertal onset of their sex discordant gender identity.

In that 2011 study they found at the intervention time point, the follow-up time point, their gender dysphoria did not change. They had persistent elevated rates of anxiety. They showed some differences in some of their psychological outcomes. Again, because of the nature of the trial design, it is not possible to conclude whether that was due to them receiving puberty blockers.

Q. Are you familiar with the follow-up 2014 study published by de Vries, et al., entitled "Young adult psychological outcome after puberty suppression and gender reassignment"?

A. Yes, I'm very familiar with that study.

Q. What's your assessment of that study?

A. That was a follow-up study of that same initial cohort of 70 individuals; however, only 55 of them were entered into the follow-up study. There were several patients that were lost to follow up. It's important to note that one of the patients died as a result of the surgical intervention that was performed on that individual.

There are many -- the similar questions and concerns about the limitations of the 2011 study apply also to the 2014 follow-up study in that it did not include a control group. All of the patients received psychological care; and, in fact, those that had severe psychiatric conditions would

not have been eligible to enter into the study.

Another major concern about that study is that their very assessment of gender dysphoria, which was a primary outcome, involved the use of a scale that was given -- a different scale that was given whether one was a biological male or female. And then at the follow-up time point after the cross -- after the gender-affirming surgery, those same subjects were given the other scale; meaning, that they changed the outcome tool and made the claim that their gender dysphoria was reduced.

But by the very way that they conducted the study, it actually proves the opposite of what they intended to show in that questions were asked that were not appropriate for somebody, depending on the sex that they had, which really was not able to capture that outcome.

Q. Can you explain why the questions were not appropriate?

A. So, for example, to ask a male subject that identifies as female whether they are bothered by menstruating would have no utility. Yet, that was the -- it also changes midstream the assessment tool. So essentially you are asking questions that are going to influence the outcome just by the basis of the questions that are being asked.

Q. So, if I understand it correctly, the question was asked before you started the treatment, if you were satisfied with your gender identity or what have you, and then when the

patient was transitioned, then the question was the opposite?
A. So in the study, in the 2011 study, they used the same scale at the start of pubertal blockade and just before cross-sex hormones, and then they switched after the surgical gender-affirming surgery to the other scale, making the decision that, for whatever reason that they used, that is what the studies showed.
Q. Okay. I just have a few more -- three more studies, Dr. Hruz.
Are you familiar with the 2018 paper by Dr. Olson-Kennedy entitled, "Chest reconstruction and chest dysphoria in trans masculine minors and young adults: Comparisons of nonsurgical and post surgical cohorts"?
A. Yes, I'm aware of that study.
Q. And what is your assessment of that study?
A. I think it's important to acknowledge this as another example of the serious limitations of the studies that are being presented to establish the efficacy of this particular affirmation approach.
There are many limitations in that study. As far as the control group itself was a convenient sample, and the study tool that they used in that study was not validated at the time they conducted the study. The author of the study devised on her own this novel scale for assessing what they refer to as "chest dysphoria."

Another concern is that the follow-up period was far too short to be able to assess that outcome. On average, it was about two or two and a half years of follow-up after the surgery intervention. When, in other studies like the Dutch cohort study published in 2018 by Wiepjes, the data shows that much of the regret from surgery can occur as much as ten years after the intervention.

Q. Are you familiar with the 2022 study by Kristina Olson, et al., entitled, "Gender Identity Five Years After Social Transition"?

A. Yes, I'm familiar with that study.

Q. What's your assessment of that study?

A. So that study actually borrows data from what's called the "Trevor Project." They are trying to look long-term about the trajectory of individuals that are with sex-discordant identity over time. The conclusion of that study, looking five years after social affirmation, was that there was, I believe, 7 percent that had undergone transition that ended up -- they call it retransition, I would say detransitioned -- over that interval.

There are -- the data themselves, which are in stark contrast to other data that show that the experience in that population in the time interval, that the desistance rate is much higher. They concluded that they had diagnostic accuracy to assert that there was an alleviation of the

concern that patients would be put on a path that was not correct for them.

An alternate way to look at the data that seems much more plausible as a hypothesis is that the intervention itself, social affirmation is not a neutral intervention, and that the process of socially-affirming somebody can change the trajectory for which one goes forward with that. Because it did not contain a control group, one cannot assess which of those hypotheses is correct.

Q. One final study, Dr. Hruz. Are you familiar with the 2022 paper by Chen, et al., entitled, "Psychosocial functioning in transgender youth after two years of hormones"?

A. Yes, I am familiar with that study.

Q. What's your assessment of that study?

A. This was a longitudinal study done at four different centers where they recruited approximately 300 patients to follow them over time. The two-year, follow-up data is contained within that Chen study, and many, many questions about that.

First off, this, as a longitudinal study, there is no control group so similar to the other studies that I mentioned. Because of that, there is no way to establish whether there is a causal relationship between intervention and outcome.

They claim it's a two-year follow-up, but a very large number of subjects in that study did not have a full set of two-year data, so the follow-up period was even shorter than that.

They did not use robust measures of psychological well-being. The ones that they do report where they have -- many of them where they have claimed that there is significance, they maybe statistically significant but clinically insignificant. There is no way to be able to follow up individual patients longitudinally from the data that they showed.

And probably most concerning in this two-year, follow-up study, that out of those patients that were enrolled in that study, two of the patients died by a completed suicide. In any other clinical study that I'm aware of, if you had two deaths during a longitudinal study, it would lead to a halting of the study and critical assessment as far as the nature of what was going on before proceeding onward.

So there are many features of that study that limit what one can conclude and raise serious questions about the outcome that has been reported by that study.

Q. Dr. Hruz, how would you characterize the evidence used to support the use of puberty blockers and cross-sex hormones to treat gender dysphoria?

A. I would say, in general, the evidence that does exist is

sparse, of very low or very low quality, and there are many questions that remain to allow one to assess both the safety and the efficacy of these interventions.

MR. PERKO: Thank you, Your Honor.

Oh, one more line of questions.

BY MR. PERKO:

Q. Dr. Hruz, were you here for the testimony of Ms. Hutton earlier today?

A. Yes, I was.

Q. And she mentioned a meeting that you had ten or so years ago. In your mind what was the purpose of that meeting?

A. I specifically called or contacted Ms. Hutton as I was in the phase of investigating the evidence related to this new affirmative model for the treatment of gender dysphoria, as I noted in my role as division chief.

I called the meeting to specifically gain better understanding of the experience that Ms. Hutton had in encountering her child that had sex-discordant gender identity. I'm very grateful for that. Much of what she shared with me during that meeting helped me to understand again the context of her experience.

That was the reason -- when I invited her for that meeting, I made it very clear that I was not convinced at that point in time by the scientific evidence, and that I had several questions related to the scientific premises that

were being put forward, and I had intended to be able to use the information from her story to help me assess some of those questions that I had.

I did recognize at that time that she was an advocate parent and not a physician scientist, and I made it very clear to her that I was not intending to debate. I was merely intending to listen to her story.

Q. Dr. Hruz, at any time did you tell Ms. Hutton that sometimes children were just born to suffer?

A. I heard that comment this morning, and I'm lost to understand how she could make that statement. I do not hold and have never held to that belief.

MR. PERKO: Thank you, Your Honor. I have nothing further.

THE COURT: Well, while he's asking that, they may want to cross.

Did you tell her any of the treatment of transgendered individuals was against God's plan?

THE WITNESS: I would not have said that, no.

THE COURT: Did you say anything about reading Pope John?

THE WITNESS: In that course of that conversation, we asked Ms. Hutton -- my intention was to learn about her experience. Her goal, as I surmised from her questioning me, was to convince me to open up the gender center at my

institution. And as she continued to become more agitated by the fact that what she was asking me was not something I could accept based upon what I had learned up to that point in time, the conversation entered into many areas of her personal life journey with details that I'm sure she would not want to make public, and really that was tangential to the purpose of that conversation.

THE COURT: Do you recall my question?

THE WITNESS: Yes, I do.

THE COURT: What's the answer to my question?

THE WITNESS: We got into questions related to anthropology, the understanding of the human individual, addressing the question of whether one could possibly be born in the wrong body. And to illustrate the understanding of that, I did include a reference to that document.

THE COURT: Cross-examine?

CROSS-EXAMINATION

BY MS. RIVAUX:

Q. Good afternoon, Dr. Hruz.

A. Good afternoon.

Q. So I understand you told the Court here that you have never treated a patient for gender dysphoria, correct?

A. It would be unethical for me to engage in a form of treatment that I have deemed not justified by an assessment of the relative risk and benefit.

Q. I understand your explanation, but the question was: Have you ever treated anybody for gender dysphoria?
A. Because of my ethical concerns, no.
Q. And you have no training in diagnosing anyone in gender dysphoria?
A. I have the same type of training of reading the DSM-5 that my colleagues that do make that diagnosis as endocrinologists.
Q. Now, but you have never had any specific training for diagnosing gender dysphoria, correct?
A. Neither I nor my colleagues that are in the pediatric endocrine division at St. Louis Children's Hospital have done anything different other than read the DSM criteria for that diagnosis.
Q. You are not a mental health professional?
A. Correct.
Q. And you haven't relied on the DSM to diagnose a patient?
A. That's correct.
Q. And you don't determine patient treatment in reliance on the DSM ever, correct?
A. That is not correct. In my practice of pediatric endocrinology, many of the conditions that I treat are heavily influenced by comorbidities that include psychiatric disease, and it is my duty as a physician to recognize that and be able to tailor my care in light of those diagnoses.

Q. You have no experience treating gender dysphoria?
A. As I said, the role of an endocrinologist is in the administration of puberty blockers and cross-sex hormones, and I have deemed that not justified by the available evidence.
Q. And you mentioned different approaches like the reparative model; is that correct?
A. That is correct.
Q. You've never used that model as a treatment with any patient for gender dysphoria, correct?
A. The only -- of those three models that I presented, the only one that involves the pediatric endocrinologist is the affirmative model.
Q. But my question was: Have you ever used that methodology for the treatment of gender dysphoria?
A. I don't know of any endocrinologist, myself or any other endocrinologist that has used that model, no.
Q. So fair to say then, you've never used the watchful-waiting methodology for the treatment of care for gender dysphoria, correct?
A. To the extent that I cared for patients for other conditions that express sex-discordant gender identity, I accompany them in the care of their other conditions. That's not fully in line with the expectant model, but it certainly does align with that.

Q. That's not gender dysphoria, right?
A. I don't know that I understand your question.
Q. I'll move on.
You've never conducted any formal research relating to gender dysphoria, correct?
A. I have not personally been able to conduct the studies that I think need to be done, though I have proposed them to my colleagues at Washington University. I am involved in the supervision of our clinical fellows, two of whom are currently conducting research studies in the area of gender dysphoria. Both of them are doing studies related to adverse drug effects related to that.
My role is as an advisor, not as a primary mentor, in helping them to generate their hypotheses, to critically evaluate their data, to make appropriate preparations for presentation at national conferences.
Q. And prior to this -- would you say that you're directly participating in a clinical trial?
A. No, I'm not directly participating.
Q. Okay. And you've never published any peer-reviewed literature on the cause of gender dysphoria in a scientific journal, correct?
A. I have published a peer-reviewed article in an ethics journal related to that question.
Q. But my question was in a scientific journal.

A. I think ethics is a field of science.
Q. Well, you published an article in the Linacre Quarterly, correct?
A. That's correct.
Q. And that is not a scientific publication, correct?
A. Well, as I just said, it was published in an ethics journal. In fact, the Linacre is the longest standing peer-reviewed ethics journal in the United States.
Q. But not a scientific journal, right? You've made that distinction.
A. I made my distinction there.
Q. And who is the publisher of Linacre Quarterly?
A. The Catholic Medical Association.
Q. Do you have any association with the Catholic Medical Association?
A. Yes.
Q. And what's your involvement with the Catholic Medical Association?
A. I have participated -- I'm a member of the Catholic Medical Association.
Q. You are member of the Catholic Medical Association; is that right?
A. Yes.
Q. Are you aware of their position on gender-affirming care?
A. Where would you be referring to where that is published?

Q. Well, I'm asking if you are aware -- let me ask it this way:

Are you aware of whether the Catholic Medical Association opposes gender-affirming care?

A. I'm aware of, amongst my colleagues, the same questions that I have related to the safety and efficacy of gender-affirming care.

THE COURT: Does the association oppose gender-affirming care?

THE WITNESS: I would say "oppose" is not the word that I would use. They have ethical objections and concerns to many of the arguments for the gender-affirming model.

BY MS. RIVAUX:

Q. Did the Catholic Medical Association issue a position statement on gender-affirming care?

A. I'm not certain.

Q. Okay. You haven't gotten any grants to study gender dysphoria, correct?

A. That is correct.

Q. And you have applied for grants for other areas of study, correct?

A. Throughout my career, I've not only applied but also received a number of grants, yes.

Q. And the reparative mode or methodology that you mentioned earlier, are you aware of what the American Psychiatric

Association says regarding the reparative model?
A. It depends on how you refer to that and how it is conceived. But I am aware of many that use the term "conversion therapy," and in general argue that it is harmful and ethical -- unethical is the statement that they have made repeatedly in relation to that approach.
Q. And you stated the reparative therapy is the explicit goal of realigning one's gender with one's biological sex; is that correct?
A. That is correct.
MS. RIVAUX: Can we pull up Exhibit 46, please?
BY MS. RIVAUX:
Q. Are you aware of the American Psychological Association's position on reparative therapy?
A. Only to the extent that I have heard repeatedly from nonscientific domains. So, again, I'm a pediatric endocrinologist. But, yes, I am aware that they have made that same conclusion.
Q. And do you recognize this document?
A. Either this or a similar type of document, correct.
Q. And this is the American Psychological Association resolution on gender identity change efforts, correct?
A. Correct.
Q. And if we go to page 2, at the bottom, are you able to read that, or no? It's kind of hard to read. We may have to

use the ELMO. You can zoom in. Page 2, bottom, third paragraph from the bottom, there we go.

Do you see where it says: *Whereas, GICE --*

What does "GICE" stands for?

A. I believe it's "Gender Identity Conversion Efforts."

Q. *-- have not been shown to alleviate or resolve gender dysphoria.*

Did I read that correctly?

A. Correct.

Q. Then going on to page 3 at the bottom, please, where it says:

Be it therefore resolved that consistent with the APA definition of evidence-based practice, APA 2005, the APA affirms the scientific evidence and clinical experience indicate that GICE put individuals at significant risk of harm.

A. Yes, you read that correctly.

Q. And after that it says:

Be it further resolved that the APA opposes GICE because such efforts put individuals at significant risk of harm and encourages individuals, families, health professionals and organizations to avoid GICE.

Did I read that correctly?

A. Yes, you did.

MS. RIVAUX: I would like to move this exhibit into

evidence, Your Honor.

MR. PERKO: Hearsay, Your Honor.

THE COURT: Same treatment as the other documents, should it not be?

MR. PERKO: Yes, Your Honor.

THE COURT: Plaintiffs' 46 is admitted with the same limitations.

(PLAINTIFFS' EXHIBIT NO. 46: Received in evidence.)

MS. RIVAUX: Thank you, Your Honor.

BY MS. RIVAUX:

Q. I was looking at your CV and looking at some of your publications. One of the publications that you have is an invited publication called, "Growing Pains: Problems With Pubertal Suppression in Treating Gender Dysphoria," correct?

A. That is correct.

Q. And this an article that you published in 2017, correct?

A. Yes, I believe that was the year.

Q. And that was in the New Atlantis?

A. Correct.

Q. And that's not a scientific journal, correct?

A. Not by the standard definition, no.

Q. And the New Atlantis is not a peer-reviewed scientific journal, correct?

A. It was editorially reviewed, not sent out to people outside of the editorial board.

Q. So the answer to the question is, it's not peer-reviewed, correct?
A. Correct.
Q. And you also published two articles in the National Catholic Bioethics Quarterly, correct?
A. Yes.
Q. And the National Catholic Bioethics Quarterly, that's not a peer-reviewed publication, correct?
A. Correct. Similar to the New Atlantis, it was an editorially-reviewed, to the best of my knowledge.
Q. But when you say, "editorially-reviewed," that's different than peer-reviewed, correct?
A. It means that the paper itself was critically evaluated, and I had to make edits to the article to satisfy the concerns by those. If you consider the editors themselves are also ethicists that are peers in the field, it would be peer-reviewed, but, to my understanding, it wasn't sent out beyond the NCBQ.
Q. Because a peer review is when you send it out to other experts in the field and have other experts opine and look and review the particular article, correct?
A. Not necessarily true. There are some papers that are reviewed by the editor as the primary peer reviewer for paper if it fits within in their area of expertise.
Q. But you have said it's not a peer-reviewed journal,

correct?
A. In the definition that you stated, as far as sending it out to external reviewers, correct.
Q. Do you remember testifying in the Katle deposition?
A. Yes, in deposition.
Q. And you were under oath in that deposition?
A. Correct.
Q. And you recall being asked: "Is the National Catholic Bioethics Quarterly a peer-reviewed journal," and your answer was "no"?
A. And, again, with the same caveats, the way the question was asked was more along your definition, as far as being sent out to external reviewers. At least that's how I interpreted that question being asked.
Q. When you were asked the question, you didn't provide that additional clarification, correct?
A. Correct.
Q. The National Catholic Bioethics Center also published a book chapter that you wrote, correct?
A. Correct.
Q. And that was called -- what was that called?
A. I published a lot of things. I can't remember the exact title.
Q. Does "Transgender Issues in Catholic Healthcare" ring a bell?

A. Yes.
Q. And the National Catholic Bioethics Center, they have -- do they have a position on gender-affirming care?
A. Yes. I believe you can read it in their publications.
Q. And are you familiar with it?
A. Yes.
Q. And it states that "insisting on affirming a false identity and in many cases mutilating the body in support of that falsehood"?
A. I'm aware of that statement, yes.
Q. Are you involved with any organizations that publicly oppose gender-affirming care?
A. What do you mean by "involved with"?
Q. Are you a member of any organizations that publicly oppose gender-affirming care?
A. Not that I'm aware of, no.
Q. Are you a member of -- are you involved with the Alliance for Defending Freedom?
A. Am I -- I'm sorry. Can you repeat the --
Q. Are you familiar with the Alliance for Defending Freedom?
A. Am I familiar with it? Yes, I'm familiar with that organization.
Q. And you have been and traveled to their office in 2017 about a meeting regarding the types of healthcare at issue in this case, correct?

A. That is correct.
Q. And you have been to their offices at two separate times, correct?
A. That is correct.
Q. And both times relating to the treatment of gender dysphoria in adolescents; is that correct?
A. That is correct.
Q. And you are familiar with an individual by the name of Dr. Lambert?
A. Yes, I am.
Q. Was he with you at any of those meetings at the ADF?
A. He was present at one of those two meetings.
Q. And in 2017 you filed an *amicus* brief in the Supreme Court in a case called *Gloucester County versus Grimm*, correct?
A. Correct.
Q. And that was a case that related to whether a transgender individual be permitted to use the restroom aligned with their gender identity, correct?
A. That's correct.
Q. And on the brief that you signed on to that was filed with the Supreme Court, it stated:

Such treatments encourage a gender dysphoric child like the respondent to adhere to his or her false belief that he or she is the opposite sex. These treatments would help the

child to maintain his or her delusion, but with less distress by, among other aspects, requiring others in the child's life to go along with the charade. Correct?

A. Correct.

Q. And also in that *amicus* brief that you signed on to, it said that:

Conditioning children into believing into a lifetime of impersonating someone of the opposite sex achievable only through chemical and surgical intervention is a form of child abuse. Correct?

A. If the statement said that, I recall -- I wouldn't challenge that reading.

Q. And your name was on the brief, right?

A. Correct.

Q. And you signed on to other briefs as well, other *amicus* briefs, correct?

A. Correct.

Q. For example, in *Doe v. Boyertown*, again, an *amicus* in the Supreme Court opposing gender-affirming care, correct?

A. Yes.

Q. And, again there in that brief, it stated:

Conditioning children into believing that a lifetime of impersonating someone of the opposite sex achievable only through chemical and surgery interventions is harmful to youths. Correct?

A. Yes, I did.
Q. And in 2020, you signed on to another brief called *Meriwether versus Hardtop*, correct?
A. Yes.
Q. And that was a brief supporting -- in support of a professor who objected to the state's requirement that faculty and staff address students according to the student's preferred form of address, including the use of the student's preferred pronouns, correct?
A. I'm trying to remember that. You know, there's many things I've done over the years.
Q. Would it help if I refreshed your recollection?
A. Yes, it would be helpful, yes. I believe you're saying it accurately, but I just want to be sure.
MS. RIVAUX: May I approach, Your Honor?
THE COURT: You may.
BY MS. RIVAUX:
Q. Does this refresh your recollection?
A. The main author of this, I -- yes.
Q. I'm sorry. I think I have given you the wrong document. I apologize. You can put it down.
A. Okay. Thank you.
Q. But you did testify in the Brandt trial, correct?
A. Yes.
Q. In the Brandt trial, you stated that you recalled signing

on to this brief, correct?
A. Yes. Often when I'm asked these questions, I accept what is presented. I don't usually, as you just did, give me the actual document, yes.
Q. But you had recalled it then?
A. I will accept that I signed on to that *amicus*, yes.
Q. Do you want to see a copy of your testimony from the Brandt trial?
A. Oh, no, I don't need to see that, no.
Q. And in that brief, you said:
The popular notion regarding, quote, gender identity that says a person has a, quote, boy mind in a girl body is not true. If it is supposed to be taken even more or less literally, it is an idea that should be summarily dismissed.
Correct?
A. I would be happy to explain the scientific justification for that statement if you'd like.
Q. Okay. But my question was: Did you say that in the *amicus* brief?
A. If you are reading it from there, I said it, yes.
Q. Did you sign on to an *amicus* brief that seeks to criminalize providing gender-affirming care?
A. I need more specific information about that.
Q. In a case in Alabama, did you sign on --
MS. RIVAUX: Excuse me.

BY MS. RIVAUX:
Q. I'm sorry. Clarification. Are you an expert in a case called *Boe v. Marshall*?
A. Yes.
Q. In that case, they are looking to criminalize the gender-affirming care in minors, correct?
A. I am involved as an expert witness to talk about the scientific evidence related to gender-affirming medical interventions. I make no assessment of the actual legislation that is being proposed on the merits of that. I'm not a politician. I'm not a lawyer. I'm a physician scientist.
Q. Understood. When you are asked to be an expert, you can choose to be an expert or not in a case, correct?
A. Correct.
Q. And you understand that the goal in that case, right, relating to that -- to the law that -- the Alabama law is to make a felony providing gender-affirming care to minors, correct?
A. The legislative initiative stands as of itself. My role is to make sure that the proper science is discussed so that the decision can be rendered accurately.
Q. I understand. But that was a choice to participate in that case, correct?
A. That's correct.

Q. You mentioned -- you talked a little bit about WPATH, correct?
A. Correct.
Q. You've never been a member of WPATH?
A. That is correct.
Q. You have no personal experience with WPATH, correct?
A. I actually have met with individuals with WPATH including Eli Coleman, who I had an extended conversation about the scientific evidence and challenged him about the research that needed to be done. So I have interacted with members of WPATH, but that is my extent.
Q. So your experience with WPATH is interacting with other doctors that are also involved in WPATH and talking about the science, correct?
A. Correct. I have not been a member, participating in their meetings.
Q. And your opinions here today are contrary to the recommendations of WPATH regarding the care for gender dysphoria, correct?
A. That is correct.
MS. RIVAUX: Exhibit 37, please.
BY MS. RIVAUX:
Q. And you told us, Dr. Hruz, that it's very important for you to keep up with the positions of not only what is happening in the United States but internationally. So it's

very important for you to keep up with these positions. So Exhibit 37, do you recognize -- let's scroll up.

And this is a document from the American Academy of Family Physicians and their position statement on the care for transgender and gender nonbinary patients, correct?

A. Correct.

Q. And the American Academy of Family Physicians, they support access to gender-affirming care for gender-diverse patients including children and adolescents, correct?

A. That is what they advocate for based upon the same concerns of evidence that I presented in this case.

Q. And gender-affirming healthcare is part of a comprehensive primary care for many gender-diverse patients, correct? That's what it says?

A. That's what the document says.

Q. And their position is also that this care includes gender-affirming hormones, puberty blockades, medical procedures, and surgical interventions, correct?

A. Correct.

MS. RIVAUX: I would like to admit this document into evidence, Your Honor, plaintiffs' 37.

MR. PERKO: Same objection subject to rulings.

THE COURT: Plaintiffs' 37 is admitted.

(PLAINTIFFS' EXHIBIT NO. 37: Received in evidence.)

MS. RIVAUX: Exhibit 38, please.

BY MS. RIVAUX:
Q. Exhibit 38, that is the policy statement, right, from the American Academy of Pediatrics?
A. That is correct.
Q. And you understand that the American Academy of Pediatrics support gender-affirming care, correct?
A. I would say that the committee that put forward this statement does. It's never been put up to a vote of the entire membership; therefore, it's inaccurate to say that the entire society supports this.
Q. Well, the American Academy of Pediatrics has put out a position statement supporting gender-affirming care, correct?
A. That statement is correct.
Q. Okay.
MS. RIVAUX: I would like to move this document into evidence, Your Honor.
THE COURT: Give me the number again.
MS. RIVAUX: Exhibit 38.
THE COURT: Plaintiffs' 38 is admitted.
(PLAINTIFFS' EXHIBIT NO. 38: Received in evidence.)
MS. RIVAUX: Exhibit 36, please.
BY MS. RIVAUX:
Q. And this is a document, a position statement from the American Academy of Child and Adolescent Psychiatry, correct?
A. Yes.

Q. And this is their position statement responding to efforts to ban evidence-based care for transgender and gender-diverse youth, correct?
A. The title threw me for a -- so, yes, at first it read that they were against evidence-based care, but it's clear from the reading of this that they are making a statement that it's evidence-based and making a statement on it being banned. So I think it's important to recognize what the document is actually says.
Q. It says: *The American Academy of Child and Adolescent Psychiatry. Statement responding to efforts to ban evidence-based care for transgender and gender-diverse youth.* Right?
A. The document states that. I challenge whether their recommendations are actually -- when we talk about evidence-based what that constitutes. But the document itself does say that.
Q. Okay. And they oppose any ban on gender-affirming care, correct?
A. Correct.
Q. Okay. And specifically, they state that they support the youth -- and this is the third paragraph at the bottom -- it says:
The American Academy of Child and Adolescent Psychiatry supports the use of current evidence-based clinical care with

minors. Correct?
A. They are stating that they are satisfied with the low-quality evidence, yes.
Q. Well, that's not what they say, right?
A. They say evidence-based, and I've shared what that evidence is.
Q. I understand what your position is, but that's not their position, correct?
A. As you read the statement, that's what it says in the document.
Q. And *the AACAP strongly opposes any efforts, legal, legislative and otherwise to block access to these recognized interventions*, correct?
A. You read that correctly.
MS. RIVAUX: At this time, I would like to move in Plaintiffs' Exhibit 36, Your Honor.
THE COURT: Plaintiffs' 36 is admitted.
(PLAINTIFFS' EXHIBIT NO. 36: Received in evidence.)
MS. RIVAUX: Exhibit 39, please.
BY MS. RIVAUX:
Q. And this is an opinion document from the American College of Obstetricians and Gynecologists, correct?
A. Yes.
Q. And it gives their recommendations for the healthcare for transgender and gender-diverse individuals, correct?

A. That's what it states, yes.
Q. And they, too, support the provision of gender-affirming care, correct?
A. Based upon their acceptance of the evidence, the low quality of evidence, yes.
Q. Well, that's not what they say, right? They don't say because of their acceptance of the low quality of evidence. Those are your words, correct?
A. Correct. They fail to recognize the low quality of the evidence.
Q. That's your opinion, correct?
A. Correct.
Q. Okay. And the American -- at the bottom here, under *Recommendations and Conclusions*, the second paragraph says:

The American College of Obstetricians and Gynecologists oppose discrimination on the basis of gender identity or public and private health insurance claims to cover necessary services for individuals with gender dysphoria and advocates for inclusive, thoughtful and affirming care for the transgender individuals. Correct?

A. You read that correctly.

MS. RIVAUX: I would like to admit 39 please.

THE COURT: Plaintiffs' 39 is admitted.

(PLAINTIFFS' EXHIBIT NO. 39: Received in evidence.)

MS. RIVAUX: Moving on to Exhibit 40, please.

BY MS. RIVAUX:

Q. And this is a statement from the American College of Physicians, and it is their position statement on the attacks on the gender-affirming care and transgender healthcare, correct?

A. You read that correctly.

Q. And they, too, oppose any efforts that seek to ban or restrict access to the gender-affirming care, correct?

A. That is what the document states.

Q. Okay.

MS. RIVAUX: I would like to move to admit Plaintiffs' 40, please.

THE COURT: Plaintiffs' 40 is admitted.

(PLAINTIFFS' EXHIBIT NO. 40: Received in evidence.)

MS. RIVAUX: Exhibit 41, please.

BY MS. RIVAUX:

Q. And here is another position paper from the American College of Physicians, correct?

A. That is what the title says, yes.

Q. And here, again, they are reaffirming their position on any bans on gender-affirming care, correct?

A. I would have to read through the whole paper, but by the title, it looks to be that, yes.

Q. Well, if we turn to -- at the bottom, 1240, next page, number two:

The American College of Physicians recommends that public and private health benefit plans include comprehensive transgender healthcare services and provide all covered services to transgender persons as they would all other beneficiaries. Correct?

A. You read that correctly.

MS. RIVAUX: I would like to move Plaintiffs' Exhibit 41 into evidence.

THE COURT: Plaintiffs' 41 is admitted.

(PLAINTIFFS' EXHIBIT NO. 41: Received in evidence.)

MS. RIVAUX: Exhibit 42, please.

BY MS. RIVAUX:

Q. And this is a document from the American Medical Association. It's a letter to the National Governor's Association, correct?

A. That's who it is addressed to, yes.

Q. From the American Medical Association, correct?

A. By the letterhead, yes.

Q. And it states:

On behalf of the American Medical Association and our physician and medical student members, I write to urge the National Governor's Association and its member governors to oppose state legislation that would prohibit the provision of medically necessary gender transition-related care to minor patients. Correct?

A. You've read that correctly. Their interpretation of what is medically necessary, yes.

MS. RIVAUX: I move to admit Exhibit 42, please.

THE COURT: Plaintiffs' 42 is admitted.

(PLAINTIFFS' EXHIBIT NO. 42: Received in evidence.)

MS. RIVAUX: Exhibit 45, please.

BY MS. RIVAUX:

Q. This is the guidelines for psychological practice with transgender and gender nonconforming people from the American Psychological Association, correct?

A. You've read that correct.

Q. And it states --

MS. RIVAUX: If we can go to what is Bates-stamped PLAINTIFFS1486, please.

BY MS. RIVAUX:

Q. At the bottom left-hand side, last paragraph:

Because of the high level of societal ignorance and stigma associated with transgender nonconforming people ensuring that psychological education, training, and supervision is affirmative and does not sensationalize, exploit, or pathologize transgender and nonconforming people will require care on the part of educators. Correct?

A. You read that correctly.

MS. RIVAUX: I move Exhibit 45 into evidence.

THE COURT: Plaintiffs' 45 is admitted.

(PLAINTIFFS' EXHIBIT NO. 45: Received in evidence.)

MS. RIVAUX: I believe we already moved 46 into evidence. Correct.

Exhibit 47, please.

BY MS. RIVAUX:

Q. This is the position statement from the American Psychiatric Association, correct?

A. From April of 2020, correct.

Q. And it's a position statement on treatment of transgender and gender-diverse youth, correct?

A. That's what it states, correct.

Q. And it states in the second paragraph, beginning:

Gender-affirming treatment of trans and gender-diverse youth who experience gender dysphoria due to physical changes of puberty may include suppression of puberty development with GnRHa, commonly referred to as puberty blockers, use of GnRH agonist, despite potential side effects, hot flashes, depression, can allow the adolescent a period of time, often several years, in which to further explore their gender identity and benefit from additional cognitive and emotional development. Correct?

A. I've already stated the error in that statement, but that is what it says.

MS. RIVAUX: I would like to move Exhibit 47 into evidence.

THE COURT: Plaintiffs' 47 is admitted.

(PLAINTIFFS' EXHIBIT NO. 47: Received in evidence.)

MS. RIVAUX: Exhibit 48.

BY MS. RIVAUX:

Q. And this is another position statement from the American Psychiatric Association, correct?

A. That's what it appears to be, yes.

Q. Okay. And it states that they take the position that the -- that the American Psychiatric Association, under number one at the bottom, *recognizes that appropriately evaluated transgender and gender-diverse individuals can benefit greatly from medical and surgical gender-affirming treatments.* Correct?

A. Without stating the evidence behind that statement, that is correctly read.

Q. So you are saying that it is important for you to see the evidence in making these position statements?

A. Absolutely.

MS. RIVAUX: Moving Exhibit 48.

THE COURT: Plaintiffs' 48 is admitted.

(PLAINTIFFS' EXHIBIT NO. 48: Received in evidence.)

MS. RIVAUX: Exhibit 49.

BY MS. RIVAUX:

Q. This is a statement from one of the associations that you are involved in, the Pediatric Endocrine Society, correct?

A. That is correct.
Q. And you understand their position on transgender health is here in Exhibit 49?
A. In this particular, because I am a member of that organization, I can state directly that the entire membership was not asked to approve this statement; and, therefore, it does not represent the opinion of the members, merely the committee that put this forward.
Q. With that understanding, this is the position statement that has been put out by the Pediatric Endocrine Society, correct?
A. Correct.
Q. And they, too, support gender-affirming care, correct?
A. "They," meaning the committee that put this together.
Q. Correct. And that's what they state here, correct?
A. That's correct.
MS. RIVAUX: Moving Exhibit 49 into evidence, please.
THE COURT: Plaintiffs' 49 is admitted.
(PLAINTIFFS' EXHIBIT NO. 49: Received in evidence.)
THE COURT: We're going to need to get to an afternoon break at some point. Tell me how we -- we can finish up with Dr. Hruz, if we can finish up.
MS. RIVAUX: I still have a little bit to go. If we want to take a break now, that's totally fine with me.
THE COURT: Let's take the break. Let's take 15

minutes. We'll start back at five till 4:00.

(*A recess was taken at 3:40 p.m.*)

(*The proceedings resumed at 3:55 p.m.*)

THE COURT: Please be seated.

Dr. Hruz, you are still under oath. You may proceed.

MS. RIVAUX: Thank you, Your Honor.

One last of these position statements, while there are so many more, I don't want to spend all of our time doing this, but Exhibit 43, please, if we can go to the second-to-last page, please, the first full paragraph at the beginning of the page, starting with "Improving."

BY MS. RIVAUX:

Q. Before I start, this is the American Medical Association and the health professionals advancing LGBTQ equality position statements on health insurance coverage for gender-affirming care of transgender patients, correct?

A. You zoomed in. So I can't see the --

Q. It's on the first page.

A. Yes.

Q. And if you scroll down, you'll see it's published by the American Medical Association.

A. I don't see that.

Q. Scroll down a little bit. Right there.

A. The footer?

Q. Correct.

A. Correct.
Q. Do you see that?
A. I do.
Q. And the second-to-last page, the paragraph starts with:
Improving access to gender-affirming care is an important means of improving health outcomes for the transgender population. Studies demonstrate dramatic reductions in rate of suicide attempts with one metaanalysis finding that suicidality rates dropped 30 percent pretreatment to 8 percent post-treatments. The studies have also demonstrated a decrease in depression, anxiety, and that a majority of patients reported improved mental health and function after receipt of gender-affirming care. Correct?
A. That is read correctly. They do have the references here. It would be nice to go through the science in those papers.
MS. RIVAUX: Right now I am looking to move this into evidence, Your Honor.
THE COURT: Tell me again the number.
MS. RIVAUX: Exhibit 43.
THE COURT: Plaintiffs' Exhibit 43 is admitted.
(PLAINTIFFS' EXHIBIT NO. 43: Received in evidence.)
BY MS. RIVAUX:
Q. Dr. Hruz, you talked a little bit about keeping up with the international positions of certain countries.

One of the positions that you looked at was the United Kingdom, correct?
A. That is correct.
Q. And you referenced the Cass review, right?
A. That is correct.
Q. And it's an interim report, right?
A. That is correct.
Q. You don't have personal knowledge about healthcare provided in the U.K., Correct?
A. I do not live in the U.K., but I do know what they have stated explicitly as far as how they are reorganizing their healthcare system based upon this interim report.
Q. But you don't treat patients in the U.K., correct?
A. That is correct.
Q. Not licensed in the U.K.?
A. That's correct.
Q. In this interim report, one of the things that Dr. Cass states is that:
It is important to note that the references cited herein do not constitute a comprehensive literature review.
Correct?
A. It is based upon the information in the NICE reviews that we've already discussed, which is a systematic review of the evidence related to -- at least from my analysis, cross-sex hormones and puberty blockers.

MS. RIVAUX: Can you pull up Defendants' Exhibit 10, please. If you go to page 7, please.

BY MS. RIVAUX:

Q. Right at the first paragraph, the last sentence, it says -- this is a page about this report. It says it does not set out final -- excuse me.

It's the bottom on the right-hand side, bottom paragraph:

It is important to note that the references cited in this report do not constitute a comprehensive literature review and are only included to clarify why specific lines of inquiry are being pursued. Correct?

A. That is referring to the references in the report itself, not to the systematic reviews conducted by the NICE studies.

Q. This says the references cited in this report. Did I read that correctly?

A. "In this report," correct.

Q. And then the last sentence of that paragraph it says:

A formal literature review is one strand of the review's commissioned work, and this will be reported in full when complete. Correct?

A. That is correct.

Q. And that hasn't been reported yet, correct?

A. That is correct.

Q. And at the top of page 7, this report also says, the first paragraph:

It does not set out final recommendations. These will be developed over the coming months informed by our formal research program. Correct?

A. Yes. And Dr. Cass has actually spoken more on the plan to be able to incorporate that as far as what is being proposed in the revision of the original Tavistock model.

Q. Right. Doctor, my question was if I read that correctly.

A. You read that correctly.

Q. On page 9 -- on page 9, Dr. Cass writes a letter to children and young people, and what she states here is in the second paragraph:

I have heard that young service users are particularly worried that I will suggest that services should be reduced or stopped. I want to assure you that this is absolutely not the case -- the reverse is true.

Did I read that correctly?

A. You have read that as it is stated in the document.

Q. And if you can turn to page 23, and this page 23 is part of the summary and interim advice, right?

A. Correct.

Q. And at the top of page 23, it says -- it refers to hormone treatment, correct?

A. Correct.

Q. At the last sentence of paragraph 1.41, it states:

Standards for decision-making regarding endocrine

treatment should also be consistent with international best practice. Correct?

A. That is what it states, correct.

Q. And they cite then three footnotes. The first footnote, can you tell me what that is?

A. These are the 2017 Endocrine Society guidelines.

Q. And then on the right-hand side under paragraph 1.42, then there is a 12, it says:

Pediatric endocrinologists should become active partners in the decision-making process leading up to referral for hormone treatment by participating in the multidisciplinary team meeting where children being considered for hormone treatment are discussed.

Correct, that's what it says?

A. That is what it states.

Q. And so they have not banned treatment in the United Kingdom, correct?

A. No, and I don't think that I said that.

Q. You also mentioned France, correct?

A. Correct.

Q. And in France, you have no personal knowledge about how healthcare is provided in France, correct?

A. I have general knowledge. I don't practice in France.

Q. Okay. And you -- you're aware that this is not a certified translation of the document, correct?

A. No, but I did read the original French.
Q. But you did not translate it, right?
A. This document that is presented was not my translation, no.
Q. And it's a press release, right?
A. I believe so.
Q. And it's not peer-reviewed?
A. Correct.
Q. Is it typical for you to rely on press releases in making decisions?
A. I would not say that I rely entirely on this document. I only include that with my other assessment of the other information.
Q. And this press release doesn't actually include other than five references, right? That's all it includes is five references?
A. Correct, and a reference to the Swedish experience.
Q. Okay. But this press release is not a scientific review?
A. No, it is not.
Q. It's not a comprehensive literature review, correct?
A. That is correct.
Q. You don't know how they came to the decision in this press release, correct?
A. Only from what they state in the document.
Q. Okay. And according to this translation of this press

release, France does not prohibit hormone blockers, correct?
A. They explicitly state that.
Q. Right. They explicitly say that they are available in France, correct?
A. That is correct.
Q. And they also explicitly say that the French medical system allows hormones at any age, correct?
A. I would have to read if they say "any age," but --
MS. RIVAUX: If we can pull up Exhibit 15, please.
THE WITNESS: I have it right in front of me here.
MS. RIVAUX: I'm sorry. Defense exhibit.
THE WITNESS: As stated by your experts, it is not given when kids are prepubertal. So that's why I am questioning your wording.
BY MS. RIVAUX:
Q. It does say:
Although, in France the use of hormone blockers or hormones of the opposite sex is possible with parental authorization at any age. Correct?
A. I'll accept it.
Q. That it says that, correct.
THE COURT: It should be on your screen.
THE WITNESS: Thank you.
BY MS. RIVAUX:
Q. And you, in fact, prescribe hormone suppressants to some

younger patients, correct, some adolescents for precocious puberty?
A. That is correct.
Q. What is the youngest age that you prescribed it for?
A. Probably about three years old.
Q. Three years old?
A. Probably -- yeah, about three years old.
Q. You also mentioned a position statement from Australia and New Zealand, right?
A. That is correct.
Q. And in this statement, do they ban the use of puberty blockers for gender dysphoria?
A. They prioritize psychological intervention.
Q. My question was: Do they ban the use of puberty blockers in adolescents?
A. That's not what the document says, no.
Q. Do they ban the use of cross-sex hormones in adolescents with gender dysphoria?
A. No.
Q. And you have no personal knowledge of how healthcare is provided in Australia, correct?
A. I don't practice medicine in Australia.
Q. You also mentioned Finland, correct?
A. That is correct.
Q. And the document you reviewed, did you read that in the

original Finnish?
A. No.
Q. Do you know how it was translated?
A. The copy that I have is an official translation from Lingua Franca, and the person that translated, I recall a name of like Arbelaez or something. I can't remember how I was given that copy. It was a while ago.
Q. What is Lingua Franca?
A. It's a translation agency, and it's certified and signed.
Q. This translation is certified and signed?
A. It looks identical to the version that I have in my files.
Q. But there is no certification on this exhibit, correct?
A. It was not given to me today.
Q. Okay. And where is the certification -- who makes the certification for Lingua Franca? Who provides the certification for those translators?
A. I'm not sure I understand your question. I don't know who sought the official translation or not.
Q. Well, you said that Lingua Franca is a translation service.
A. Correct.
Q. In what country?
A. I have no idea where they are based.
Q. Do you know the qualifications of the translator?

A. I can only state what I stated.
Q. So the answer is "no"?
A. I can only state that I saw a copy that was translated by something called Lingua Franca that was signed by an individual by the name of Arbelaez.
Q. And this copy does not have that certified translation?
A. What I have seen of that document is identical to what I had seen in that translated document.
Q. You compared this document to the translation?
A. Not in its entirety, but what I have been able to see today.
Q. Okay. And, again, in Finland you have no personal knowledge of how they provide healthcare, correct?
A. Other than what I know from the United States, I do not have a license to practice medicine in Finland.
Q. And this document is not peer-reviewed?
A. In the sense -- again, we're getting into this question of what is meant by "peer review." But it was a systematic review that you can say that the people putting it through were the peers themselves. So it wasn't a single individual submitting this for publication. It was a healthcare organization where they are their own peers.
Q. But it would not be what we would consider a peer review of a scientific journal in the United States, correct?
A. In the sense that we talked about earlier, as far as

sending it out to external reviewers, I don't believe it was.
Q. And the version that we have here doesn't have any of the citations of any literature to it, correct?
A. I believe that there is. Let me make sure. This is the summary. It does not.
Q. And the document also says that:
Puberty suppression treatment may be initiated on a case-by-case basis after careful consideration and appropriate diagnostic examinations if the medical indications for the treatment are present and there are no contraindications. Correct?
A. In the experimental setting.
Q. But does it say what I just read?
A. And the section that you are reading?
Q. Paragraph 2.
A. My recollection, when I read this document, is that they specified the need for this to be done as part of a research study.
Q. And there are two hospitals that are providing this treatment in Finland, according to this document, correct?
A. Correct.
Q. And, again, they also provide for the provision of cross-sex hormones, correct, for gender dysphoria?
A. Recognizing it as being experimental.
Q. And you also talked about a summary from Sweden, correct?

A. Correct.
Q. Did you review the translation of this document as well?
A. No, but I did read the systematic review that was used as it was published in English.
Q. But that's not what we have in front of us, right?
A. This is the Swedish policy statement.
Q. Right. So it just says "Summary," right?
A. Which I believe uses the same language that's included in that systematic review.
Q. But this one only references eight articles, correct?
A. I would have to look at the references, but it doesn't have the full references in there, correct.
Q. And you have no personal knowledge about how healthcare is provided in Sweden, correct?
A. As a practicing physician, I do not have a medical license in Sweden.
Q. And they're still able to receive treatment in Sweden for gender-affirming care in adolescents for gender dysphoria, correct?
A. As part of an experimental procedure.
MS. RIVAUX: Your Honor, if I can have one moment.
THE COURT: You may.
MS. RIVAUX: I may wrap up.
Could you pull up Exhibit 170, please, plaintiffs', please. It's been a long day. I'm sorry.

BY MS. RIVAUX:

Q. Dr. Hruz, early in your testimony, you mentioned that under watchful waiting there is no medical intervention that is provided, correct?

A. That is not correct.

Q. You said that there's no medical care that's provided under watchful waiting?

A. No. In fact, I think that's an erroneous portrayal of the expectant model. In fact, the expectant model does recommend provision of care to address underlying psychiatric comorbidities.

Q. Well, not just psychiatric care, correct?

A. That's correct. All of the needs of the patient can be provided, the needs of their psychiatric needs and regular well healthcare. It does not mean doing nothing.

Q. Right. So under -- this is the Adolescent Health Medicine and Therapeutics article called, "Gender Nonconforming Youth, Current Perspectives."

And if we go to page 61 of the document at the bottom, it has a Bates number 6627 at the bottom, and the paragraph that reads, "Under the Watchful Waiting Model," it says:

The watchful waiting model was designed by the members of the interdisciplinary team at the Amsterdam Center of Expertise on Gender Dysphoria, VU University Medical Center under the leadership of Dr. Peggy Cohen-Kettenis, borrowing

from the medical use of GnRH agonists for children exhibiting precocious puberty. The Netherlands team is responsible for introducing the use of puberty blockers for gender purposes to put a pause on pubertal growth and allow more time for a youth to explore their gender and consolidate their adolescent gender identity with the future possibility of cross-sex hormone therapy to align their bodies with their affirmed gender identity.

Did I read that correctly?

A. You have read that as stated in the document.

Q. And continuing on to the next page, under this watchful waiting model as explained under this article, on the top, on the left-hand side:

If a child's cross-gender identifications and affirmations are persistent over time, interventions are made available for a child to consolidate a transgender identity once it is assessed through therapeutic intervention and psychometric assessment as in the best interest of the child. These interventions include social transitions, the shift from one gender to another, including possible name change, gender marker change, and gender pronoun changes, puberty blockers, and later hormones and possible gender-affirming surgeries.

Is that correct under the watchful waiting model?

A. Are you asking whether it's a correct portrayal of the

model or is it correctly read from the document?
Q. Is this the explanation provided for the watchful waiting model under this article?
A. Under this article, you have read that correctly.
MS. RIVAUX: Dr. Hruz, I don't believe I have any more questions for you, but thank you.
THE COURT: Redirect?
MR. PERKO: May it please the Court?

REDIRECT EXAMINATION

BY MR. PERKO:
Q. Dr. Hruz, you were asked a number of questions on redirect -- I'm sorry -- on cross-examination about some *amicus* briefs that you signed on to.
A. Yes.
Q. Do you recall that testimony?
A. Yes.
Q. Did you write any of those *amicus* briefs?
A. I was not the author of these *amici* briefs.
Q. Do you know how many others signed on to the briefs?
A. There are multiple other peoples who signed on to the briefs. I did mention that some of the wording I would have worded differently.
Q. I would like to refer you to an exhibit that my friend on the other side referred you to, Plaintiffs' 38.
Do you recognize this document?

A. Yes.
Q. And that's a position statement from the American Academy of Pediatrics?
A. That's correct.
Q. Do you know whether a majority of the pediatricians, members of the American Academy of Pediatrics support the statement in P38?
A. My understanding is that a single individual that is listed here as the author of this paper crafted this statement. It was not -- at the time this statement was published, I was a member of the American Academy of Pediatrics, and I was never given the opportunity to review this document, nor have any of the other members outside been able to comment on this before it was published.
Q. If I can zoom in on this second paragraph, second column, it begins "Dr. Rafferty." It says that:

Dr. Rafferty conceptualized the statement, drafted the initial manuscript, reviewed and revised the manuscript, and approved the final manuscript as submitted and agrees to be accountable for all aspects of the work.

Is that what it says?
A. Yes. It says that Dr. Rafferty was the sole author of this paper and was responsible for it being put together.
THE COURT: That's just not what it says, but on to the next question.

BY MR. PERKO:
Q. Do you know who Dr. Rafferty is?
A. I believe at the time he was a medical student when he wrote this or he was in training.
THE COURT: I hate to interrupt, but when you put a document up and it says that Dr. Rafferty drafted the initial manuscript, and then the witness says he was the sole drafter, it just doesn't match. I mean, and who wrote this document doesn't make much difference. But how willing a witness is to take an observable fact and just jump ahead, that doesn't matter.
MR. PERKO: Yes, Your Honor.
BY MR. PERKO:
Q. Dr. Hruz, Judge Hinkle asked you a question to the effect of whether you would prescribe hormonal treatment for gender dysphoria if the evidence showed them to be safe and effective.
Do you recall that?
A. I do recall that, yes.
Q. And what type of evidence would convince you that it is safe and effective?
A. As I have long maintained, the evidence that needs to be done in this area is a solid randomized controlled study showing the efficacy of this intervention; and, again, in a way that it is -- cannot be provided with another

intervention with lower risk and greater efficacy.

Q. And what type of evidence would you want to see?

A. A randomized controlled trial.

Q. The plaintiffs have suggested that the randomized controlled trials are unethical in this context.

What do you say to that statement?

A. I think it's based upon a false presentation of how a randomized controlled trial would be done. Generally, it's conceived that that would involve an experimental group and a controlled group that received no care. I have long advocated for the design of a randomized controlled trial that would be ethical, and in the initial stages of proposing these interventions could be done in a way that ensured the safety of these individuals. And this is based upon, for example, comparative group that received psychological intervention.

I base that on even some early evidence, for example, the 2015 Consta paper that actually compared in a nonrandomized way psychological intervention alone in comparison to psychological intervention and pubertal blockade.

In that study, both groups showed improvement during the course of observation. That would be a modest randomized controlled trial that would allow one to begin the process of designing larger trials with more ambitious gains, outcome measures, and that is the type of information that one needs

to be able to make the conclusion that this would be supported by the evidence as being both safe and effective. So, again, very carefully delineated what we mean by "safe" and what we mean by "effective."

And that's the basis for my concern in this area, is that that evidence does not yet exist, and there is not a willingness to even construct these trials. And I believe it's based upon not only a false conception of the way that randomized controlled trials are done, it's actually a distortion of the normal scientific method.

The basis for saying the randomized controlled trial is not ethical is to accept the conclusion without the evidence. As I may have said previously, the way science is normally conducted is to begin with the state of skepticism with your hypothesis assuming that there is no difference between intervention and control, and then looking for evidence to disprove that null hypothesis.

What is being portrayed as unethical is to begin with a forgone conclusion and then to look for evidence to support that conclusion, and that is not the way science is conducted.

MR. PERKO: Thank you, Dr. Hruz.

I do not have any additional questions. I was remiss. I don't believe I moved the exhibits that we talked about on direct.

THE COURT: Give me those numbers.

MR. PERKO: Plaintiffs' 8, 9, 10, 11, 12, 13 and 14.

THE COURT: So 8 through 14, those are defense exhibits?

MR. PERKO: Yes, sir.

MS. RIVAUX: Those are the ones we objected to as they related to the different report summaries from the different countries.

THE COURT: And if I didn't rule, I need to. It's the same ruling I made on the rest of these. Those are admitted for the purposes indicated earlier.

MR. PERKO: Thank you, Your Honor.

THE COURT: Doctor, a couple of things that are kind of detailed in clarification, and then some more important questions.

There was some question on cross about your relationship to Alliance Defending Freedom. You said you'd gone there for two meetings.

I have a colleague who wrote in a published opinion that you had a connection to Alliance Defending Freedom. Sometimes my colleagues are wrong as I am, and different records have different things.

Is going to two meetings your entire connection to Alliance Defending Freedom or is there more to it than that?

THE WITNESS: There is no more to that. I have been

contacted by the Alliance Defending Freedom for information related to my knowledge of the scientific evidence in the same way that I presented this knowledge to dozens of other organizations. It's exactly the same information that I presented multiple times to multiple different groups.

THE COURT: It sounds like that judge just got it wrong.

THE WITNESS: It has been by many misconstrued and misinterpreted.

THE COURT: All right. You said that something -- and to be candid, I don't recall now exactly what -- produced a three-to-five-times increase in the stroke risk. What was it that has that increase?

THE WITNESS: That is the administration of estrogen to a biological male. The reference to that paper, I believe, is Gettahun. I don't remember the year of the journal, but I would have to look it up.

THE COURT: So what I wanted to ask about was three to five times more than a stroke risk of what? What -- just somebody walking around in society, the risk they are going to have a stroke?

THE WITNESS: So if you are asking the question in relation to a biological male or a biological female, so the comparison is what happens to an individual when they get put on estrogen with their stroke risk. And that is actually

known for both males and females. It's dependent upon the route of the administration of the estrogen and the dose.

THE COURT: So if you give estrogen to a woman as you do sometimes --

THE WITNESS: Right.

THE COURT: -- it has a stroke risk.

THE WITNESS: That is correct.

THE COURT: And if you give estrogen to a man, the stroke risk is three to five times higher.

THE WITNESS: That is what the evidence showed in that paper.

THE COURT: I take it the risk of stroke from giving estrogen to a woman is very low.

THE WITNESS: That is correct.

THE COURT: You've done it before; you've given this treatment.

THE WITNESS: Correct.

THE COURT: And you tell the patient, one of the side effects, you could have a stroke.

THE WITNESS: Correct.

THE COURT: But you apparently say it's not a very high risk because the patient takes it, and I take it if you said, by the way, you got a 70 percent chance of having a stroke, nobody would take it. So you must say this is a small risk.

THE WITNESS: Correct. Again, it's in relation to counseling a patient on the risk they are accepting by getting the medicine.

THE COURT: Got it. The risk of all of these medicines, and you make a benefit analysis and --

THE WITNESS: That is absolutely correct. And I think that is the key question, is to whether the risk that is assumed relative is acceptable to the purported benefit. That is key.

THE COURT: But at three to five times higher, three to five times more than a very small number is still a very small number. True?

THE WITNESS: The patients that die from the stroke still die.

THE COURT: Yeah, but it's a very small number, right?

THE WITNESS: Yes, but by the more people that get exposed, then that risk increases.

THE COURT: It is. I haven't done the study, but my guess is the risk of flying on a private jet is a substantial multiple of the risk of flying commercial. But people who can afford it, they take the private jet. Sometimes when a risk is very small, an increase in the risk still is a very small risk. That's true, isn't it?

THE WITNESS: That is true. To put it in context,

when you look at the absolute mortality rate with gender-affirming care, and you look at -- it's not insignificant. If you look at the Kaplan Meier curves to look at things that are not irritation or -- so, anyway, your point is well taken. It is true.

THE COURT: When you analyze this kind of medical care or any kind of medical care, does clinical experience matter?

THE WITNESS: Yes. I'm not going to say it's not important.

THE COURT: So assume for me that -- we have had evidence in this case of many hundreds of individuals who have been treated medically and have had very substantial improvements in their quality of life. Should that be a factor in the analysis at all?

THE WITNESS: So I would say that there is a longstanding history within the medical profession of practitioners making statements based upon a belief that they are helping their patients only to find out later that they have not. So that one needs to interpret with caution the clinical experience supported by the available scientific evidence.

THE COURT: My question was: Should the clinical experience be taken into account in assessing that?

THE WITNESS: It should be considered.

THE COURT: Now, I understand that you don't always know what the situation is medically. My experience is, when somebody thinks they are happy, they're happy. And when they think they are unhappy, they're unhappy. It's almost tautological. So if there are hundreds of patients that have been treated, and the record shows that the patient said that they were happy, they were better after the treatment, how is it that you are able to say they are probably wrong, or they may be wrong, or we can't rely on what they think their mental position is?

THE WITNESS: To be clear, Your Honor, I did not definitively conclude that they're wrong. I said that the scientific information is insufficient to make a conclusion about their long-term welfare. In this situation here, the existing data for those that undergo detransition or have regret is a very long time frame. And it's very well -- to make a conclusion based upon an outcome of just several years is not sufficient in light of what scientific evidence that we have about long-term effects.

Another factor that I did not have a chance to mention during my testimony is, in many of these clinical trials, there is a substantial dropout rate of patients; sometimes as many as a third.

THE COURT: I'm not talking about clinical trials. I'm talking about doctors who treat real patients. We had

patients sitting on that witness stand where you are sitting now, a young man who thinks he's a lot better off. Do you doubt that he's a lot better off?

THE WITNESS: I haven't had that conversation, but I have talked with people that are not happy with what they had, and they universally tell me that they want to stay as far away from their practitioners as possible.

THE COURT: And let me tell you the people on the private jet that went down, they were not happy either.

They quoted to you *amicus* briefs, one talking about false belief and delusion, and you signed on to that brief.

THE WITNESS: That's correct.

THE COURT: Do you think that, let's say, a 12-year-old girl at birth who identifies as a boy is delusional?

THE WITNESS: I have had this conversation with multiple individuals.

THE COURT: I really don't want to know about your conversation. I want to know what you think. Do you think that that person is delusional?

THE WITNESS: It depends on how you define the word "delusional." Delusional, whether one recognizes the discrepancy between biological sex and their gender identity versus somebody that does not.

THE COURT: Probably a bad question because

"delusional" may be a medical term, and I didn't mean to use it that way.

The other thing in the brief was that this was a false belief. Do you think that the person who was assigned male at birth who identifies as female has a false belief?

THE WITNESS: Again, the statement is in reference to whether a male can become a female, and the argument from a biological -- and this is why it's very central to my discernment of this about the scientific premise about whether one can be born in the wrong body -- that the assertion that is made, I say that it is false to say that sex can be changed.

THE COURT: This is in reference to a false belief. Look, maybe I'm not describing it very well. Let's just get it out in the open and talk about it.

There are people who believe that a trans individual is indeed trans; that the person was born with male physical characteristics, assigned male at birth, but identifies as female, that that is a thing. There are people that believe it's all poppycock, and it's just a decision that somebody made, and that it's a false belief. I would have thought that when a brief said this is a false belief and delusion, and these are people impersonating someone else, that that was the view, the second view I described, the view that this is not really a thing; that this really is not a case that somebody

is born in a male body but identifies as female. That's not what is going on. It's just a false belief. I just need a straight-up answer.

Do you think it's a false belief or do you think there are really people that's who they are? They are born in a male body but believe, identify as females.

THE WITNESS: I accept that there are people that are born that are biological males that identify as females. The falseness is in whether they truly are females. They identify as, and they have a gender identity as, that's a different question. I would say that I do not deny that people present with a perception of their gender identity that is discordant with their gender, their biological sex.

THE COURT: Their perception. But, I mean, are they wrong or is -- is there somebody that their whole life identifies as a different gender from the sex assigned at birth?

THE WITNESS: I would imagine that there may be, yes.

THE COURT: You gave puberty blockers to a three-year-old once.

THE WITNESS: More than once.

THE COURT: More than once. Tell me the grade of evidence using the GRADE system that supports providing puberty blockers to a three-year-old. And then I'm going to get you to give me the control random studies that support it

or whatever for a three-year olds.

THE WITNESS: Correct. To my knowledge, there has not been a clinical practice guideline using the GRADE system to assess that question.

THE COURT: Are there any randomized controlled trials that support giving puberty blockers to three-year olds?

THE WITNESS: No.

THE COURT: Did you just use your clinical judgment to decide that this would improve this child's prognosis?

THE WITNESS: No. I used much more than my clinical judgment. I looked at the existing literature as far as the use of the medication for that purpose, the outcomes, and also in consideration of risk and benefit in that setting.

THE COURT: And was there a lot of literature about three-year olds?

THE WITNESS: It covers the -- yes, there is literature on three-year olds.

THE COURT: I have known of a couple of situations where a child was too young to swim at a cocktail party or whatever. The pool is there. The child winds up in the pool. The adult jumps in and gets the kid out. That's the right thing to do, right?

THE WITNESS: Yes.

THE COURT: What quality of evidence, using the GRADE

system, supports the view that the right treatment for that child is to get the child out of the pool?

THE WITNESS: There is no need for a GRADE system for that. Again, there are -- it's not unique to the gender dysphoria endocrine guidelines using the GRADE system. But at any time when one assesses a medical intervention and a recommendation, it is consideration of the relative risk versus the relative benefit. I would say that your example, hypothetical, is vastly different than the situations that we're talking about.

THE COURT: Vastly different. I did it for that very reason. You get a five-year-old with a peanut up the five-year old's nose. There are probably not any randomized studies for that either. You just take the peanut out of the nose the best you can, right?

THE WITNESS: Correct.

THE COURT: Now, there are two possibilities, and I think they are exhaustive. They exhaust the universe of possibilities. You have a 12-year-old, for example, who presents with a belief or identity of the other gender. So male sex assigned at birth, 12 years old says, I'm a girl, and has been saying this consistently for a long time.

I think there are only two or -- there are variations, but there are two possibilities that exhaust the universe. You can provide medical care or you cannot provide

medical care. Tell me the quality of evidence using the GRADE system that supports not providing medical care.

THE WITNESS: I would disagree with the way that you presented that because the two options are not the same.

THE COURT: Nobody ever likes my hypotheticals. But tell me what's wrong with the idea that that exhausts the universe. It's either yes or no; it's got to be one or the other.

THE WITNESS: No, it is not. The reason why it's not is that it's what type of medical care you provide. Nobody would argue to give more medical care.

THE COURT: Let me back up and try to straighten this out. By "medical care," I mean puberty blockers, hormone -- cross-sex hormones or eventually surgery. So define medical care as those. That's the medical care we are concerned about in this case, so define it that way. This child either gets medical care or does not get medical care.

THE WITNESS: Again, they could either receive the affirmative approach or they could receive psychological interventions that don't require those hormones. That's not no care.

THE COURT: I didn't say no care. I get it, and we can dance around this as long as you want to dance around it. Sooner or later you're either going to answer this question or you're not. And I'll draw whatever conclusions from that I

draw.

I think it's either you get medical care or you don't get medical care. That -- I'm not a medical doctor. I've had a few philosophy classes. It's got to be one or the other. You either got medical care or you didn't get medical care.

So you talked a lot today about the quality of evidence using the GRADE system that supports providing medical care. My question is: What quality of evidence supports providing no medical care?

THE WITNESS: I'm not able to answer the question as you phrase it because I would say there is significant data in the existing scientific literature that has not addressed whether the improvement that is seen is due to psychological intervention versus the affirmative hormones and surgery. And, therefore, when we're talking about how you care for these individuals, it's not give them the affirmative approach or give them nothing. It is to be able to give them the affirmative approach or an alternate approach that actually explores and addresses other aspects.

THE COURT: List for me the high-quality evidence that supports not providing medical care.

THE WITNESS: I'm not advocating nor I know anybody advocating no medical care.

THE COURT: Yes, you are. Maybe I missed it. When you define medical care as puberty blockers, hormone therapy

or surgery, unless I just totally missed your testimony, I thought what you were advocating was no medical care. Did I miss that?

THE WITNESS: Yes, you did.

THE COURT: What medical care do you advocate?

THE WITNESS: I advocate for high-quality research studies looking at alternative methods including psychological intervention.

THE COURT: When it comes to closing argument, I take the answers to be, he knows of no high-quality evidence that supports providing no medical care; and, frankly, I think that's correct. There is not. I think that -- you can address this when we get to closing. I think that you really do either get medical care or you don't get medical care. It's a decision one way or the other.

Your side seems to say, the Doctor seems to say, oh, we don't have good evidence to do it this way, and so the default is to do it that way. But that way is a choice, too. And I haven't heard any high-quality evidence for that way; and, frankly, I think, it's the same thing.

So you keep hammering this low-quality evidence, and I hear the argument. But if you want to persuade me with it, you are going to have to explain why what you're going to do is provide no medical care, because I think that's a decision, too.

Doctor, I have done the best with it I can.

Any questions just to follow up on mine?

MR. PERKO: No, Your Honor.

MS. RIVAUX: No questions, Your Honor. Thank you.

THE COURT: Thank you, Dr. Hruz. You may step down.

Ten to 5:00. You probably don't have a ten-minute witness. We haven't had a lot of those in this case.

MR. PERKO: No, Your Honor.

THE COURT: Where do we stand?

MR. PERKO: We have Dr. Levine next, Dr. Lappert after that, and then Dr. Kaliebe, and then we have two fact witnesses from AHCA, Ann Dalton and Matt Brackett. Oh, Dr. Scott, I forgot. She will be participating by Zoom. She's in the U.K.

THE COURT: They are five hours off. It's okay with me if she testifies at odd hours, but it's probably better for her if she testifies during her day. If you need to switch things around to accommodate that scheduling, we can do that.

MR. PERKO: Thank you, Your Honor.

THE COURT: 9:00 tomorrow. Anything else we need to do tonight?

MR. GONZALEZ-PAGAN: Not from the plaintiffs, Your Honor.

THE COURT: 9:00 tomorrow morning.

(*The proceedings adjourned at 4:50 p.m.*)

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I certify that the foregoing is a correct transcript from the record of proceedings in the above-entitled matter. Any redaction of personal data identifiers pursuant to the Judicial Conference Policy on Privacy are noted within the transcript.

Judy A. Gagnon *5/17/2023*

Judy A. Gagnon, RMR, FCRR
Registered Merit Reporter

Date

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