UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF FLORIDA
TALLAHASSEE, FLORIDA

AUGUST DEKKER, et al.,	)	
	)	
Plaintiffs,	)	Case No: 4:22cv325
	)	
vs.	)	Tallahassee, Florida
	)	May 18, 2023
JASON WEIDA, et al.,	)	9 A.M.
	)	
Defendants.	)	
_____	)	

VOLUME IV
(Pages 963 through 1151)

TRANSCRIPT OF FIFTH 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

THE COURT: Good morning. Please be seated.

Mr. Perko, please call your next witness.

MR. PERKO: Defendants call Dr. Stephen Levine.

DEPUTY CLERK: Please stand and raise your right hand.

***STEPHEN B. LEVINE*, DEFENSE WITNESS, DULY SWORN**

DEPUTY CLERK: Be seated.

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

THE WITNESS: Stephen B. Levine. L-e-v-i-n-e.

DIRECT EXAMINATION

BY MR. PERKO:

Q. Dr. Levine, what academic and professional positions do you presently hold?

A. I'm clinical professor of psychiatry at Case Western Reserve University in Cleveland, Ohio. I am the staff -- a staff psychiatrist at a private practice, and I'm the head of the gender diversity program at that private practice.

Q. And what do you do in those positions?

A. Well, as a professor, a clinical professor, I teach, I write papers, I supervise. And as a clinical psychiatrist, I see patients five days a week.

Q. And could you please summarize your educational background?

A. I graduated summa cum laude from the Washington & Jefferson College in Pennsylvania, went to Case Western Reserve Medical School, graduated in 1967. Did a medical internship for one year at University Hospitals, went to the public health service and worked at the NIH field studies unit in Phoenix, Arizona, studying diabetes in the Pima Indians.

I then went back to University Hospitals of Cleveland and had a three-year psychiatric residency, and then I obtained a Robert Wood Johnson Foundation two-year fellowship in research and academic pursuits. And then I have been practicing psychiatry ever since.

Q. Could you briefly explain your professional experience since obtaining your degrees and fellowships?

A. I'm sorry?

Q. Can you briefly summarize your professional experience since obtaining your degrees and your fellowships?

A. I'm sorry, I am confused by your question. I thought I just explained my professional degrees.

Q. Yes, I was asking about your professional experience since obtaining your degrees.

A. Well, my degree as a board-certified psychiatrist required passing exams and a certain number of years of clinical experience. The Robert Wood Johnson Foundation was -- I didn't even apply for, I was given by the chairman

of the department who had arranged it because he's -- I guess because he saw that I had some kind of developmental potential.

And I've always been interested in how things work and how people get to be mentally ill and how people get to be mentally unwell -- get to be mentally well with therapy and medications and so forth.

So I consider myself to be a student of various subjects. And, oh, I think I now understand your question. I'm sorry.

My specialty since the beginning of my academic career has been human sexuality, and I was originally hired by the department to develop a curriculum in human sexuality for medical students. And in the process of developing those lectures in that curriculum, I was known in my community as a young doctor interested in human sexuality. And I began to see all kinds of patients with sexual problems that I never even heard of when I was a resident, and that includes gender identity problems.

And in the process of coming to grips with all of these new things coming at me, I established five or six clinics within our system and gathered people around me to help me understand marital problems, sexual dysfunction, professionals who sexually offend, paraphilic problems, and male and female sexual dysfunction.

And for our purposes today, in 1974, I started the first

clinic for gender -- what we called in those days under a different name. We called it transsexualism. And so I was the first colleague, and I started the Case Western Reserve Gender Identity Clinic in 1974.

Q. Dr. Levine, do you have any experience with the treatment of gender dysphoria?

A. Well, I've continuously been involved in the evaluation and treatment of gender identity disorders since one month after I started my academic career. And within nine months of that first patient, a colleague and I started the Case Western Reserve Gender Identity Clinic. And that clinic has evolved into different -- under different names and has been in place at different locations. But I have been continuously, without interruption, taking care of gender patients and their families since 1970, middle of 1973, and formally since 1974.

Q. And have you -- approximately how many patients have you treated with gender dysphoria?

A. Well, the emphasis is on the word "approximately," and I would say 3 to 400.

Q. Dr. Levine, have you authored any peer-reviewed publications?

A. Many.

Q. Approximately how many?

A. Close to a 150, 160, and that doesn't include chapters,

but chapters are peer-reviewed in a sense, too. So I think at last count I have about 180 on publications.

Q. Have any of those involved gender dysphoria?

A. About 30, 35 of them have.

Q. Dr. Levine, did you attach a curriculum vita to your expert report?

A. I'm sorry?

Q. Did you attach a curriculum vita to your expert report?

A. Yes, I did.

Q. Is that a true and correct summary of your professional experience?

A. Except that on April 14th I published another paper, and I'm not so sure it's in my CV. But other than that, it's correct.

Q. Okay.

MR. PERKO: Your Honor, I believe Dr. Levine's CV is on the stipulated exhibit list as Exhibit Number DX32. We'd offer it into evidence.

THE COURT: DX32 is admitted.

(DEFENDANTS' EXHIBIT NO. DX32: Received in evidence.)

MR. PERKO: Your Honor, at this time I would tender Dr. Levine as an expert in psychiatry.

THE COURT: Questions at this time?

MR. LITTLE: No, Your Honor.

THE COURT: You may proceed.

MR. PERKO: Thank you, Your Honor.

BY MR. PERKO:

Q. Dr. Levine, what is gender dysphoria?

A. Gender dysphoria is a DSM-5-TR diagnosis that is characterized by fundamentally a current incongruence between the sense of one's self and one's gender and the biologic sex the person inhabits.

It has certain criteria, including duration criteria of at least six months and an impairment of social, vocational, educational function and other important areas of function. And it has to fulfill a certain specific criteria like the aspiration to have -- have the sexual -- secondary sex characteristics of the opposite sex, dislike of one's body, et cetera, et cetera.

Q. Dr. Levine, is gender identity biologically based?

A. Well, if you mean by biologically based biologically determined, the answer is definitely not. But the origin of gender identity disorder is a complex interaction between biologic givens, temperamental tendencies, developmental factors, psychological developmental factors, interpersonal factors, and cultural factors.

So these are the four great forces that shape all sexual behavior including identity, behaviors that stem from identity, biologic, developmental, interpersonal, and cultural.

So if we can accept that general principle, we would never say it's simply biologically determined.

Q. What are the different models of therapy for gender dysphoria?

A. There are three basic models.

Well, I'm sorry. Would you ask that again?

Q. What are the models for therapy -- different models of therapy for gender dysphoria?

A. For therapy, yes.

One is to characterize the problem that is accurately diagnosed, the presence of the current gender identity and meeting criteria for the gender dysphoria and then follow the family and -- the patient and the family over time without any intervention, knowing that development itself helps a child or a minor discern how he wants or she wants to live their lives.

So without anything but a follow-up, watchful waiting we sometimes call that, that's the same term we use, for example, if people have mild prostate cancer or low grade prostate cancer, we watch them over time rather than intervene. We monitor them over time to see what the course of the illness is. So watchful waiting is one approach.

The other approach because many of these children and their families have multiple forces that are adverse or negative or tense, tension, and the child developmental ideal

concepts how to raise children are not present in that family, so the second approach would be a psychotherapeutic approach addressing the symptomatic expressions of the child, like bed wetting or anxiety or depression and so forth, without a focus on gender identity at all, but a focus on helping the family function better to enable a healthier developmental process for the child.

And the third general category is the affirmative care where the child's current gender identity is supported, and maybe even the child is socialized. A grade school-aged child, a prepubertal child might be socialized in the opposite or aspired to gender, followed by medical, hormonal and then eventually surgical intervention.

So in summary, there is watchful waiting. There's a psychological approach to address the underlying developmental forces that are less than ideal in the family, and then there is the watchful waiting, which privileges gender identity to treat the gender identity. And so the psychological, the second force, the psychological force privileges the associated psychological problems in the child and in the family, whereas the affirmative care approach privileges the symptoms of gender identity.

Q. Is the psychological approach --

THE COURT: Let me -- when you say "privileges," would another word for that be prioritizes?

THE WITNESS: Prioritizes, yes.

THE COURT: I just wanted to make sure I understood your use of the word.

BY MR. PERKO:

Q. Dr. Levine, you mention the psychological approach. Is that conversion therapy?

A. In my mind it is not conversion therapy. It is just prudent traditional psychiatric approach to any other psychological problem that a child may have. This is a really pejorative term, and it frightens many mental health professionals from even being involved in the evaluation and treatment of kids with gender identity disorder.

I just need to emphasize that prudent, judicious and traditional psychiatric care that begins with an evaluation of the child and the family circumstances is how we approach every other psychiatric condition in a minor or a teenager.

Q. Are you familiar with the term "standard of care"?

A. I am.

Q. What does that mean?

A. A standard of care is a formal document that is derived by every medical specialty for each major disorder in that specialty. It is hopefully derived by a scientific review every five years of the current literature of the research, and it issues a brief recommendation for how a particular problem should be handled. I mentioned low-grade prostate

cancer. There is a standard of care for a low-grade prostate cancer. It is written by urologists and people who have great expertise in evaluating the quality of science.

So standards of care generally are to be issued every five years because science changes. It's to be constructed by people in the field, at least the minority of people in that committee in the field but also with people outside the field who have expertise in research -- development and research evaluation of papers, often people from epidemiology and different fields who have sort of expertise in how to construct research and how to the interrupt research.

So that's the standards of care. Standards of care are often used almost synonymously with clinical guidelines, but clinical guidelines -- well, let me say this again.

Standards of care have a highfalutin kind of connotation that it's kind of almost universal that the world agrees that the way to take care of low-grade prostate cancer is this, and the alternative is this. Clinical guidelines tend to be much more regional, much more local and not necessarily universally accepted.

Q. Dr. Levine, are you familiar with an organization called the World Professional Association for Transgender Health or WPATH?

A. I am.

Q. And what is your experience with WPATH?

A. I was one of the original members from the early '70s, and I was in the organization for 25 years, and I was asked to be the chairman of the development of the fifth edition of the Standards of Care which were published in 1999.

I attended their every-two-year meetings, and in those early years, my association with -- it wasn't called WPATH then. It was called The Harry Benjamin International Gender Dysphoria Association. But in those years, it was an international organization of people who were interested in answering the question, what is this thing called transsexualism and why do people want to do this, and what are we supposed to do about it?

We were a group of people, international academic people or just people interested in this subject who came together to try to figure out the answers to those questions. So it was in my view, a young doctor's view, a scientific organization seeking answers to vital questions.

But when I presented the WPATH the fifth Standards of Care to the executive committee of HBIGDA -- it was called -- the chairman of the department -- the president of HBIGDA had read the 21-page report that our committee created, and he objected to one aspect of the recommendations. And that was that people should have two independent psychiatric evaluations that recommended hormone therapy.

He thought it should be one, and he was really quite upset with us, and he told me at the meeting where it was accepted -- or the fifth version was accepted that he was going to appoint a sixth committee because he thought it was excessive that we asked -- he thought it was too conservative that we asked two independent psychiatrist to -- or psychologists to make an opinion that this is a reasonable choice for this particular person. And, in fact, I think in 2002, the next Standards of Care was issued, and if I remember correctly, it's almost word-for-word, that -- for our Standards of Care except that it asked only for one letter of recommendation for hormone treatment.

So that -- so I guess I wasn't pleased, but I was also reassured that my language or the language of my committee persisted in all but one section in the sixth Standards of Care. But I had attended the meeting and then the next meeting, and I realized that Dr. Green was committed to advocacy for trans care, and he was -- and the entire organization had become committed to advocacy rather than understanding the answers to these fundamental questions. And instead of a bunch of scientists and clinicians attending these meetings, they were suddenly cross-dressed people who were booing when they heard things that they didn't like.

And so I decided that I no longer could be a member of HBIGDA, and I think about 2002, I didn't renew -- after

attending a meeting, I didn't renew my manipulate.

Q. Dr. Levine, are you familiar with the WPATH Standards of Care Version 8?

A. Yes.

Q. Do you consider those to be true standards of care?

A. No. I think -- true in a scientific sense, you mean? True in a way that is -- accurately reflects the state of understanding. I think it's much more -- it's much more comprehensive. The fifth and sixth Standards of Care were 21 pages. The seventh Standards of Care were 121 pages. The eighth Standards of Care are over 300, I think 360 pages.

So if you ask a doctor to read the standards of care and follow the standards of care, you are asking the doctor to read a book which is not going to happen. But the construction of the standards of care are not based upon an accurate balanced view of the state of science. They are based upon a consensus of people in the field who have agreed that, even though the quality of the data, the scientific data is very low or low, the standards of care recommend that hormonal treatment be the first step for teenagers in affirmative care.

So the relationship between the tradition of how people have been cared for versus which I might call fashion-based treatment versus scientifically based or evidence-based treatment, those things are very different. And in the

eighth Standards of Care, 360 pages of rhetoric of talking about evidence and -- lead to the conclusion that the fact that there is a low quality of evidence does not mean we shouldn't use hormones and surgery when patients want them.

So I'm not impressed with the standards of care. They certainly are not universal. Certainly you have already heard that the European countries don't follow those standards of care anymore. And not -- the standards of care have been written by people who believe in hormonal treatment, and they do not include people who have any skepticism about it.

Q. Could you please explain how WPATH's standards of care historically dealt with psychotherapy as a treatment for gender dysphoria?

A. Well, in those early years, the '60s, '70s and '80s, psychotherapy was a tool for evaluating and understanding the answers to the basic questions. By the seventh standard of care in 2012 -- 2011, '12 and '13 were the years where the seventh edition became widespread -- psychiatric evaluation and the previous recommendation for psychotherapy before we had endocrine treatment, that was downgraded dramatically. So the psychiatric evaluation extended the psychiatric evaluation which had been previously the standard recommendation was downgraded, and people like me who performed these psychotherapeutic evaluation processes were

called gatekeepers.

And because there was a great influence from the community of trans adults themselves who wanted a particular form of treatment, this -- "a gatekeeper" a pejorative name. And so when psychotherapy as a reasonable process to begin the evaluation of people who wanted to change their gender expression suddenly became an enemy of the trans community.

And so nowadays when you read psychotherapy in the eighth edition of the Standards of Care, it's usually preceded by the word "supportive." So you have to have supportive therapy. And what supportive mean is helping the people live with all the conflicts and dilemmas that they may feel about being trans and all the environmental problems they encounter, and you have to support their concurrent gender identity.

Whereas psychotherapy used to be an evaluation of the psychological developmental conflicts and ambivalences that the person had, the worries that they had about this transition. So psychotherapy used to be respected, and now it's viewed -- you have already introduced this word, "conversion." It went from an expected prelude to considering medicalization to being some kind of an enemy of the trans person. And that's been the dramatic transformation over 40, 50 years, especially actually over the last 20 years.

THE COURT: At some point, I'm going to make sure I understand that, if you are still on the same subject and want me to wait just a minute. Is this a good time as any to interrupt.

MR. PERKO: Yes, Your Honor.

THE COURT: Let me make sure I understand this. I'm not going to put a meaningful timeframe on it, but basically I'm going to talk about early in your career as you were starting into this. And I take it the approach that you would think would be appropriate now, the idea is good psychiatric care, psychotherapy, an analysis of the individual, supporting the individual but not necessarily supporting the individual -- the individual's current gender identity, not necessarily opposing the person's gender identity but evaluating the gender identity and trying to come up with a plan for the individual.

Basically is that the approach?

THE WITNESS: That is the approach, but I want to add one thing to that. In evaluating the individual, we want to understand the forces that may have influenced the solution, I am a trans person. See, a new current gender identity is a solution. We're asking the question, what is the problem?

So what we want to know through the psychotherapeutic process over time is what things are disturbing this person in such a way that they imagine that, if they transfer -- if they

change their gender expression, all their preceding problems, which I can enumerate, the recurrent serious preceding problems, all those problems will be ameliorated.

So a psychotherapy is an attempt to identify what is -- in the courtroom it's called comorbidities -- and to see if we can address the sources of those comorbidities and attenuate the symptoms of those comorbidities if not eradicate them entire.

THE COURT: How did we get here and how do we solve any problem going forward, essentially?

THE WITNESS: Exactly. How did we get here?

THE COURT: So prioritizing hormone treatment or medical care is not what you advocate. What's been called conversion therapy resisting the gender identity is not what you advocate. What you are saying is you need to figure out how we got here and how we ought to go forward without a preconceived notion of which of those is appropriate.

THE WITNESS: Right. And ultimately, it is the individual patient's decision on how to live his or her life. And if that person chooses to medicalize after a period of careful evaluation, which is not done in one hour or two hours or three hours, you know, that's their right as an individual person, especially if they are 18 years old, an age of majority.

THE COURT: Jumping to medical care -- by "medical

care," I mean puberty blockers, hormone treatment, something other than therapy but medicines -- jumping straight to that inappropriate -- and you've talked about conversion therapy. You understand there are some places where the preconceived determination is we're going back to the natal sex and without the individual evaluation already know the answer.

Just like there are some people that know the answer is medicine. There are some people on the other side that know the answer is going back.

That's true, isn't it? Aren't there some people that do that?

THE WITNESS: Well, you know, the word "know" in your sentence is really "believe" that they know.

THE COURT: Absolutely.

THE WITNESS: What we're talking about here is long-term negative impact on sterility, on sexual dysfunction, on the ability to form and maintain lasting relations with a pool of people who are interested in participating in long-term stable relationships, and the fact that we know that there is premature mortality in the trans populations.

So when we say people know what is the best way of treatment, if -- they need to know what the long-term impact is of the comorbidities, plus the current gender identity, and so --

THE COURT: You're jumping ahead to stuff that I need

to let Mr. Perko deal with first before I start following up. So you answered. I think I understand what you told us to this point.

Mr. Perko, you may carry on.

MR. PERKO: Thank you, Your Honor.

BY MR. PERKO:

Q. Dr. Levine, are you familiar with the longitudinal studies by de Vries, et al.,?

A. Yes, I am.

Q. And can you tell us about those studies?

A. First, I want to tell you about the amazing significance of this study, that when this study was published in 2014, the world accepted the results of this and began at rapid acceleration, what we call rapid defusion of the new treatment standard of taking minor children, giving them puberty blockers and cross-sex hormones and surgery.

So nobody really right after this -- with one exception, no one tried to replicate the study. There was a replication attempt in England and it failed. But here are the problems with the de Vries study. This study is often referred to as "the Dutch protocol. "

The Dutch had 197 families, of kids and families. They offered the Dutch protocol to a 111 of them. The reason they didn't give them to the rest was their family was not supportive or the child was too mentally ill, too

symptomatic. So they had a 111 families that they offered this to, and 70 families agreed to enter into the protocol. When the protocol finished, there were 55 children reported upon.

Now, this study was not controlled. So you couldn't -- when a study that doesn't have a control, even though you may interpret that this -- we did this and this is the result, scientifically you can't know that because many things could have determined that result.

And one of the things that is very important to know is the Dutch protocol selected healthy families who were supportive and children who were not very symptomatic. Number one, they cherry-picked healthy people predisposed to have good results.

Number two, they only took into this protocol children who were cross-gender identified consistently during this prepubertal ages. They did not -- so no child was socially transitioned before because the de Vries group at that time knew -- at that time we already knew there was a very strong desistance rate for the cross-gender identified children. That means if you do watchful waiting in the cross-gender identified children, up to 85 percent of them will eventually reidentify with their biological sex.

So they waited. They took kids that were not socialized, who continued to be cross-gender identified and who entered

into puberty and got more symptomatic. Those were the children that were selected for the Dutch protocol. In America and elsewhere, today most of the children -- and by the way, the Dutch protocol had a preponderance of male children who would the cross-gender identify.

THE COURT: Natal males.

THE WITNESS: Natal males.

Today in America, the vast majority of the people now asking to be hormonally treated are females, and the vast majority of them did not have cross-gender behaviors and identifications during grade school.

So today's treatment is not based upon the same kind of kids that the de Vries study did. And in 2020, I think de Vries and the second author reminded the world of that, and more research needed to be done on the children who were beginning to be cross-gender identified only after puberty. So that is not controlled.

The children and the families in the Dutch protocol had concomitant at the same time they all had psychotherapeutic intervention, the child and the family. So there were two things going on at one time there. There was a hormonal treatment, and then there was the psychotherapeutic treatment.

They knew at that time these children needed a lot of help. So they did both things. And because it wasn't

controlled, you see, you can't conclude that those children did better, did okay.

Now, what they said was -- in 2014 is that the 55 children who constituted the end product of the Dutch protocol were between 12 and 18 months post surgery. There was no long-term follow-up. And they said that it cured a gender dysphoria. Cured gender dysphoria.

And as you heard yesterday, that is thought to be an artifact to the fact that when you are a natal male you were given a questionnaire before you started for a natal males, and when you were done with your surgery, you were given a questionnaire for the natal females.

And so questions about are you satisfied -- are you distressed -- what level of distress you have when you have erections, which at age of 11 or 12 -- I should say 12 or 13, because they waited longer in those days -- of course, the kid was distressed because he had an erection. So there was no question about that -- so the question is, are you distressed when you menstruate, for example, well, to -- at the end of protocol. So the new female is not distressed when they menstruate.

So what we think is by -- and de Vries herself has recognized that switching the protocol was -- the protocol -- switching the questionnaire was not an ideal way of evaluating this.

The other thing is of 15 people didn't complete the protocol. And some of the reasons that they didn't complete the protocol had to do with the development of diabetes, a development of obesity, and there was one death. So in some of the papers, there are eight different criticisms for the limitations of this study. I have given you five.

BY MR. PERKO:

Q. Does the use of puberty blockers and cross-sex hormones for the treatment of gender dysphoria been shown to improve mental health outcomes?

A. It depends who you ask and what studies you use, but a recent review of this by Thompson and published, I think, in 2020, published in -- was an attempt to do a systematic review of exactly that question, and they could not conclude that mental health was improved.

More recently, there was a study published in the *New England Journal of Medicine* whose lead author was Dr. Chen, and they studied, I think, 315 kids at age 16 who were given cross-sex hormones, and they found that statistical significance to the children at age 18 were highly happy, were very happy with their new appearance.

But when they study depression and anxiety, although, looking at the 315, there was some improvement for the whole -- the group as a whole for depression and anxiety, the actual experience is if you look case by case, there were

many kids that got worse and some kids got a little bit better. So it was all over the place. And as Dr. de Vries, who wrote a commentary on this in the *New England Journal of Medicine*, said there is no mention in the study about the physical complications of this; it was just about the mental health.

Now, if you look closely at the study, there is some reason to doubt about the mental health improvements, but there were definite improvements in the happiness with one's appearance, you see. They've had two of those kids suicided during the course of those two years. So obviously -- and there was no -- I think no mention of who got admitted to the psychiatric hospital during those two years.

So with the data presented, the glib conclusion is that -- by this group is that the mental health is improved. But when you talk about improved mental health, it's very important to say what parameters are you using.

And from one study to another, the parameters that are used to support the idea that mental health is improved varies from study to study. There is a very little consistency.

Q. In your opinion, Doctor, has the use of puberty blockers and cross-sex hormones been shown to the improve the mental health condition in your opinion?

A. No.

Q. In your opinion, has sexual reassignment surgery for the treatment of gender dysphoria been shown to improve mental health outcomes?

A. By "sex reassignment surgery," you mean mastectomies?

Q. Yes.

A. And genital re -- conformations?

Well, here again, we have a tradition --

Q. I'm asking for your opinion, Doctor.

THE COURT: Let him answer the question.

THE WITNESS: I will answer the question this way:

In the last three years, there have been two studies by advocates of sex reassignment surgery, whose introduction have said that it's unclear whether sex reassignment surgery improves mental health, and they undertook two studies to demonstrate one way or another did it improve the mental health.

The most famous of the studies was published online in 2019 in the *American Journal of Psychiatry*, which the prestigious journal in our field. Twelve people immediately wrote letters to the editor saying that the conclusions of this study were not -- could not possibly based upon the facts that were presented, the data that were presented. So the American -- the editor the *American Journal of Psychiatry*, after it had peer reviews and got accepted, sent it out to two different statisticians who independently concluded the same

thing, the same way that the 12 letter writers concluded.

So when this published -- when this study was published, not online but in print in August of 2020, Dr. Kalin, who is the editor in chief, said that -- what he did and explained the method and agreed with the letter writers that the conclusions of the study were not based -- could not be scientifically be based on the data presented, and so he asked the two authors of the study to write a retraction.

They concluded that more sex reassignment surgery should be done, and when they retracted the study, they said more scientific studies needed to be done and that the answers to their original questions were still unclear.

So when you ask me, do I believe the sex reassignment surgery improves mental health, I say to you that many of the of the people -- I would say all of the people who recommend sex reassignment surgery believe that it improves mental health, but we haven't been able to prove that it improves mental health.

Again, we get back to what are the parameters of the mental health that an individual study uses to conclude that it improves mental health, because it's admittedly a complex subject of what is mental health, how do you measure mental health, you see.

And what we are longing for is an international

consensus about how to evaluate mental health and when to evaluate mental health. Is it one year, three years, five years, ten years, you see? And under what parameters.

The diagnosis of gender dysphoria has to include an impairment in social, vocational, educational or other important areas of function. Other important areas of function probably include sexual capacity or relational capacity, you see? And many of the consequences of sex reassignment surgery on the genitals impair the sexual capacities of the patients.

MR. PERKO: Thank you, Your Honor. Nothing further.

THE COURT: Cross-examine?

MR. CHARLES: Good morning, Your Honor. Carl Charles for the plaintiff.

CROSS-EXAMINATION

BY MR. CHARLES:

Q. Dr. Levine, you have been a psychiatrist seeing patients since 1973, correct?

A. My residency began in 1970.

Q. So you were an officially credentialed psychiatrist starting in 1973?

A. Yes.

Q. And the overwhelming majority of your patients have been adults, correct?

A. Well, in the -- probably early 30 years of my profession,

that's true.
Q. You have previously estimated that you have seen about 15 minor patients in your more than 50-year career, correct?
A. Yes, I always emphasize the estimate. I -- somewhere along the line I've testified to that number.
Q. And you've also seen personally approximately six prepubertal children?
A. Directly, yes.
Q. Dr. Levine, earlier this morning you used the word "minor" to include both prepubertal children and adolescents; is that correct?
A. Yes.
Q. In my questions, I'm going to make a distinction between those two groups for clarity for the record.
Will you understand when I do that?
A. Certainly.
Q. When you evaluate adolescents for gender dysphoria, you meet with their parents or legal guardians as well, correct?
A. I do.
Q. And you take reports from the parent and legal guardians about the adolescent when you meet with them, correct?
A. Yes. You see, parents know what happened during pregnancy, they know what happened in early life bonding processes, they know about their own mental availability to the infant and toddler child, they know about the experience

of two and three-year-olds, and no adolescent can tell me anything about anything substantial and verifiable about his early or her early life.

So it's imperative that the evaluation of adolescent trans people or adolescent any patient, we get that kind of information because one of the aspects of evaluation is development, you know. If there are four things that influence the development of gender identity, biology, interpersonal, psychological development and culture, you need the parents to teach you about the early parts of the child's life.

Q. And so those parent and guardian reports contribute to your assessment about whether an adolescent meets the criteria for gender dysphoria, correct?

A. No, no. No, what --

Q. Parent reports don't contribute to your assessment?

A. They contribute to the assessment of the origin, the influences of the child. Whether a child meets criteria depends on what the child says, not what happened to them in pregnancy.

I don't seem to be clear to you. You asked --

Q. Let me ask a different question.

When you diagnose any patient for conditions like depression or bipolar disorder, you rely on the self-report of the patient, correct?

A. Depending on the age of the patient, I rely on self-report and parental report. And the parental report is very -- is very important to any psychiatrically-symptomatic person who is brought to us.
Q. And reliance on self-report from the patient and information from the parents or guardians is not, as you said, unique to the diagnosis of gender dysphoria?
A. Correct.
Q. So it would be fair to say that diagnosing patients based on self-report, and in the case of an adolescent information from others who know the patient, parents, guardians, is ideally how the practice of psychiatry works?
A. Yes.
MR. CHARLES: Your Honor, I would like to show the witness what has been parked as DX16 from the stipulated exhibit list.
BY MR. CHARLES:
Q. Dr. Levine, it should appear on your screen in just a moment.
THE COURT: It's slow.
MR. CHARLES: It will just take a moment.
THE COURT: I said it will get there based only on my clinical experience. We have no studies to confirm that.
THE WITNESS: It's here now.
BY MR. CHARLES:

Q. Okay. If you could please turn to S50?

Oh, I'm sorry, S48.

THE COURT: We're in DX16, and you are going to page S48?

MR. CHARLES: Yes, Your Honor.

BY MR. CHARLES:

Q. Dr. Levine, how small is that print on your screen?

A. I can read it now.

Q. You can read it now? Okay.

A. Uh-huh.

Q. Dr. Levine, this is DX16, the WPATH Standards of Care, Version 8, that you were discussing earlier.

Would you like to look at title page or did you see the title page before we scrolled to the --

A. I saw it.

Q. Okay. So if you would please look with me at about --

A. May I ask you to speak a little louder?

Q. Yes, of course.

A third of the way down the page, 6.3, do you see that, Dr. Levine?

A. Yes.

Q. Okay. And this is a recommendation, 6.3: *We recommend healthcare professionals working with gender diverse adolescents undertake a comprehensive biosocial assessment of adolescents who present with gender identity related concerns*

and seek medical surgical transition related care and that this be accomplished in a collaborative and supportive manner.

Did I read that correctly?

A. Yes, you are an excellent reader.

Q. Thank you.

And if then if you look a little bit further down, Dr. Levine, the bottom third of that section, statement of recommendations, at 612(d), and I'll read the italicized font at the top of this section:

The following recommendations are made regarding the requirements for gender-affirming medical and surgical care (all of them must be met)?

Did I read that sentence correctly?

A. Yes.

Q. And then back to 612(d):

The adolescent's mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and gender-affirming medical treatments have been addressed?

A. Would you give me the name of that? Is it 12(a) or 12(b)? Which one is --

Q. I was reading 612(d) as in dog.

A. Oh, D. Okay.

Q. Would you like me to read it again?

A. No, I'll reread it.

I read it.
Q. Okay. Did I read it correctly after your reading?
A. I have a feeling you are going to ask me this question 15 times, and I would like to compliment you on your ability to read. So I'll just --
Q. Thank you, Doctor.
A. We're wasting time.
Q. I appreciate your understanding of our -- the requirements of the legal practice in this regard.
Dr. Levine, you testified earlier this morning that you have treated patients with gender dysphoria, correct?
A. Correct.
Q. And without specifying an age group, you have supported some patients' social transition, correct?
A. Yes, we used to refer to this as the real life test.
Q. I'm sorry, Dr. Levine, I appreciate your speaking to the judge. But when you do so, you turn away from the microphone and I can't hear you.
A. I'm sorry.
No, we used to -- in supporting some people's transition, social transition, we used to refer to this as a real life test. Please live your life in the aspired-to gender for a while, go to school, do -- present yourself and see what the problems are both intrapsychically and interpersonally, and then that will help you to decide whether you want to go

further.

That was a standard in the fifth version, sixth version of standard of care. That real life test has disappeared from the current standards of care. In other words --

Q. I'm sorry. Dr. Levine, just a moment.

You have written letters of authorization for adult patients for gender-affirming surgeries, correct?

A. Correct.

Q. And you have done this as recently as within the past two years, correct?

A. It's probably now two and a half years. Probably to be safer, three years. I'm not sure. It was for a 26-year-old.

Q. Dr. Levine, do you recall a deposition that you sat for in a case called *Brandt versus Rutledge* in May of 2022?

A. I think that was North Carolina, in North Carolina?

Q. Arkansas.

A. Arkansas, sorry.

Q. You do recall that?

A. Yes.

Q. Do you recall testifying in that deposition under oath?

A. I do.

Q. And in that deposition you testified that you had written letters of authorization for adult patients as recently as 18 months ago.

A. Okay. If that was 12 months ago, so it would now be 30

months. So that's two and a half years.
Q. Thank you for helping me with that math.
A. My pleasure.
Q. And you've also written letters authorizing hormone therapy for adult patients with gender dysphoria, correct?
A. Somewhere in the past, yes.
Q. And these are letters that patients can take to an endocrinologist?
A. Yes.
Q. And you have written such letters authorizing hormone therapy for adolescents in a few cases in the last five or six years, correct?
A. Oh, yes.
Q. Dr. Levine, you would not write a letter supporting hormone therapy for an adolescent if you did not believe the patient had gender dysphoria, correct?
A. Correct.
Q. Dr. Levine, it's your understanding that there is no medical intervention that is appropriate for prepubertal children, correct?
Let me -- let me re-ask my question.
Aside from psychotherapy, it's your understanding that there is no appropriate medical intervention, puberty blockers, cross-sex hormones, surgery, for prepubertal children, children who have not reached Tanner Stage 2?

A. Well, as asked -- as phrased, the question -- the answer to your question is, yes, there is no appropriate medical intervention. But it really raises -- we really have to answer that question by saying that if you socially transition a six-year-old, it does have long-term medical implications.

Q. I appreciate that, Dr. Levine, but my question was very narrow and specific.

A. Your narrow question -- I've answered your narrow question.

Q. Thank you.

And Dr. Levine, you would not write a letter authorizing hormone therapy for an adolescent without first determining that they had a longstanding, stable gender identity?

A. Yes. May I elaborate on your question?

Q. No, not right now, Dr. Levine. Defendants' counsel will give you an opportunity in redirect.

Dr. Levine, you testified earlier this morning that standards of care should be re-renewed every five years. What empirical data or reference are you referring to for that assertion?

A. Well, I don't know if there are any empirical data. I think that's the standard across the medical profession. I don't think it's the result of studies. It's the result of experience, about new research appears, and we -- and the

seriousness of what we do needs to be reconsidered approximately every five years.

Q. I appreciate that, Dr. Levine. But let me make my question broader.

I'm asking your assertion that it is standard, what is that based on? Is that your clinical opinions?

A. No, that's based on a 2021 study by Sara Dahlan. I forget where it appears, but you can readily find it where they -- this study evaluated the seven standards of care and enumerated the -- what you're asking about.

Q. Thank you.

A. This is the understood standard throughout medicine.

THE COURT: Spell Dahlan for us.

THE WITNESS: D-a-h-l-a-n.

BY MR. CHARLES:

Q. Dr. Levine, your view -- isn't it your view that if parents and guardians are fully informed about the risks and the state of the science, the decision about whether to pursue hormone therapy for adolescents should be made by parents, patients and doctors?

A. That's not quite true. I kind of think that doctors don't know enough about the future of the patient to make a strong recommendation for what should happen. I think that doctors need to inform the parents about the state of science, what is known and what is not known, and they, the

patients with the child, should make the decision.

When you asked me previously about do I write letters of recommendation and you didn't want me to further elaborate, what I needed to tell you is that I don't actually say I recommend this person to have surgery.

Q. I appreciate that, Doctor.

THE COURT: I want to hear the rest of the answer.

THE WITNESS: What I say is the person and I have gone through a process that satisfies my ability to understand the forces that shape this decision. And as I believe the patient gets to choose how he or she lives their life, I see no reason to sustained in the patient's way of doing this if the patient continues to want to have the hormones. I have written letters for people who never actually do what the letter allows them to do, whether it's take hormones or to have orchectomies and so forth.

I don't think I know enough to recommend that this is the best course for the future of this patient. I recognize that my job is to teach the parents what science knows, and if they and the child in conjunction with me or some other clinician think this is the best thing to do, then they may do it.

I don't think I know enough about the long-term outcomes for this child to say I recommend this is the only and the best treatment for this child. So I don't want you to

confuse a letter that says this is what the child is about and this is what I know about the child with a strong recommendation from Dr. Levine that the only treatment for this is hormones or surgery.

THE COURT: Doctor, do you think the Florida legislature or the governor has enough information to make that decision for any given child?

THE WITNESS: I think doctors, myself are aware of the uncertainties, and legislatures and governors, I don't know what they know. I think they are responding to a kind of sense of political and moral concerns that generally are not my concerns.

BY MR. CHARLES:

Q. Dr. Levine, do you recall testifying in November 28, 2022, in a trial in Arkansas for that case we discussed earlier, *Brandt versus Rutledge*?

A. I was there, yes.

Q. When asked the same question I just asked you, your response was yes, that you do believe if parents, patient and doctors are fully informed about the state of the science, the decision about whether to pursue treatment for minor adolescents should be made by that same group?

A. Well, I'm older now, and I have had a chance to reflect upon your term "recommendation," "recommend," and I stand by my statement today. I'm a maturing person, and I'm allowed

to change the emphasis of my answers.

Q. And, Dr. Levine, you understand you testified under oath at that trial?

A. It was true. I wasn't being -- you evolve; I involve. My answers can change. I read new papers since that time, for example. You know, just to give you an example, sir, in January of this year, there was a paper published in the JAMA, the Journal of American Medical Association by a group led by Jackson that demonstrated an increase mortality of young adults with transgender identifications.

It was a further study about reduced -- an additional study that demonstrated, as previous studies had done, the limited life cycle, the increased mortality of trans people. Now, when you talk about making recommendations and informing parents, it's very hard to inform a parent that there is data out there that had been consistently been present for the over a decade that there is an increased death rate of people who are transgender identified. That's very hard to tell a parent.

And so the question is, is the informed consent process going on actually telling the parent what science knows?

Q. But, Dr. Levine, you yourself do not write letters of authorization unless you are sufficiently satisfied that you have informed parents and the patient about those risks and benefits as you just mentioned?

A. Well, I haven't written a letter of recommendation since that study was published; that's just in January of this year.
Q. But in the past, in your clinical experience.
A. In the past I have -- as I explained to you, I believe that it's the parent's decision, and I have told the endocrinologist what I know about the patient and I don't stand in the way of getting hormones if they continue to want hormones. But kids are much more ambivalent than they seem on initial presentation, and sometimes they get a letter for either surgery -- actually this is true for adults as well. They get a letter for hormones and surgery, and then they don't go through with it. And as you had me --
Q. I'm sorry, Dr. Levine. You agree that there are some people who benefit, including long-term, from gender-affirming medical treatments?
A. I hope that is true, yes.
Q. And, Dr. Levine, you have testified previously that discontinuing treatment for adolescents who are current receiving hormone therapy could create a psychological and physiological problem, correct?
A. I have.
Q. And you have concerns about youth who have already been stabilized in their new gender having to discontinue that treatment, correct?

A. I have expressed concerns about that in the past under oath.

Q. Dr. Levine, you've previously testified that in your estimation, there are roughly 70 or more gender clinics in the United States?

A. At that point, yes. I've subsequently seen reports on the internet that there are even more; there are closer to 400. But I have no way of ascertaining that, especially you see that there are clinics associated with hospitals, and then there are individual practitioners who specialize or who write letters or who see patients.

So it's -- and probably before 2014, there was a handful of places associated with universities, and now most major universities have gender clinics. For example, in Cleveland today, besides our clinic, we have three major hospital systems, and we have three -- every one of those hospital systems has a clinic for gendered -- for gender youth.

Q. And, Dr. Levine, you said you heard -- you read on the internet there were 400 clinics, but you don't have any evidence to point to to support that?

A. Yes.

Q. And, Dr. Levine, you personally don't know how different practitioners or clinics provide care, correct?

A. Yes. Neither do you.

Q. I'm sorry, I couldn't hear that.

THE COURT: Neither do you.

BY MR. CHARLES:

Q. Dr. Levine, you understand you are under oath today, correct?

A. Yes.

Q. And I'm not.

A. Okay. I didn't presume you were.

THE COURT: If you think that means that you are free to say things untrue, I choose to differ with you.

MR. CHARLES: No, Your Honor.

THE COURT: I expect you to be just as honest as the witness on the stand.

MR. CHARLES: Yes, Your Honor.

THE COURT: With an advocate's privilege mixed in there.

MR. CHARLES: Appreciated, Your Honor, thank you. My apologies.

BY MR. CHARLES:

Q. And so, Dr. Levine, you personally do not know how common it is for clinicians to provide gender-affirming hormone treatments to adolescents without the careful assessment and fully informed consent of their families?

A. I'm just reviewing the phrase that you uttered.

Q. I can repeat the question if it would be helpful.

A. Yes, please do. Perhaps you could change the wording a

little.
Q. So you, Dr. Levine, don't know how common it is for clinicians across the United States to provide gender-affirming care, that is, hormone treatments to adolescents without careful assessment?
A. Well, of course, the answer to your question on the surface is that I don't know how it's done everywhere. But I do have sources of information that let me know that it's not done carefully, and I am certainly am aware of the informed consent processes in other places. And some of the sources of my information are the parents who have come to me and told me about their children being diagnosed and recommended for affirmative care after one hour.
So -- and I have spoken to -- on two occasions in the last year to groups of parents who have invited me and in the question-and-answer period, they have told me this story repeatedly. That they took their child, their minor child, and before they knew it, before the hour was over, there was a recommendation for affirmative care. One of my -- the mother of one of my patients went to a nurse practitioner, and in 45 minutes at the first visit to the nurse practitioner got an estrogen prescription. This is very common in my experience and in the experience of parents.
So the answer to your question is, as you phrased it, of course I don't know what's happening everywhere in the

United States, but I do have lots of clinical experiences that you would call anecdotal that tell me -- consistent antidotal experience about the parents' concerns that their child is not getting a thorough comprehensive psychiatric evaluation.

MR. CHARLES: Your Honor.

THE COURT: You ask an argumentative question; you get an argumentative answer. I'm going to hear everything he has to say.

MR. CHARLES: Thank you.

THE WITNESS: So the answer is yes, I don't know, but -- and I've told you but.

BY MR. CHARLES:

Q. But, Dr. Levine, sitting here today, you don't know and can't point to empirical data about how most practitioners around the country, how credentialed they are or how they provide care. Yes or no?

A. I know to be credentialed by WPATH, you have to attend the WPATH conference, educational conference. And so you can have various degrees of clinical experience, and you can be credentialed. And being credentialed by WPATH means that you accept the principles of WPATH. And so again, the answer to your question is I don't know, but I have lots of reasons to believe that the credentials to qualify as a knowledgeable gender expert is quite variable.

Q. But you couldn't say, Dr. Levine, based on your personal experience whether that number of practitioners is a minority or a majority, correct?
A. In some empirical way, meaning having counted, correct.
Q. Dr. Levine, you don't have any knowledge about how gender-affirming medical care is provided to adolescents in Florida, correct?
A. Correct.
Q. Dr. Levine, in your report in this case, you stated that there is no credible scientific evidence beyond anecdotal reports that psychotherapy can enable a return to male identification for genetically male boys, adolescents and men or return to female identification for genetically female girls, adolescents and women.

Do you recall including that in your report?
A. Yes. We need to be honest not just because we are under oath. We need to be honest about this. In my field of psychotherapy, psychiatry, we have a paucity of studies that are controlled that demonstrate the long-term impact of psychotherapy. We only have a tradition of doing psychotherapy and helping people.

We think we help people; sometimes we're wrong. But the only controlled studies in psychiatry about psychotherapy are usually short-term studies based upon cognitive behavior therapy. They are usually six weeks or two months follow-up

using questionnaires.

So we've practiced in psychiatry on a kind of psychiatric faith-based notion that human attachment and investigation in a caring, confidential way helps many people get over the things that are ailing them. But when you ask about empirical studies, what you're quoting from my report is the statement that alternate treatments for psychotherapeutic approaches. Whether we are talking about the psychotherapy versus affirmative care, we do not have strong empirical evidence that were effective.

That being said, I have helped people and I currently am supervising a child psychiatrist who I know is helping people with added skills, hopefully that I'm helping her to achieve, that she has helped people. Last Tuesday, a week ago Tuesday in our gender diversity conference, we heard about a case who has reidentified and through psychotherapy and is being benefited.

But this is what you would call anecdotal evidence, and I just say to you that in my expert opinion report, I shared the lack of controlled studies. But nonetheless, psychiatry has been providing psychotherapy for over a hundred years, and so that is a tradition-based assumption, and it's considered prudent by many of us.

Q. Dr. Levine, in your clinical experience, you've had only two patients who have detransitioned after medical

interventions, correct? I should add that you are aware of?
A. Well, I have written a paper about -- you're referring to that. I'm just trying to think about the other one. There was a child that I never saw, but I saw their parents, and I helped their parents to be witness to the reidentification as a little girl. Perhaps that's the second one.
I've certainly talked to many adults who are considering and then reconsider this. So I guess you would say at least two, but I think there's probably more.
Q. And just to clarify, I was speaking about your clinical experience.
A. That's what I'm talking about. As I think about it, there have been more than two.
Q. Dr. Levine, you testified earlier today generally about the concept that the dissenting views in the treatment of gender dysphoria are not well tolerated.
Do you recall generally that testimony?
A. I'm sorry. You mumbled. Will you please repeat?
Q. Sure. Let me re-ask the question.
Dr. Levine, you presented at an American Psychiatric Association annual conference in May of 2022.
Do you recall that?
A. I certainly do.
Q. And it was in a symposium on reexamining best practices for transgender youth.

Do you recall that?
A. That was the title of the symposium.
Q. And, Dr. Levine, it's correct that your co-presenters on that panel included Ken Zucker, Lisa Marchiano, and Sasha Ayad, A-y-a-d. Is that correct, Dr. Levine?
A. Correct.
Q. And is it fair to say, Dr. Levine, that all four of you, yourself and those three individuals, have generally dissenting views from the American Psychiatric Association policies on transgender healthcare?
A. Yes.
Q. And the American Psychiatric Association was aware that the four of you were presenting ideas that were not in keeping with those official policies, correct?
A. Yes.
MR. CHARLES: Just to be clear, I'm to speak up not to shout at witness but just so he can hear me properly.
THE COURT: I wasn't concerned about you being too loud. And even a little louder would be --
MR. CHARLES: Okay. Yes, Your Honor. Thank you.
THE WITNESS: Your Honor, may I have a bathroom break?
THE COURT: Absolutely. Let's take the morning break. We'll come back at ten minutes to 11:00 by that clock.
(*A recess was taken at 10:35 a.m.*)

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

THE COURT: Please be seated.

Dr. Levine, you are still under oath.

Mr. Charles, you may proceed.

BY MR. CHARLES:

Q. Dr. Levine, before the break we were discussing a symposium where you and four other people presented a discussion about reexamining best practices for transgender youth.

Do you recall that?

A. I do.

Q. And the American Psychiatric Association that put on the conference was aware that all four of you were presenting ideas that were not in keeping with the official policies of the American Psychiatric Association, correct?

A. I can modify that slightly, sir. The American Psychiatric Association reviewed the abstract for the proposal that was written by me, and it didn't state that -- that we were against the policy or anything. We just -- the idea I summarized for the abstract was: Is it time? I think there is evidence that we ought to re-exam this official policy of what is called a quote, best practices. So whether the APA knew that Sasha Ayad felt one way or the other, they had no idea.

Q. And while you were speaking, Dr. Levine, on the panel,

the audience group was polite and no one interrupted you, correct?
A. No one interrupted me. The discussion session was not polite, but the presentations were.
Q. Dr. Levine, you've prescribed medications to patients for off-label use in your clinical practice, correct?
A. Yes.
Q. And off-label drug use is common in the field of medicine, correct?
A. Correct.
Q. And the fact that a drug is being used off-label does not alone make that drug experimental, correct?
A. It really means it's unproven for the use that a doctor is employing it for. Whether "unproven" is the same as "experimental" depends on your concept of experimental.
THE COURT: Let me interrupt one point about that. It means that it's unproven in a formal submission to the FDA --
THE WITNESS: Exactly.
THE COURT: -- not that it's not proven in some other forum, right?
THE WITNESS: Yeah. For example, I don't think trazodone as a sleep aid has ever undergone controlled studies but is commonly prescribed by psychiatrists for insomnia, especially for people who are on SSRI antidepressant medicine.

So fashion has created that. Word of mouth has created that.

THE COURT: But you know from FDA approval that taking the drug without more isn't so dangerous that it should never be done, and then you know from clinical experience that it works for what you are using for and it's not --

THE WITNESS: Yes. And the drug was originally approved for some other purpose. It's very common.

THE COURT: And part of the reason for that is it's really expensive to get FDA approval of a drug. So if you are the pharmaceutical company and you've gotten our drug approved by the FDA, there is really no reason to go spend all of those hundreds of thousands of dollars or millions of dollars.

THE WITNESS: Closer to a billion.

THE COURT: A billion dollars.

No reason to spend that money for further FDA approval, because once it's approved by the FDA, doctors can prescribe it.

THE WITNESS: Nonetheless, in certain psychological -- drugs for psychiatric conditions, drug companies do approve -- go to the FDA for approval for another indication. I don't think it costs them a billion dollars to do it, but it does cost a lot of money. You are certainly right about that.

THE COURT: And one reason to go back for a second approval is because if doctors are prudent, they are going to

look at the studies and the literature and make a determination. And so if what you are trying to do is get doctors to prescribe your drug, if you can show them a controlled study of the kind that would lead to FDA approval, might be a good idea to go get the study done.

THE WITNESS: Exactly.

BY MR. CHARLES:

Q. Again, Dr. Levine, you recall testifying November 28, 2022 at trial in *Brandt versus Rutledge*?

A. Yes.

Q. And do you recall when asked that same question, the fact that a drug is being used off-label does not alone mean it's experimental, you stated, "I would agree with that."

Do you recall that?

A. Yes. I've agreed with that just now.

Q. Dr. Levine, you're not an expert in health insurance coverage, correct?

A. Correct.

Q. And you're not offering any opinions about whether defendants should have an exclusion for gender-affirming medical care in their state Medicaid program, correct?

A. Yes.

Q. Dr. Levine, you're aware that cross-sex hormones were used to treat gender dysphoria prior to 2014 and prior to Annelou de Vries' study you mentioned earlier, right?

A. Yes.
Q. And some clinicians also used puberty blockers in the United States before that 2014 study, correct?
A. I think it began in 2009 in a Boston clinic.
Q. You said -- I'm sorry, Dr. Levine. You said 2009 in the Boston clinic?
A. Yes.
Q. And the Endocrine Society guidelines from 2009 provided a recommendation for the use of puberty blockers, correct?
A. I'm not certain.
THE COURT: While you are going to the next, 2009 in Boston clinic, do you remember which clinic?
THE WITNESS: It was -- there was a man named a Norman Spack who went across to see the Dutch group and came back very enthusiastic and started promulgating that this is a treatment of choice and this is saving people's lives.
THE COURT: Was he associated with one of the established institutions in Boston?
THE WITNESS: You know, the famous Boston clinic is the Fenway clinic, and I'm not sure that -- whether -- I don't know whether he was part of that or had his own clinic. I think he's an endocrinologist.
BY MR. CHARLES:
Q. Dr. Levine, is Dr. Spack affiliated with Boston Children's Hospital's GeMS clinic?

A. That's what I just said. I wasn't sure what his affiliation was.
Q. I missed it. Thank you.
A. If you are telling me -- you must -- perhaps you know, and I would trust your information.
MR. CHARLES: Your Honor, I would like to show the witness an article. May I approach?
THE COURT: You may.
MR. CHARLES: Your Honor, should I also give you a copy of this?
THE COURT: Depends on what you are going to do with it.
MR. CHARLES: It's just going to be reviewed.
THE COURT: I don't need to see it. You should give Mr. Perko a copy, but I take it you already have.
MR. PERKO: I've got one, Your Honor.
MR. CHARLES: Yes.
THE COURT: Okay.
BY MR. CHARLES:
Q. Dr. Levine, earlier today you were speaking about -- I'm going to refer to her as doctor; I think that's accurate -- Dr. de Vries and her 2011 and 2014 studies.
Do you recall that testimony?
A. Would you repeat that question, please?
Q. Yes.

Earlier today you discussed on your direct Dr. Annelou de Vries and her 2011 study and her 2014 study.

Do you recall that?

A. Yes.

Q. And I'm showing you an article titled "Ensuring Care for Transgender Adolescents Who Need It: Response to Reconsidering Informed Consent For Trans-Identified Children, Adolescents and Young Adults" written by Dr. Annelou L.C. De Vries.

Have you seen this article before?

A. Of course.

Q. Okay. And if you would, Dr. Levine, please turn to page 110 in the upper-left-hand corner.

At the bottom, Dr. Levine, of that page, you do you see the highlighted text?

A. Yes.

Q. Okay. So if you will please follow along with me.

In the design of these follow-up studies, the UGDS scales were flipped as Levine states. At baseline, according to the birth-assigned gender, after treatment according to the experienced gender (Levine, et al., 2022) questions whether the improvement in the gender dysphoria does then not stem from this switching and not from the treatment. However, this seems turning the matter around. What the measure shows, the disappearance or resolution of the gender

dysphoria is what the gender-affirming treatment is aimed to resolve. Medical-affirming treatment alone might not have resulted in this improvement.

I'm going to continue on, Dr. Levine, but did I read that highlighted portion correctly?

A. You are excellent.

Q. I feel like I've only asked you that a few times, which I think is a record for our conversations.

As stated in the conclusion of the 2014 paper, clinicians should realize that it is not only early medical intervention that determines the success but also a comprehensive multidisciplinary approach that attends to the adolescents' gender dysphoria, as well as their further well-being and a supportive environment.

Did I read that correctly?

A. You did.

Q. *Further, the UGDS was not specifically designed to be used after treatment and is, as such, not ideal. (Steensma et al., 2013 and properly referenced by Levine et al., 2022.) But that does not imply that UGDS falsely measured the improvement in gender dysphoria. Using the version of the assigned birth gender would also make no sense.*

Did I read that correctly?

A. You did.

Q. And do you recall earlier today, Dr. Levine, when you

testified that Dr. de Vries admitted that the scales used were incorrect?

A. They were not ideal. They have subsequently I think redesigned their follow-up scale.

MR. CHARLES: No further questions, Your Honor.

THE COURT: Redirect?

MR. PERKO: Yes, Your Honor.

REDIRECT EXAMINATION

BY MR. PERKO:

Q. Dr. Levine, if there is a paucity of evidence for your psychotherapy approach to treating gender dysphoria in the gender-affirming approach, why is your approach better in your mind?

A. Well, it's better because, number one, I don't think gender dysphoria ought to be an exception to how psychiatrists -- how the medical profession approaches any psychiatric difficulty. So I don't see any reasons for an exception.

Number two, the affirmative care model will result in, if followed through its entire spectrum, will produce certain outcomes that go against age-old medical principle of above all, do no harm and do not operate on normal -- do not change normal anatomy, un-diseased anatomy, and do not change unimpaired physiology.

So we are rendering a child where -- and I think I could

use the word child meaning adolescent as well as. So we are rendering a minor, if they follow their entire affirmative care, sterile and with the consent of parents of a 12 or 13-year-old child. So we are causing sterility. What is rarely mentioned in informed consent processes we are causing sexual dysfunction, the inability of the -- the current or the new gender, new genital organs to not function normally. We are reducing the pool of human beings who are available to trans people for stable adult emotional connections, marriage, for example.

And as I've tried to emphasize today, we have a number of studies that demonstrate that the average life expectancy of a trans person is significantly reduced.

So given these -- given sterility, sexual dysfunction, limited capacities to enter into stable relationships, premature mortality and predisposition to cardiovascular disease, for example, I think it's very prudent that we should approach the child's distress in a psychiatric way without medicalization, a psychiatric way and a thorough way before we can consider a medicalization.

We are not talking about the treatment of some minor condition here. Because if you look -- the natural -- I'm sorry, the concept of natural history in medicine means what happens if we don't treat this disease? The natural history, will it get better on its own, will it cause other problems

or will it lead to premature death?

So when you think about premature death, there is -- I mean, all of us disagree that there ought to be treatment for these children because -- and these children and these adolescents and these adults because the natural history of this is negative.

So the question only becomes what is the treatment, what treatment should be offered? And because we are talking about changing the body and the body's anatomy, the body's physiology and the social implications of those changes, it seems very prudent to be conservative and thorough in the evaluation not just to state these are the comorbidities but the treatment of those comorbidities, you see? And the comorbidities that we have are serious things like eating disorders and self harm and depression and anxiety and school avoidance and so forth. These are very serious conditions, and we know that the prognosis for that person is negative.

So we want to treat them, but the question is how to treat them. So the other aspect about why psychotherapy ought to be treated is that there has been a dramatic tsunami, a change in the sex ratio of people coming -- there are two things. One, there's been an increased number of people who say they want this treatment, the affirmative care, and the switch in sex ratios we have now a tsunami of teenage girls who never before seemed to indicate a

repudiation of their female gender who are presenting as transgender. This is unexplained. And if we go back to my concept, that biology, development, interpersonal relationship and culture all contribute to this, we need to understand why it is we are having this tsunami of girls that want to present themselves as trans males.

And so given all these facts, what is known and what is unknown, that is, what is unknown is why these girls are doing this now, I say be conservative, be thoughtful, be traditional, pay attention to the parents who know this child for more, far better than the evaluating pediatrician, you see. And let's take our time because we have this person's future at stake.

Q. Mr. Charles asked you some questions about a presentation you made at a symposium of the American Psychiatric Association. Do you recall that?

A. Yes.

Q. Would you explain the circumstances that led to your presentation?

A. Yes. In July I submitted an abstract to the American Psychiatric Association. As is in keeping with months before, the year before the meeting, people, investigators, present abstracts, submissions to be accepted. I don't remember exactly the date, but I'm going to arbitrarily say on November the 9th, everyone should have heard about whether

they have been accepted or rejected. November the 9th came and I heard nothing. Another couple of weeks passed, I heard nothing. I wrote to the APA and I said, how come I haven't heard? Within 24 hours I got a rejection. I wrote back a little outraged, could you explain, number one, why you didn't tell me on deadline, and would you tell me why this was rejected? I heard back in two days I was accepted.

Now, wait a second, one more thing. In the prelude to -- this symposium was at 1:30 in the afternoon. We gathered about 1:00. And the presenters and other people I didn't know were there and talking, and I told this story. And one of the people there, who was a child psychiatrist, said same thing happened in the American Academy of Child & Adult Psychiatry. Every time they submit anything that seems to be against the policy, the affirmative care policy, they get rejected.

We're well aware that there is a suppression of any -- and institutions who have made these commitments to affirmative care, there is a suppression of alternate views. We can't even get on the symposium. And so my experience with the November 9th deadline I found out was not just from the APA but other institutions as well.

This is not what we consider to be science. This is what we consider to be a politic suppression of alternate views. And there is more and more, but there is plenty of

information that is going on. There is such a partisanship here that it interferes that even being allowed to express an alternate opinion.

Q. Dr. Levine, Mr. Charles asked you some questions about the American Psychiatric Association's position on gender-affirming care. Do you remember that?

A. Yes.

MR. CHARLES: Objection, Your Honor. Outside the scope of cross.

THE COURT: I don't know what he is going to ask, but he started by saying that you asked questions about the subject he's going to introduce. So if indeed it's something you asked him, it's almost by definition not outside the scope.

Overruled, but let me hear the question.

BY MR. PERKO:

Q. Dr. Levine, did the American Psychiatric Association ask for your views on the position statement?

A. No.

Q. Do you know if the majority of the members of the American Psychiatric Association agreed with the position statement?

A. Oh, I have no way of knowing that.

MR. PERKO: Thank you, Your Honor. I have nothing else.

THE COURT: Doctor, I appreciate you being here, and I appreciate your candor. You've taught me some things, and I'm going to give you a chance to teach me some more.

You referred just a moment ago to the tsunami of adolescent women presenting identifying as males. The experts on the other side have suggested that the reason for that is that 20 or 30 years ago treatment was not available, now it is, and one would expect the number of people presenting for an available treatment to be more than the number of people presenting for an unavailable treatment.

I get the argument. And, of course, at one level it's just true as a matter of plain logic, the number of people that presented ten years ago for a COVID vaccine was zero. In that case, it's because there was no COVID ten years ago. The number of people presenting today for some other kind of a vaccine may just reflect the availability of treatment, even though the disease has been with us for the whole time, shingles, for example.

And so if you looked at the people presenting for the shingles vaccine and said, well, there's a tsunami of people presenting for a shingle vaccine today compared to 30 years ago, that's certainly true, and it would tell you absolutely nothing about the number of people with shingles.

On the other hand, the tsunami you're talking about doesn't necessarily reflect the change in available treatment.

There may be other factors. And I think I understood what you to say is we need to figure out why that is. And my question is:

Part of the explanation, at least, could be the availability of treatment or the change in social acceptance of the possibility that somebody is trans. True? I mean, is the answer we just don't know?

THE WITNESS: Well, I think the truth is that every explanation is a -- is a guess. But I should point out, which I think I heard earlier yesterday, that before the turn of this last century, a number of studies have shown that between 3.5 and four boys who wanted to be girls, there was one girl that wanted to be a boy. So in the 20th century, that was the pattern almost all over the world. There were two exceptions. Australia and Poland for some reason didn't show that, but every other country that measured it got data between three and a half and four boys for every girl presenting.

Suddenly in this century, there's been a reversal. So that the usual clinic today, if you looked at say the last 12 months, the usual clinic has, number one, had an increase number of requests from boys and girls, but ratio of girls to boys, instead of being 3.5 to one is now closer to seven to one. And so --

THE COURT: Seven to one the other way?

THE WITNESS: The usual thing is for say five, six or

seven girls. For every five, six, and seven girls, we now have a boy that wants to be a trans woman. Now, that's going to vary from clinic but --

THE COURT: And previously it was three and a half boys to one girl?

THE WITNESS: That's right. And so the explanation is we had -- you know, we've had testosterone available since the 1930s. And in the 1950s, there were a few rare endocrinologists that were giving testosterone to girls, you see. So it's not that the treatment was available.

What has become -- what is also true is that society is talking about this issue, you see. And one of the hypotheses for the explanation for the tsunami is that, one, the transition from little girl to young woman, adolescent, the onset of the body changing and menstruation, it's not unusual for 12-year-old girls, 11-year-old girls to be distressed about bodily changes. Puberty has been well known to be an arduous process. All you have to do is ask most adult women what it was like for them at this stage in life. Parents of those kids will tell you it's difficult.

But what is happening now is that we have the internet, and all kids -- almost all kids are on the internet. And there are -- there are sites that -- that help people to understand that they may be a transsexual person because they're distressed over menstruation, they're not happy with

their breasts, the presence of their breasts.

And so when I talk about one of the four major influences on the creation of transgender phenomenon, I'm talking about culture and culture in this century is characterized by access to the internet. And so almost everybody who has de-transitioned from being a trans man to going back to a living as a woman with or without breasts or uterus, these transitional people, they mostly -- many of them say how influential the internet has been. They created -- if they didn't have a lot of friends in their local community, they had virtual friends who were trans friends from the internet.

And so we do not want to affirm that culture has caused this, but culture is a part of this, you see. I think we have a disturbed -- disturbed about what is happening in puberty, and often in a girl who has been disturbed psychiatrically before, people with eating disorders, people with prepubertal depression and anxiety and school avoidance and autism and, you know, the variety of the problems, they hit puberty. They undergo the natural processes of being distressed about their bodily changes, and then they start having sexual attractions, which may or may not be, quote, their concept of normal, you see. So they say they're bisexual or they're queer or they're a lesbian. And then finally they say that they are trans.

So these are intrapsychic, interpersonal. Some of these people declare they are trans after they have said they have been rejected in a relationship. So we have cultural, interpersonal, biologic and psychological reactions to normal biologic processes.

So what psychiatric approach to a transgender person who previously did not seem to be highly distressed about being a girl and now with puberty is highly distressed is to evaluate and treat through continued therapy the investigation of why they have solved, why they declared this identity. What are they escaping from?

Now, some people think, for example, that most people who have eating disorders hate something about themselves. They are trying to get rid of something that's hateful, some sense of themselves that is not acceptable to them. And so what they do is they starve themselves. And many of those kids go -- before they are transgender identified have been anorexic. They have been starving themselves, you see, or they are depressed or they're anxious, or they're skill-avoidant where they are having social problems.

They have an intrapsychic creative solution. I'm trans. That's often been helped by someone on the internet that they don't know, you see.

So I think what I'm giving you is another speculation. It's as speculative as, oh, I've always a trans

and their parents didn't know and all that stuff.

THE COURT: Some are actually trans.

THE WITNESS: Actually, "trans" means will be consistently identified and happy in that identification until they discover the consequences like they can't have a child, or their sexual life is impaired, or they can't find somebody who wants to spend -- sojourn with them for the rest of their life. So we don't want -- we say that one can be happy being trans. It's okay with me, they are trans, right? But if you want to look at the outcome of a trans identified in a 14-year-old that is stable, that we are going to label a trans person as though that's some kind of entity, you see, then we need to evaluate what is going to happen to that person over time.

THE COURT: I was going to ask you about eating disorders, and -- not related to trans individuals but just eating disorders separate and apart. There are people that are anorexic -- people with anorexia that are not trans and trans doesn't figure into it.

THE WITNESS: Yes, most people with eating disorders are not trans.

THE COURT: And if a person comes to you with an eating disorder, you provide psychotherapy. That's the primary way to deal with it, I take it. There is no drug you can give somebody to fix that. You are going to counsel the

person, true?

THE WITNESS: It's largely correct what you just said, but there is now a drug that we tend to use.

THE COURT: Many of my questions will reflect my lack of medical training.

There's now a drug. Let's just posit a world where there wasn't. Was there a time in your practice when there was not a drug and the way you treated anorexia was with counseling?

THE WITNESS: Absolutely.

THE COURT: Were there any studies where some people with anorexia were treated with counseling and some people got no treatment at all, and you did this study to see which was better?

THE WITNESS: There have been -- Your Honor, I'm not an expert in this subject.

THE COURT: Well, surely there was none because nobody is going to see a patient with anorexia and say, you're on your own. I'm doing a study. And so even though counseling may help, you're on your own. I have got to do my study. Nobody would do that, right?

THE WITNESS: I think there have been studies that have looked at the rate of resolution of the eating disorder when they had psychodynamic psychotherapy. And then there were studies of when they had specialized treatment programs

where they got hospitalized and they were fed and so forth. So there have been comparative studies, but they are not -- in the light of what we have been talking about the last couple of days, they are not high-level studies.

THE COURT: Low-level evidence, and yet you treat those patients.

THE WITNESS: Absolutely, absolutely.

THE COURT: You said that the life expectancy of a trans patient was reduced. I want to make sure I understand what you're talking about.

You're talking about all trans individuals. Whether they got one kind of a treatment or another or no treatment, it's just that trans people don't live as long on average as others.

Is that what it was or is there something else?

THE WITNESS: I think these are based on insurance data, and so most of the people that were trans identified have been treated with medications. One of the earlier studies that identified an increased death rate were people who were being treated with hormones. It also was a Dutch study.

There's been a VA study in the United States that demonstrated reduced life expectancy, and I mentioned in my testimony a recent study from the U.K. I think most of those people have been people who have had one form of affirmative

care or another.

THE COURT: Your testimony is studies show that people who get medical care -- I'm going to define medical care as puberty blockers, hormones or surgery. Your testimony is studies show that people who get medical care have shortened average lifespans than trans people who don't?

THE WITNESS: No, than the general population.

THE COURT: Than the general population.

THE WITNESS: Yes.

THE COURT: That's what I wanted to find out.

THE WITNESS: And you know --

THE COURT: And that would be -- the same was true if I said people with anxiety and depression -- I'm going to guess people with anxiety and depression at a clinical level have reduced life expectancy as well.

THE WITNESS: They do. When you add puberty blocking to that, since some of the older studies were done before puberty blockers were used, so I think the safest thing to say is cross-sex hormones and surgery.

THE COURT: You may have been in the courtroom yesterday when I was talking to Dr. Hruz.

THE WITNESS: Yes, I was.

THE COURT: I'm going to ask you a similar question; it's not going to be identical. Again, I'm defining medical treatment as puberty blockers, hormones or surgery.

It seems to me that it is the whole universe; somebody either gets that treatment or they do not. It changes over time, but at any given point in time, if you look at people, you could say either that person did get medical treatment or that person did not get medical treatment. That's just like saying the robe I have on is black or it's not black. One of the other of those statements has to be true. You're wearing a necktie or you're not wearing a necktie. One of those statements has to be true. And you do have a necktie.

As a matter of pure logic, proposition A and proposition not A fill up the universe, it seems to me. And so if a 12-year-old presents to you, then either the person will get medical treatment at some point or the person will not get medical treatment at any point. One of the other of those propositions has to be true; that's correct, isn't it?

THE WITNESS: Okay.

THE COURT: So the defense has made a big deal out of the fact that the evidence in favor of providing medical treatment is low-quality evidence. It seems -- and that's true, I think. I think the record shows that it is low-quality evidence.

THE WITNESS: Can I just add to your summary? It's low-quality evidence, and there is the absence of long-term follow-up on the interventions that were offered. That's

really the concern. It's not simply low-quality evidence. It's you are giving these 12-year-old children things, and you have no idea what happened to the -- ten years ago the 12-year-old children that you gave medical treatment to. And we have evidence from the adult transsexual community they are not doing so well. Not just dying; they have more substance abuse, for example. So that adds to it. It's low-quality evidence and there is no long-term follow-up.

THE COURT: I understand. Different problem. We'll double back to that. But it low-quality evidence that supports medical care. On the GRADE system, what is the quality of evidence that supports not giving medical care?

THE WITNESS: I don't think we have any studies of that.

THE COURT: It's not just -- it's not just no high-quality evidence; it's no evidence.

THE WITNESS: It's no evidence. But you see, I think you probably heard testimony the terrible outcomes will happen if we don't give these children. That they have no follow-up studies of people who haven't given the treatment. There is no systematic evidence about that.

THE COURT: But we have anecdotal evidence, and we know that some people who have gotten medical treatment have had bad outcomes.

THE WITNESS: Yes.

THE COURT: And many people who got no medical treatment have had bad outcomes. Sometimes trans kids that don't get medical treatment commit suicide; that's true, isn't it?

THE WITNESS: Yes, and at an increased rate, people who have had medical treatment have committed suicide.

THE COURT: Well, now what study shows that? When you compare the people that get medical treatment to people that don't get medical treatment, the suicide rate is higher for those who got treatment?

THE WITNESS: No, we don't have that -- I don't think that study has been done. The studies that have been done is that the suicide rate of everyone in Sweden over a 30-year period published in 2011 show that are the suicide rate compared to controlled groups of non-trans people both males and females was 19 times higher.

THE COURT: And you would -- absolutely, even if you never seen the study but you lived on this either in our society, you would absolutely expect the suicide rate among trans individuals to be higher than the rate among the population at large; would you not?

THE WITNESS: Because for many reasons, I guess I would, yes.

THE COURT: You would agree with that.

THE WITNESS: But 19-fold higher. And actually, if

you look at females who were living as males, it was 40 times higher. That's not insignificant. That's not something that we can just ignore, and that's not the only study that demonstrated that at every stage in affirmative care, there is a higher suicide rate.

THE COURT: Compared to the general population.

THE WITNESS: Yes. And we don't know the controlled group of people who are trans identified who elect not to have or don't have access to -- we don't know their suicide rate. And so this is part of the uncertainties that parents should understands and judges, I mean, all politician should understand.

THE COURT: Even politicians.

THE WITNESS: Even politicians.

THE COURT: You said something about we don't do surgery to change unimpaired physiology.

THE WITNESS: Yes.

THE COURT: I don't want my next question to suggest that I disagree with the wisdom of not doing surgery to change unimpaired physiology, but unless I'm missing something, there are a whole slew of plastic surgeons who make a darn good living doing surgery on unimpaired physiology.

THE WITNESS: We call that cosmetic surgery.

THE COURT: Absolutely. But we do that, and Florida hasn't prohibited that.

THE WITNESS: But they don't pay for it either. Medicaid doesn't pay for it.

THE COURT: Fair enough.

THE WITNESS: Out of pocket.

THE COURT: Fair enough. Medicaid doesn't pay for anything I get, but I grew up in this state, so I go to the dermatologist accordingly and there is always something there that can be removed. And sometimes the dermatologist says, that's -- and the dermatologist has some fancy name and says, that's never going to be bother. That's no problem unless it just bothers you, and I say, yeah, let's be done with it.

THE WITNESS: $35.

THE COURT: And they take it right off. Probably more. The dermatologist may get $35 and then the pathologist gets a hundred because if they took it off, they are going to a pathology test even though the doctor was more than willing just to leave it on there.

THE WITNESS: We could have a wonderful conversation about medicine.

THE COURT: Yeah, we probably aren't getting anywhere with that so enough of that.

There's been discussion all through the case about gender identity and gender dysphoria and the DSM-5 and what it requires to diagnose somebody with gender dysphoria. I'm going to tell you my understanding, but I'm not at all sure I

got it right, so I need you to tell me whether I have it right.

From the evidence and discussion at this point, it seems to me there are people whose gender identity is different from their natal sex but who do not have gender dysphoria. Is that correct?

THE WITNESS: Yes.

THE COURT: A lot of discussion about medical treatment has articulated it in terms of only gender dysphoria. Some people who get medical treatment have trans identity but not gender dysphoria. True?

THE WITNESS: Yes.

THE COURT: Mr. Perko asked you some questions right at the end of his direct, and I think he phrased his question very deliberately. I'm not going to be able to do it justice in terms of the actual substance of it, but the question was something like: These treatments have not been shown -- and the quotation is, not been shown or have been shown -- to improve mental health. I think that was the question. The treatment has not been shown to improve mental health.

Do you have an opinion?

Yes.

And the opinion is -- essentially was these have not been shown to improve mental health. My question -- and what has been shown is important. I'm not suggesting it's not, but

I have a different question. Not what's been shown but what's happened. There has been a lot of testimony in the case about clinical experience.

Sometimes medical treatment has improved mental health, true?

THE WITNESS: Happiness with their current state and improved happiness with their current state would be a -- one of the -- a criteria for improved mental health. And certainly after undergoing sex reassignment surgery that doesn't have any major complications and doesn't have to have yet a second surgery and so forth, or if the breast's removed, the chest does not feel painful or -- we call it dysesthetic. It doesn't feel normal.

Assuming people don't have complications to the surgery, people can be happy with it. And people like me say, initially, when you measure the happiness with it, we expect the people to be very happy and to say their quality of life is better because they are happier now; they are less dysphoric.

However, we want to see what happens over time, and we wonder what happens, for example, if you take off the breasts of a person of whatever age and they maintain their female genitalia at 70 percent, at least of those people maintain their female genitalia, they present themselves as a male in the society, and in their intimate relationships, they

have a vagina and a clitoris, vulva and so forth, there's a kind of incongruity that they bear every day for the rest of their lives, that incongruity between their body and their presenting gender and then their sense of themselves, you see.

So over time, we want to know what happens to those people, and that brings us back to the elevated suicide rates in people who've had sex reassignment surgery. So initial happiness for the vast majority of people, it's not in question.

A continued happiness is the question, and the presence of suicidality, the presence of the depression, the use of antidepressants and so forth.

THE COURT: Sometimes it works, and sometimes it doesn't.

THE WITNESS: Yes. And we really want to know, based on when we are measuring these events, what percentage of people are happy or have improved mental health or have the same mental health or worse mental health. They are natural reasonable questions to ask about these treatments, and the answers to the questions are "I don't know."

THE COURT: When you sit down to evaluate that question, you would love to see double blind studies. By definition, that's impossible because this can't be done blind. You would like to see high quality studies over long periods of time -- I shouldn't say a high quality. That's a

term under the GRADE system, but you would like to see good longitudinal studies?

THE WITNESS: Exactly, with a huge percentage of the people treated available for follow-up, not 30 percent.

THE COURT: Without that kind of long-term study, if you just -- if you're a parent today with a 12-year-old deciding are we going to have this treatment or not, what you would like the parent to do is to have all of the information, everything you've talked about and then an evaluation of the individual decision, individual circumstances.

One thing that parent might want to know is what's the actual clinical experience, true?

THE WITNESS: You mean of the doctors who is talking to them.

THE COURT: All the doctors, as many good doctors you could find that are honest about this. Look, part of the problem -- I'll grant you, part of problem is most of the people involved in this are partisan. You have said that about the folks that took over WPATH. These are people that are advocates of one position.

I don't think I'm giving away the defense trade secrets. There are some people on their side that are just advocates. So there's plenty of partisanship across the way. But what you would really like -- as the parent, what you would really like to know is a good honest assessment of

clinical experience. That would be important, wouldn't it?

THE WITNESS: Yes. And you want the doctor who you are working with to tell you what science knows, what the states of the controversies are, what the controversies are, rather than what the doctor believes him or herself.

THE COURT: Absolutely.

So you weren't here -- you might have been. Were you here when Dr. Shumer testified?

THE WITNESS: No.

THE COURT: Have you read Dr. Shumer's report.

THE WITNESS: No.

THE COURT: Dr. Shumer is a pediatric endocrinologist at the University of Michigan. It's not Case Western, but it's a pretty good school, yes?

THE WITNESS: Fine.

THE COURT: He's at a clinic. He has had over -- I think it was over 500 patients. He testified that many of his patients have had very good results and that if you deny treatment, you are needlessly going to cause --

THE WITNESS: Harm.

THE COURT: -- harm. That may not be a very good description of his testimony. Basically, you're going to worsen the outcome for many patients.

THE WITNESS: I mean, my point has been we don't have any long-term follow-up of those kids who don't have

treatment. We have doctors who believe in -- passionately believe that they are on the side of angels in giving children these hormonal treatments, and they have this concept that without the treatment, a terrible thing will happen to them.

But, Your Honor, the first phase of the puberty is distress for everybody. The second phase of puberty brings people into awareness of their sexual feelings towards others, and their own sexual feelings and their attractions to others sometimes lead to romantic situations and pleasures with the body that helps some kids retransition back to identifying.

So if we give puberty blockers or cross-sex hormones, we delay the positive impact of the socialization that comes from the sexualization of the body by the natural puberty. And so sometimes this idea that these kids will never change is not -- it's not in keeping.

One of the major people in Europe --

THE COURT: I mean, I understand all of that. Dr. Shumer is just wrong about this, when he says he's treated these kids and he's had a profound impact on their lives? He still gets Christmas cards five years later. I understood that five years is not 50 years. Is he just wrong that he helped these kids?

THE WITNESS: No, no. I believe he is helping these kids because the kids want this, and their parents have bought on to this. And so he has a 15-minute follow-up every three

months, and how are you doing? I'm fine. I'm happier now. This is not a psychiatric sophisticated reevaluation every three months.

THE COURT: How do you know what Dr. Shumer does with his patients?

THE WITNESS: I don't know, but I hear all these --

THE COURT: Do you have any reason to think that the clinic at the University of Michigan is providing substandard care?

THE WITNESS: If I was shown the portion of WPATH about how comprehensive evaluations should be done, Your Honor --

THE COURT: You don't have to persuade me that are partisans at WPATH. I'm talking about Dr. Shumer.

THE WITNESS: I have no idea about Dr. Shumer. I just know that clinics are busy, and when people are doing well, they don't have prolonged sessions. And a pediatric endocrinologist is responsible for lab results and physical health and ask a question about psychological well-being and gets an answer and moves on to the lipids and to the bodily changes and so forth.

THE COURT: He has a team. So there is a psychiatrist involved in this care.

THE WITNESS: Well, when you say "psychiatrist," oftentimes that's a mental health profession who is not as

trained as a psychiatrist. But listen, the devil is in the details about how things happen. Everyone doesn't follow the same standards or interpret the standards in the same way. But as you said, I don't know. I don't know anything about Dr. Shumer.

THE COURT: I was going to ask, do you know anything about the gender clinic at the University of Florida or the University of Miami?

THE WITNESS: No.

THE COURT: If I understood you correctly, before you would sign off -- sign off may be the wrong word. I did understood that when you write the letter that is part of process, you're not making a recommendation. You're just saying, this is really what the parent and child want to do after sufficient workup, it's okay with you, essentially.

The -- and before you got to that point, you would want to follow the patient for at least a couple of years, something along those lines. That's what one should do before approving or recommending medical treatment is have a couple of years. I get that, and it certainly seems like a good idea. Here's, though, the question:

Suppose this well-trained psychiatrist with a team of well-trained doctors participating in the process who share your skepticism, who understand the limitations, somebody presents it's a 12-year-old, they take the history from the

parent, the history shows long-term gender identity different from the natal sex. You've got pretty much all of the information that you would have gotten if you had been following the patient for the last, two, three, four, five years, but they didn't go to the clinic or to any doctor during that two, three, four, five-year period, they are just now showing up. But if you followed the patient for that whole time, you would be at the point of saying, yes, medical intervention is appropriate if that's what the parent wants to do.

Now, what do you do then? Maybe it's just a bad a hypothetical. But the idea is can't you have all of the same information, occasionally, and so that you can go ahead and make the decision for the 12-year-old until waiting till the child is 14?

THE WITNESS: Your Honor, the experience of being a psychotherapist for many years teaches, I think, many of us that people have no aspects about their lives that they do not want to share until they have a deeper level of trust. For example, sexual abuse is not something that is -- it's something that can be stated at the first visit, but I have experienced many times people tell me about the adversities in their lives six months after, two years into treatment and so forth.

So the idea that you can get a comprehensive view of

parents will tell you everything that they know about the child at their first one-hour visit or two-hour visit, they will tell you what you think you ought to know, and they will not tell you the things they are ashamed about. And so it takes time.

The other big issue about your question is the difference between children who are specifically and consistently cross-gender identified throughout their prepubertal years, and the vast majority of new presentations in this century of kids who were not cross-gender identified who now in retrospect tell you, oh, they were never comfortable with their body, you see.

So the question is -- I should say the hardest thing for a young psychiatrist to know is to realize that people don't tell us the truth. And one of advantages of long-term treatment is that more of the truth and sometimes prevarications are admitted.

I have had people that have been in treatment for two years who haven't told me for two years about extra-marital sex that they have been having, you see. So people -- we want to trust the narrative that is told to us, but they are not always trustworthy. And we ever never sure they are entirely a trustworthy.

I'm not saying that everyone is lying to us. I'm saying that everybody has a sense of what's appropriate to say

when, and it takes time for people to tell us more of the truth. Parents don't like to talk about their interpersonal relationship when the child is three years old.

THE COURT: I get it. It doesn't just happen to psychiatrists. Sometimes it happens to judges. Not everybody tells me the truth either.

If the governor of a hypothetical state came to you and the president and speaker -- president of the senate and the speaker of the house or whoever the legislative leaders came and the leading -- the surgeon general of the state, they came to you and said, "we want to make sure we are providing the absolute best care for the children of this state that can be provided, and for the adults. And so for trans individuals, we need to make sure that care is provided properly. Tell us what we need to do to make sure that we're not getting a 20-minute consult and then straight to the medical treatment. We need to do this right."

Could you tell them how to do it?

THE WITNESS: I would tell them to fund new programs for the treatment -- the evaluation and the treatment of autistic human beings with or without gender dysphoria.

THE COURT: Autistic human beings?

THE WITNESS: Autistic. That's number one because a large percentage of people who present with gender dysphoria have autism. In fact, many studies in several continents have

shown that the incidence of autism in transgender clinics is seven fold the incidents of autism in the general population.

So number one --

THE COURT: Hold the thought.

I trust you to remember the thought better than me, so let me interrupt and ask what occurs to me.

Is the increase that has occurred in autism a factor in the increase in the presentations for trans?

THE WITNESS: There is a worry that that's true.

THE COURT: All right. I interrupted you. So first, you treat the autism?

THE WITNESS: Well, so I would say in order to answer your question, all you politicians, you need to think about how to create mental healthcare in your state that approaches the problems that are commonly seen in the gender dysphoric populations, right? So autism is just one little new program I want you to support.

The other is I want you to train mental health professionals to do long-term psychotherapy and to evaluate families over time. So and then I want you to take the transgender child, whether the child is by a definition of prepubertal and the transgender adolescent, and I want you to ensure that they have a prolonged period of family and individual intervention with a qualified mental health professional. And I want you to set certain standards before

they have access to these medical treatments. And I would explain to these politicians those things I have explained to the Court about mortality and sterility, et cetera, et cetera.

So I want to give these trans children every chance that society, our profession has to improve their mental health before and during their medicalization treatment. I want to give them a chance not to have a premature mortality from all kinds of problems, you see. I want to increase their mental health, their capacity to cope. I want to have them identify the adversity and say, well, this is a child whose parents have sold them into -- I don't mean to be so dramatic. This is a family who has had dysfunction. There has been violence in the family, there has been physical violence to the child, there has been abandonment of the child by a parent. I need you to have programs and -- and people in them who understand these adversities that many of these children have. And when they're identified in the comprehensive evaluation, I want them in a treatment program for those particular adversities.

Whether we can overcome or not, we can help the child and the family appreciate the adversity and then help them deal with their feelings that they had about it and not escape by changing their sense of self, you see. See, "I want to reinvent myself as trans person" could be "I want to escape from the misery I have expressed as a boy or a girl."

So politicians I would say I want you to focus on mental health in a serious way that addresses the problems that 70 percent of these kids have when they are evaluated, you see.

Now, that's not what has been happening. That would be my advice. It's a long answer to a short question.

THE COURT: And then you would not prohibit medical care when appropriate after that whole evaluation, true?

THE WITNESS: Yes, but I would like them to provide medical care in a study, in a protocol that guarantees follow-up and that will compare people who get affirmative care and people who get psychotherapy only and people who, for various reasons, are just followed up with -- are just followed up without any intervention. That ideal thing.

But short of that, I would say if the politicians created programs and capacities within their state to address the mental health of those children and adolescents, then I would say, okay, although we don't have all the answers, affirmative care might be considered. But not without --

THE COURT: By that, you mean medical care as I defined it.

THE WITNESS: Yeah affirmative care, medical care, that's what I mean. Yeah.

THE COURT: Tell me what about the studies that were in progress at the Johns Hopkins Clinic or the University of

Florida or the University of Miami that now have been shut down were different from what you just outlined as the optimal way to treat this.

THE WITNESS: Well, the John -- the only one that I'm aware of is the Hopkins study.

THE COURT: They have a study in Florida, did you know that?

THE WITNESS: No.

THE COURT: They may not have a study. They had clinic in Florida, and there was a clinic at the University of the Florida and a clinic at University of Miami. And I know there were studies going on at a couple of those places. But --

THE WITNESS: I'm not aware.

THE COURT: All right. Fair enough.

Questions just to follow up on mine?

MR. PERKO: No, Your Honor.

MR. CHARLES: No, Your Honor.

THE COURT: Thank you, Doctor. I appreciate your input. You may step down. You're free to go about your business.

THE WITNESS: Thank you.

THE COURT: It's probably lunchtime. Anything we need to do before we break? Have anybody that needs to be handled or some short witness or some witness whose testimony

won't be long?

MR. JAZIL: I don't think, Your Honor, we have a witness that fits in that category. We have Dr. Lappert and Dr. Kaliebe in the audience who will be our next two witnesses.

THE COURT: Let's start back at 1:10 by that clock.

(A luncheon recess was taken at 12:07 p.m.)

AFTERNOON SESSION
(1:10 P.M.)

THE COURT: Please be seated.

Mr. Jazil, please call your next witness.

MR. JAZIL: Thank you, Your Honor. Dr. Lappert is our next witness for the defense.

DEPUTY CLERK: Please raise your right hand.

PATRICK LAPPERT DEFENSE WITNESS, DULY SWORN

DEPUTY CLERK: Be seated.

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

THE WITNESS: Patrick Walter Lappert, L-a-p-p-e-r-t.

DIRECT EXAMINATION

BY MR. JAZIL:

Q. Good afternoon, Dr. Lappert. What do you do?

A. I'm a physician and surgeon.

Q. What kind of physician surgeon?

A. Plastic and reconstructive surgery.

Q. Dr. Lappert, to speed things along a bit, I'm going to have my friend pull up DX31, which is your CV, which has already been admitted into evidence.

Doctor, does this CV accurately reflect your training and experience?

A. It does.

Q. Your publications and awards?

A. It does.

Q. I would like to ask you a few questions about this CV. It says here that you received an M.D. from the Uniformed Services University of Health Sciences. What is that?

A. USUHS is the federal medical school that trains physicians for service in the three branches of the military as well as the public health service.

Q. And it says you did a general surgery residency, Doctor. What is that?

A. For me that was a five-year program to train me to be a general surgeon that included training and management of cancer, gastrointestinal disease, pulmonary diseases. The whole gamut of general surgery.

Q. And it says you were chief resident, Department of Surgery. What does that mean, sir?

A. That's -- in the final year, if you're selected to be a chief resident, you also manage the day-to-day operations of the general surgery department including the management of

the surgical schedule and the training of the residents.
Q. It says that you did a plastic surgery residency.
First, Dr. Lappert, what do plastic surgeons do?
A. We are responsible for reconstructive surgery of defects caused by trauma, congenital deformity, cancer care, infectious illness. It's the restoration of form and function that may have been lost to any of those causes, and then there's also the additional dimension of cosmetic surgery.
Q. Understood.
And what exactly does the residency in plasty surgery entail?
A. So the majority of us are prior board eligible or board certified in general surgery, as I was. That is followed by a two- to three-year residency program that involves training in all of the aspects of reconstructive surgery, including the care of congenital deformities in children, the care of the elderly and chronic wounds, the care of limb salvage, hand surgery, cancer reconstruction of the head and neck.
Essentially what I used to tell my residents in training is that plastic surgery is surgery of the skin and its contents because we cover all body areas under a variety of different circumstances.
Q. If we scroll down on here, it says that you had a board certification in surgery from 1992 until 2002.

First, Doctor, tell us what a board certification in surgery means.

A. Well, if the American Board of Surgery approves your training program -- and that's a process in and of itself -- if you graduate from an approved training program, you are considered board eligible. You're invited to sit for the written examination; and that if you satisfactorily pass the written examination, you're invited to take the oral examination. And then having completed all those areas, you are then considered board certified.

Q. And it says that your board certification ended in 2002. Why is that, sir?

A. Beginning in the early '90s -- it used to be that board certification in general surgery, among others, was a lifetime thing. But beginning in the early '90s, they made it a recurrent recertification process. So in 2002, my general surgery board certification expired.

Q. And your CV says that you were board certified in plastic surgery from 1997 until 2018.

First, Doctor, tell us what a board certification in plastic surgery means.

A. Well, as with general surgery, if your training program is certified, at the completion of your residency, you are considered board eligible in plastic surgery. In the case of plastic surgery, it's a bit more rigorous because you, in

addition to having to pass the written examination, during the years that I was certified, the -- you are required to collect every case for an entire year and report those cases listed to the American Board of Plastic Surgery.

From among those hundreds of cases, they will select -- I think my year it was ten cases for critical examination. And you have to submit comprehensive records, everything from clinic visits, operative reports, anesthesia records, billing records, all of it; and then the oral examination is basically a review with you of those selected cases. And if you satisfy the examiners, then you are now board certified in plastic surgery.

Q. Sir, why did your certification end in 2018?

A. In 2018 -- having recertified, in 2018 I was within two years of my retirement from my life as an active surgeon. So being that at that point in my career I was a solo practitioner in a small town, it didn't seem reasonable to go through that whole recertification process only so that I could use it for two years. And at that point in my career, none of the hospitals I operated in even considered it a requirement, so I -- I deferred recertification.

Q. Doctor, I would like to ask about a couple your medical appointments.

It says here that you were chairman of the Department of Plastic and Reconstructive Surgery at Naval Medical Center of

Portsmouth. What were your responsibilities in that role, sir?

A. Well, as a department head, I had the care of the entire department including our five plastic and reconstructive surgeons, a number of enlisted service members who were responsible for the running of the clinic and the operating room. I had a number of a civilians working for us as well. And I was responsible to the director of surgical services. So our department was responsible for offering comprehensive reconstructive surgical services to all eligible service members and their dependents as well as retirees for a catchment area that included all of Virginia and south to Florida and all the way east to the Eastern Mediterranean. So all complex reconstructive issues within that catchment area were sent to us, and we were responsible for their care.

Q. Doctor, it also says that you were a clinical assistant professor at the Department of Surgery at the Uniform Services University of Health Sciences.

What did that job entail?

A. As a professor assistant, I was responsible for -- I was the point of contact for any medical students who were doing clerkship rotations at the Portsmouth Naval Hospital, responsible for not only their training but their care and feeding, if you will. And I was responsible for offering lectures on matters pertaining to surgery in general and

plastic surgery in particular.
Q. And the last line on this page, Doctor, it says here that you were a specialty leader, plastic and reconstructive surgery for the Office of Surgeon General, U.S. Navy?
A. That's correct.
Q. What did you do in that role, sir?
A. So, while I was the chairman of the department at the Portsmouth Naval Hospital, I was also in that position as specialty leader. What that required of me was that I was to assist the Surgeon General of the Navy in making policy decisions about coverage, care, eligibility for care, what we call the evacuation policy for any injured persons in that catchment area, how they were to be brought back stateside in the event of conflict, what the evacuation policy would be.
And then I was also responsible for advising him on the recurring issue of what constitutes reconstructive surgery and what constitutes cosmetic surgery, because it basically impinged upon how the local medical treatment facility commanders had to spend their money in the care of active duties and dependents, whether a covered benefit was available in the military treatment facility. If it was a covered benefit, we would have to pay for it in a civilian hospital if they were eligible beneficiaries. And if it was cosmetic surgery, basically the determination was made that it's not something that the military or the government is

responsible for.

Q. Doctor, how long have you been a plastic surgeon?

A. Thirty years.

Q. Can you approximate for me the number of surgeries you have done in that time?

A. It would be a rough approximation, but over that time period somewhere around 6,000 major surgeries and innumerable lesser procedures.

Q. Doctor, can you briefly describe for us the kind of surgery you did in your military service as a plastic surgeon?

A. Well, as I explained before, we covered all body areas and all demographics from neonates to the elderly and the dying. That included craniofacial reconstruction for children born with craniofacial anomalies like cleft pallet and things like that. We established and ran a comprehensive multidisciplinary cleft palate craniofacial board through which those children were brought.

We worked very collaboratively with the ENT surgeons doing head and neck reconstruction for cancer and trauma. We worked with the orthopedic department in doing limb salvage and hand reconstructive surgery for combat trauma victims or other victims.

We worked with the thoracic surgeons doing chest wall reconstructions, worked with the general surgeons doing

breast cancer reconstruction, and worked with urologists, again for congenital anomalies, developmental anomalies. Did I leave anything out here? I think that's probably all of it.

Q. I understand. And in your civilian practice, can you briefly describe the kind of surgeries that you did and do in that role?

A. A much simpler life because much of what I outlined to you earlier required multidisciplinary care as well as the presence of a lot of additional physicians to monitor the patients. So did a lot of breast cancer reconstruction, did a lot of breast reductions, did a lot of skin cancer care postoperative reconstruction. Some hand surgery, as well as operating a wound care center for the management of chronic wounds, and again a cleft palate board for the management of children with congenital deformities.

In that setting I wasn't doing a lot of the cleft palate surgery, but I was screening the patients, developing a care plan and referring them to university centers.

Q. Doctor, in your work do you keep up with the academic literature?

A. I do.

Q. Why?

A. It's my duty. It's my duty to stay abreast of the current literature in the event of new developments that

would give better results or make care available to people it wasn't available to before.

Q. How do you in your practice judge whether or not to follow a particular recommendation?

A. Well, one of the things we emphasize in surgical services is maintaining currency in the literature and doing things like having a journal club where practitioners get together and review current articles in recent journals. So the Plastic and Reconstructive Surgery Journal is one we use frequently where you review articles. You will select articles for particular doctors to review and then present and then discuss.

The American Society of Plastic Surgery offered us -- I think it was about 15 years ago -- an evaluation tool -- I think the lead author was Dr. Rod Rohrich -- where you can assess the value of scientific evidence presented in the article that enables you to judge whether what is being presented in useful in making clinical decisions or if it's just interesting and may inform research experimentation or further study.

So the system that the American Society of Plastic Surgery uses is a 1-to-5 grading scale to grade the quality of the evidence itself. So, for example, Level 5 evidence, which is entry level -- to get into a peer-reviewed journal, you at least have to have that -- and much what is published

in peer-reviewed journals is Level 5 evidence.

What does that constitute? Anecdotal report of an interesting case -- I have got a couple of those in my CV -- where something unusual happens, you see something going on with the patient that has not been previously reported, or you have a novel way of managing something that was previously reported, and you publish that literature. Level 5 evidence.

Anecdotal report, not sufficient to guide clinical decision-making. If I had of series of cases like that and I collected those cases over time, I might be able to say more about what's going on with those patients. But a case series, a retrospective review of my database, for example, that would be Level 4 evidence. And that's more compelling and certainly more useful in designing research.

So Level 4 evidence retrospective review, no case control group. There is no control group, so I can't emphatically say that what I did for these patients got me the result that I'm claiming. I can just say there is an interesting correlation here, and we need to examine where we're going to go in the treatment of these patients.

The next level in the ASPS scheme is where you do have a control group, Level 3 evidence. Longitudinal study, where not only do we have the case series that I'm reporting on, but I have a comparable control group that I'm following both

over time. That is a -- for example, if I see that in a journal article, then that is something that can guide my clinical decision-making, particularly if we're dealing with surgical interventions that can have long-term consequences.

When you get to Level 2, now you're talking about randomized trials, and then further on into the systematic review of randomized trials.

So that's -- the goal standard is randomized controlled trials or systematic review. But as was discussed earlier, you can't do that with surgical patients. You can't do sham surgeries. It's unethical. So you can't have that kind of control. But you can have comparison populations followed longitudinally and use Level 3 evidence to make those kind of decisions.

Q. What were you asked to do in this case?

A. I was asked to review the surgical procedures that are offered in the care, affirmation care of transgender persons, to look at the levels of evidence that are used to support that, to examine the issues of medical necessity, efficacy and the safety of those procedures, and to examine the scientific evidence as presented particularly by the plaintiffs' witnesses in support of those treatments.

MR. JAZIL: Your Honor, I can tender him as an expert in plastic surgery if the Court would prefer, or just go on questioning.

MR. MILLER: I do have brief voir dire, Your Honor.

THE COURT: All right.

VOIR DIRE EXAMINATION

BY MR. MILLER:

Q. Good afternoon, Dr. Lappert. My name is William Miller.

A. Pleasure.

Q. Dr. Lappert, you've never provided any kind of gender-affirming surgery as treatment for gender dysphoria; that's correct, right?

A. That's correct.

Q. You have not published a peer-reviewed article since 1998; is that correct?

A. I think that's correct, yeah.

Q. And over the course of your career, you've published six articles, none of which were about gender-affirming surgery, surgery?

A. Correct.

Q. You've never conducted or published research on gender dysphoria or transgender people, correct?

A. Correct.

Q. You agree that gender dysphoria is not your area of care, correct?

A. Correct.

Q. And you do not claim to be an expert in the treatment of gender dysphoria, do you?

A. I do not.

Q. Okay.

MR. MILLER: Your Honor, based on that testimony, I think we land in the same area we were with Dr. Hruz, and so we would not object to Dr. Lappert testifying to the field of plastic and reconstructive surgery, but we would object to any testimony that goes beyond his area of care and clinical expertise.

THE COURT: Mr. Jazil, I know he was part of what they relied on at the administrative area. What gives him any expertise relative to this case?

MR. JAZIL: Your Honor, as testimony will show and as Dr. Lappert will hopefully testify, we are going to walk through the surgeries that are used for the treatment of gender dysphoria, and he can talk about their efficacy, their use, the risks, et cetera.

THE COURT: Surgery he's never performed, true or not true?

MR. JAZIL: Not true. He has performed these surgeries, just not for gender dysphoria.

THE COURT: Isn't that their point? It's sort of the same thing I said before. I will let you tender the testimony, and probably the most reliable way to take the tender is by allowing you to ask the questions and then subjecting it to cross-examination.

It seems to me the plaintiffs are right that to the extent he wants to speak to the question of whether this surgery is appropriate for a trans patient, what trans patients need or don't need, how this affects a trans patient, those seem to me to be things that are just not his area.

Daubert, of course, is a rule that applies in all kinds of cases. If you had a malpractice case involving trans surgery and the question was whether the surgery was appropriate, how it impacted the trans patient; and you brought Dr. Lappert, there is no question in my mind that the testimony would be excluded. In *Daubert* it's difficult to say every judge with our considerable discretion would make the same ruling on any given set of facts, but I think we would all make that ruling.

Now, if there were issues in that case that dealt with how does one perform mastectomy, then I'm sure that is something that Dr. Lappert can speak to. But whether that's appropriate treatment for a trans patient, I don't think there is a judge in the country that would say he can give that testimony.

So some of the subjects and the reason I denied these motions in limine before we started was that all of these doctors -- all these experts had some things they could properly testify about, including Dr. Lappert. But it does seem to me that, when you get his testimony about how one

should treat a trans patient, you're beyond the pale.

But we're going to get it proffered anyway; and as I said, this is probably the best way to take a proffer, so carry on.

MR. MILLER: And just for clarity, Your Honor, you wouldn't want us to object question by question. Can we have a standing objection to the extent he testifies as we did with Dr. Hruz, or would you prefer to handle it differently?

THE COURT: Yes. I don't want you to object to every question. I probably should make it clearer than maybe I did when we brought this up before. I only ask for one clear chance to rule on any given issue, but I do ask for one clear chance. So if there is something other than just he doesn't treat trans patients, if there is some other difficulty, raise it.

MR. MILLER: Certainly, Your Honor. Thank you.

MR. JAZIL: Thank you, Your Honor.

DIRECT EXAMINATION

CONTINUED BY MR. JAZIL:

Q. Doctor, I'm going to ask you a couple of questions about surgeries generally.

What goes into your decision about whether or not to do a particular plastic surgery?

A. Well, it depends on whether it's a reconstructive operation or a cosmetic operation, because they differ

significantly, and I will get into that.

So the first question is: What is the nature of the patient's problem? In the case of a reconstructive surgery, what is the nature of the defect? What is the missing part? What is its dimensions? What's the history of injury or how that may have happened? What does it mean to the patient?

Loss of a helping hand is different than loss of a dominant hand, for example. So if he's a left-handed patient, it's different than if he's a right-handed -- those sorts of things.

So having defined the defect and what the defect means to the patient, then I have to go through what the options of reconstructive surgery are; and among those options, what am I capable of doing, so my skill level for that particular reconstructive challenge.

Then I have to be able to offer the options of care to the patient so that they can make an informed decision. And I have to be able to go through with them what the likelihood is of a successful outcome, what they're risking in having the operation.

So it begins with a definition of the defect, an examination of the patient's particular problems, and what are the options of care and reconstruction, am I capable of doing that, and what does the patient choose to do.

It's a different process when you are talking about

cosmetic surgery because such operations begin in the subjective life of the patient. They are not referred to you because something is wrong or something is missing. They are referred to you because something is going on in their interior life, and they're usually self-referred.

So the beginning of that evaluation is really an evaluation of what the patient is thinking, what they are seeing, what they are feeling, and whether or not I can see and understand what they see and understand.

And then having determined what their complaint is and what they are seeking from cosmetic surgery, I have to examine what's the likelihood that I can satisfy what it is that they want from the surgery.

So it may be something trivial, like the person just wants their two ears to match because one of them is loppier and the other one is not. And I can see the defect, I can define the defect, I can offer several options of care to the patient. And in discussing that with the patient, I can get a sense for what their expectation of the result is. Well, symmetry, and I would like people to stop looking at my left ear. That's a reasonable thing. So that's not a very challenging one.

But if I patient come in and say that they want their nose modified, I will -- getting into the details, if I see what they see, you know, I have a hump on the top of my nose

or the base of my nose is too wide, I think it looks ugly, well, if I can see what the patient sees, then I can proceed on.

If in the course of the evaluation the patient voices to me the idea that by changing the appearance of their nose, they are going to radically alter the course of their life; that they are going to go from a condition of great sorrow to a condition of joy. If they say things like, "The reason I'm not getting ahead in the firm is because I have this hump on my nose," I'm going to basically seek to disabuse the patient of the idea that changing their nose is going to change their career.

But that would be an example of a person ascribing to their physical appearance the causes of their sorrow, particularly if it's within the normal range of what humanity experiences.

So that's where you get into the moral and the ethical issue of reconstructive surgery versus cosmetic surgery. In both cases you have to have an understanding of what the likely outcome is going to be based on your skill and the patient's condition.

But in the case aesthetic cosmetic patient, you have the additional problem of recognizing, when a patient has a condition that we -- in our training, we learn it is called "body dysmorphic disorder." This is a very important thing

for cosmetic surgeons to understand because it's considered malpractice to offer surgery to a person who is suffering with body dysmorphic disorder. It unethical.

Q. Doctor, before we go on to specific surgeries, can you tell us briefly what the risks are associated with surgery generally?

A. Well, surgery generally, if you make an incision in the skin, you have a risk of wound infection. Depending on where on the body you make the incision, the risk may be higher or lower.

Anesthetic risks, unexpected reactions to medications, length of anesthesia, length of immobilization, all can be associated with significant risks of everything from adverse reaction to anesthesia to pulmonary embolus from thrombophlebitis, various things like that. Depending on where in the body you are operating, the potential risk can be higher.

MR. JAZIL: I would like to DX16, page 138.

BY MR. JAZIL:

Q. Doctor, take a look at these surgeries and look back at me when you have had a chance.

A. Okay.

Okay.

Q. Doctor, which of the surgeries on this list have you performed in your experience?

A. Let's see. Going from top to bottom under the heading of "Brow," I have performed all of those operations, lip, lip reconstruction, jaw modification, chin reshaping. I have not done a chondral laryngoplasty. That's not an operation I have done.

Breast surgery, all of those. Genital surgery. I have not done metoidioplasty. I have done vulvoplasties, vaginoplasties, phalloplasties. I have not done gonadectomy electively. All I have done is a removal of an infarcted gonad but not a bilateral. Body contouring, I have not done monsplasty.

Under "Additional Procedures," I have not done uterine transplantation or penile transplantation. And as far as the various options of those operations, I have done -- none of the things listed under metoidioplasty, but the others, I think I have done all of those.

Q. Doctor, can you tell us which of the operations on that list are reversible?

A. Well, all of those facial surgeries are reversible. Mastectomy is not a reversible procedure. Any operation that involves the -- you know, obviously the removal of the genitalia is not reversible, like gonadectomy, hysterectomy, those are not reversible surgeries. The ordinary body contouring procedures are reversible.

Q. Doctor, based on what you just said, my understanding is

you have done a phalloplasty?
A. For reconstructive purposes, yeah, on a couple of occasions, for management of infectious destruction as well as traumatic amputation.
Q. Can you briefly describe for us what that surgery is?
A. Well, in the one case it involved local regional flaps where we -- in order to do such reconstructions, you have to import soft tissue from adjacent places or from distant locations in order to get the reconstruction going.
So the penile reconstructions, one of them involved a replant with a local regional flap, and the other one involved reconstruction with local regional flaps and free skin grafts.
Q. What does that mean?
A. It means that you lift and you rotate an area of adjacent skin, keeping it on its blood supply, and shaping that tissue into the structure you are trying to reconstruct. And oftentimes when you do -- use that technique, you come back and do additional modifications to the result in order to achieve a more aesthetically normal result.
Q. What are the risks associated with the surgery?
A. Any time you lift and rotate tissue in order to achieve a reconstruction, you are challenging the blood supply to that area of skin. In simply making the incision around the skin, even while preserving its named blood supply, you are

compromising blood flow in that flap.

So to lift and rotate an area of soft tissue like that risks loss of blood supply and the concomitant wound-healing problems, and that sort of thing. When you are importing tissue from remote locations using the free flap technique or the microvascular flap, that's even more challenging, because now you are working under the microscope to reconnect blood vessels, and they have their own particular risks of infarction and thrombosis and that sort of thing.

Q. If you were to do the surgery on a natal female, would the risk be different?

A. Which operation are we talking about?

Q. Phalloplasty.

A. Phalloplasty. So in order to do a phalloplasty, you are importing tissue from remote locations, typically. Not exclusively, but the typical operation these days is a microvascular neurotized free flap reconstruction, which involves a couple of risks. One of them is the risk to the tissue that you've transplanted. The things that we talked about earlier, loss of blood supply and difficulties with wound healing.

Additionally, you have donor morbidity, which includes -- the typical donor site is the forearm. The donor morbidity there is exposure of muscles, tendons, nerves, joints, ligaments, that can comprise function of the hand, cause

lymphedema in the hand, besides the aesthetic problem. Because you're covering that with a skin graft, you have the potential of partial or complete loss of the skin graft that is being used to protect the previously exposed muscles, tendons, and so on.

And then you have what -- you have to put in the category of donor morbidity, which means what is the patient losing in order to achieve the reconstruction. There is the donor morbidity of the arm --

THE COURT: Doctor, I don't want to interrupt.

Do you remember what the question was?

THE WITNESS: Yes. I think the question was what are the risks.

THE COURT: No. That was not the question. The question was: What risks are there doing this to a natal woman as opposed to doing it to a natal male? What increase -- what different risks?

THE WITNESS: I understand, sir. Sorry.

So the difference in risk is that, in the natal male, it's what you're risking is the donor site and the fact that the flap might fail. In the natal female, there is the additional risk -- well, the additional penalty, I guess, of the loss of the reproductive capacity.

BY MR. JAZIL:

Q. Doctor, you said you've done a vaginoplasty. What are

the risks associated with that?
A. Similar risks. The particular vaginoplasty I've done were in the setting of essentially IED trauma. So, again, lifting and rotating tissue, the risk of loss of the tissue, the risk of fistula communication between the reconstructed structure and adjacent structures like the bladder and the rectum, where you can get communication between those structures and the external world.
Q. Doctor, you have said you have mastectomies before.
Can you approximate for me how many mastectomies you have done in your career as a plastic surgeon?
A. Somewhere between 3- and 400, I'm going to estimate.
Q. When do you typically do these mastectomies?
A. A mastectomy is a therapeutic operation, typically done in the setting of a diagnosis of malignancy or more recently in the setting of a diagnosis of increased risk of malignancy in people who have inherent traits.
It can additionally be done for other problems where you can have painful fibrosis of the breasts that the patient's having difficulty dealing with, and that would be a different kind of a mastectomy. It wouldn't be a total mastectomy but a subcutaneous mastectomy. You then replace it with either autologous tissue or an implant.
Q. Doctor, earlier in your testimony you talked about some of the ethical concerns associated with dealing with

surgeries.

Why aren't there any ethical concerns in your mind when you're moving healthy tissue from a woman who hasn't yet been diagnosed with breast cancer?

A. Well, there are a couple of circumstances where you might be doing that. So, for example, in a breast reduction, you are removing healthy tissue, but you're doing it -- it's considered a reconstructive operation because it doesn't begin in the subjective life of the patient. It begins in a known problem of orthopedic difficulties that the patient is having. Neck, back, and shoulder pain associated with overgrowth of the breast is a common problem, which I had to manage on active duty women.

So there what you are managing is a known objectively qualifiable diagnosis of neck, back, and shoulder pain, and the breast reduction has known benefit; that is to say, I know that if I remove x-amount of tissue, the neck, back, and shoulder pain will resolve.

So in the setting of removal of normal tissue, say from a woman who has a diagnosis of an inherited trait and has a family history of breast cancer, there you are, again, doing it to manage an objectively quantifiable disease.

And in this case, what's quantifiable is her lifetime risk of breast cancer. And so the operation is done there to manage that. Very different thing if I'm doing mastectomy to

manage a subjective complaint. So that's where the ethical problem would come in.

Q. Doctor, have you done breast augmentation surgeries before?

A. Many.

Q. And let's say a 40-year-old mother comes to your office asking for a breast augmentation surgery. What's the conversation you have with her to decide whether or not you can do the surgery on her?

A. Well, as we talked about before, it's characterizing what the patient's goals are, what she sees, and if I can see what she sees. Is she -- is she in a condition to tolerate the surgery, even though it's a relatively brief operation. Does she have any contraindications to implant augmentation? A woman who has chronic problems with infection would not be a good candidate for implant surgery of any kind.

If her expectations are reasonable, then it would be a reasonable thing to discuss with her. And then we would discuss what the options of care are, whether an implant or autologous fat grafting or something of this sort.

What I would be wary for in a patient like that is, again, motivation. If her expectations are the ordinary kind where she just would prefer to look like she looked before she had her children, that's the typical breast augmentation patient. If in the course of my evaluation she became

tearful and said something like, "I'm glad you're going to do this operation for me because I'm sure that if I don't do this, my husband will leave me," then that would be an unethical reason for me to offer -- I mean, that would be a circumstance of ethical problems because the patient would have an expectation of the surgery that obviously I cannot meet.

Q. Understood.

THE COURT: Did I understand you just to say that the typical reason why somebody presents for breast augmentation is because they've had children and want to be restored to where they were before they had children?

THE WITNESS: Yes, sir. I think that the most common breast augmentation patient is a woman in her forties who is multiparous. There is obviously a large cadre of patients who are young who are looking to enhance their appearance, and it also varies from one area of the country to another. When I was doing surgery in San Francisco, very different from when I was doing surgery in Tennessee, the expectations of surgery.

THE COURT: We've gotten so far from the issues in the case that we're just spending time.

MR. JAZIL: Your Honor, I will wrap this up quickly.

BY MR. JAZIL:

Q. Doctor, the surgeries on that list there, do you do any of those surgeries for transgender patients?

A. No.
Q. Would you do any of those surgeries for transgender patients?
A. No.
Q. Why not?
A. Because that is -- the problem we talked about earlier, the transgender patient --
THE COURT: This is particularly the area where this witness has no expertise and nothing to add. If I'm not mistaken, he was prevented from giving this testimony by the District Court in North Carolina, was he not?
MR. JAZIL: I don't know, Your Honor.
THE COURT: I don't think I'm the first judge to say this man has no expertise that passes *Daubert* on this subject.
MR. JAZIL: Your Honor, may I --
THE COURT: The earlier ruling -- go right ahead. Basically, you're going to testify that doctors providing a service he's never provided for patients of the kind he's never dealt with are committing an unethical practice, essentially malpractice, every day when they treat their patients. It's a remarkable assertion for someone who has never worked in the area.
Carry on.
BY MR. JAZIL:
Q. Doctor, why wouldn't you provide those surgical

treatments to patients who are seeking them for the treatment of gender dysphoria?

A. Because I would place those operations in the category of cosmetic surgery. And for the reasons we discussed earlier, cosmetic surgery, because it begins in the subjective life of the patient, in this case the expectations are not anything that I could offer even a glimmer of a prediction whether it would satisfy their needs because the expectation is very, very high that it would be life transforming. And because it is a cosmetic operation, I would consider it something I would not offer.

MR. JAZIL: Thank you. No further questions, Your Honor.

THE COURT: Cross-examine?

MR. MILLER: Yes, Your Honor.

CROSS-EXAMINATION

BY MR. MILLER:

Q. Dr. Lappert, you've previously attended meetings sponsored by the Alliance Defending Freedom, correct?

A. Yes.

Q. Is it all right if I refer to that as the ADF? You'll know what I --

A. Certainly.

Q. The ADF is not a professional scientific organization, is it?

A. I don't think it is, no.
Q. Would it be fair to describe it as a Christian-based, legal advocacy organization?
A. That's my understanding. I'm not affiliated with them, so I don't understand the entirety of what they do. But I do know that they are Christian-based, and they seem to be an advocacy organization that's based in the law.
Q. And you attended an ADF meeting sometime in 2017; is that correct?
A. Sounds right. I'm -- I don't know the exact dates that I was there, but...
Q. The meeting certainly preceded the time that you've ever testified as an expert witness; is that correct?
A. Yes.
Q. And at that meeting there was a discussion about the lack of people willing to testify and the difficulty of finding expert witnesses on transgender issues?
A. I think that was discussed, yes.
Q. And people at that meeting were asked whether they would be willing to participate as expert witnesses, correct?
A. I don't remember that question being asked, but...
MR. MILLER: Anna, could you pull up Plaintiff Exhibit 81, please?
THE COURT: You have to say it where we can all hear.
MR. MILLER: Yes. Plaintiffs' Exhibit 81, please.

BY MR. MILLER:

Q. Dr. Lappert, do you recall testifying at the trial for *Brandt v. Rutledge* in Arkansas?

A. Yes.

Q. And that was in 2022, November?

A. Correct.

MR. MILLER: And, Anna, could you go to the page 1081?

BY MR. MILLER:

Q. I'll just read it out. You were under oath at that trial, correct, Dr. Lappert?

A. Yes.

Q. Do you recall a question being posed, and I'll quote:

"Question: And people at that meeting were asked whether they would be willing to participate as expert witnesses, weren't they?

"Answer: Yes."

Do you recall that testimony?

A. Well, I don't recall it, but I'm certainly confident that they recorded it correctly.

Q. Thank you.

And were you present in court yesterday when Dr. Hruz testified?

A. Yes, I was.

Q. And you're familiar with Dr. Hruz?

A. Oh, yes, we're good friends.
Q. Dr. Hruz was also present at that meeting, correct?
A. Yes, he was. In fact, that's where I met him.
Q. And it's fair to say that ADF is an organization that has moral objections to gender-affirming care to treat gender dysphoria?
A. I suspect that's true. Again, I don't have any association with the ADF. I was just invited to make a presentation there and met some people and had a discussion and left.
MR. MILLER: Anna, could you please pull up Plaintiffs' Exhibit 135?
BY MR. MILLER:
Q. Dr. Lappert, this is a 2019 article from LifeSiteNews titled, "Plastic Surgeons, Sex Change Operation Utterly Unacceptable and a Form of Child Abuse," right?
A. Yes.
Q. You're the plastic surgeon quoted in this article, correct?
A. Yes; that's correct.
Q. The article reports on your 2019 appearance in a radio interview on a broadcast called "Relevant Radio Trending With Timmerie," correct?
And you did appear on that radio program, correct?
A. That's correct.

Q. On the first page this article states:

Dr. Lappert, a Catholic Deacon in Alabama, says changing a person's sex is a lie and also a moral violation for a physician.

Did I read that correctly?

A. Yes.

Q. You hold that view, correct?

A. I do.

MR. MILLER: Would you go to page 7 of the document, please, Anna?

BY MR. MILLER:

Q. We're looking at the bottom two paragraphs, very bottom of the page. Thank you.

So the second-to-the-last paragraph quotes you as saying, quote:

It's leading us to see the human person as a commodity that is regulated by the government, by government institutions, universities and by laboratories, and that is a huge evil. It's a huge evil, and never forget that transgender surgery is right at the heart of that evil.

Did I read that correctly, Dr. Lappert?

A. You did.

Q. That's an accurate quote of your words?

A. Yes, it is.

Q. The article then indicates, you continue -- I'm going to

the last paragraph on that page. Quote:

First of all, because it utterly perverts our sense of human sexuality, it internally divides the human person from their very own bodies. And now it's separating the human community from their reproductive faculties in the era of assisted reproductive technology. So this is diabolical in every sense of the word. Diabolical.

Did I read that correctly?

A. You did.

Q. And that's an accurate quote of your words, right?

A. Yes, it is.

MR. MILLER: You can take that down, Anna. Thank you.

BY MR. MILLER:

Q. Dr. Lappert, you yourself have previously lobbied state legislators to pass laws banning the provision of gender-affirming care to adolescents, correct?

A. I have.

Q. And you submitted information to the Utah legislature in relation to such proposed law; is that right?

A. I think that's correct. I didn't -- the involvement with Utah didn't proceed I think beyond one -- one interaction, and I don't remember the details.

Q. Do you recall making a submission of information?

A. I think so, yes.

Q. And in that submission, with respect to gender-affirming care, you said, quote:

All that is happening is that the patient is undergoing an intentional mutilation in order to create a counterfeit appearance of the other sex.

Does that sound correct?

A. That's very correct, yes.

Q. And you consider gender-affirming surgeries to be an intentional mutilation, correct?

A. Part of it is intentional mutilation, yes, it is. So, for example, the intentional destruction of a reproductive faculty is considered mutilation as surely as if I mutilated somebody's hand, only in this case it's the genital. You are robbing them of a natural human facility through the process of destruction of natural human structures.

Q. And you think it would be a good idea to criminally prosecute doctors who provide gender-affirming care, correct?

A. Actually, I would hope it would be unnecessary to do that.

Q. But you do agree it would be a good idea if the care was still being provided?

A. Yes.

THE COURT: Let me make sure I -- what the last question and answer were. You think it be a good idea to prosecute doctors who provide the care?

THE WITNESS: What I think is that having publicly reviewed, first of all, what is going on, what is the level of scientific support, if it is, you know, the desire of the government to regulate that, then it would be -- as surely as we criminally prosecute the mis-prescription of anabolic steroids to children who want to be athletes, it's the same kind of duty that the government has. And I consider that one of the duties not only of the government, but I would hope that the medical community would take action to prevent those things first.

THE COURT: I was just to trying to make sure. The question was, you agree it would be a good idea, and you said yes. And I just wanted to make sure that a good idea that you were referring to was prosecution of doctors who participate in this care.

THE WITNESS: If it's -- yes, if they violated the law in doing it, yes, I would agree.

MR. MILLER: I have no further questions, Your Honor.

THE WITNESS: Redirect?

MR. JAZIL: Nothing, Your Honor. Thank you.

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

Please call your next witness.

MR. PERKO: Defense calls Dr. Kristopher Kaliebe.

DEPUTY CLERK: Please raise your right hand.

KRISTOPHER EDWARD KALIEBE, DEFENSE WITNESS, DULY SWORN

DEPUTY CLERK: Be seated.

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

THE WITNESS: My full name is Kristopher Edward Kaliebe. The last name is K-a-l-i-e-b-e.

DIRECT EXAMINATION

BY MR. PERKO:

Q. Dr. Kaliebe, you might also want to spell your first name.

A. Oh, yeah. Kristopher is with a K., K-r-i-s-t-o-p-h-e-r.

Q. Dr. Kaliebe, what positions do you presently hold?

A. Yeah. I was just promoted to full professor at the University of South Florida in the department of psychiatry and neuroscience, and I teach there. I have a clinic which is an adult psychiatry clinic which is a resident clinic. The residents work with me.

I have a child psychiatry clinic, which the child psychiatry fellows who are trainees or adults who are training in child psychiatry do see patients with me.

I cover Tampa General Hospital on nights and weekends. I do some collaborative care with pediatricians around the state with the Medicaid hotline, and I also work in juvenile corrections. In addition to that, I do private forensic work.

Q. What did you do before you came to the University of South Florida?

A. Well, for 11 years, I was on staff at the Louisiana State University Health Science Center in New Orleans. So I started off as an assistant professor, and by the time I left, I was promoted to associate professor at LSU. There, I worked mostly in what are called federally qualified health centers. Those are centers where they have to have an underserved or disadvantaged population. I had one clinic that was outside of New Orleans, which is sort of -- it's a primary care setting where you're in a primary care setting, but you're doing psychiatric care.

So at that clinic, I saw about 80 percent children and 20 percent adults. About five years into being at LSU, we started to do a collaborative care initiative where we would go into family practice docs, pediatricians' offices, and this type of thing. Either you'd beam in via telepsychiatry or you'd do colocated or collaborative care onsite.

And you would go in and you would help those people, like handle mental health issues, you know, within primary care. They would still kind of own the patient, but you would be a consultant and help out.

In addition to that, I was doing lots of teaching of medical students, psychologists, you know, child psychiatry fellows, general psychiatry. I taught the psychotherapy

course for the residents in psychiatry. I was teaching their yearlong CBT course for much of that time. I also worked in juvenile corrections and a little bit in adult corrections during that time.

Q. What was your work with the corrections?

A. Well, ever since I finished my forensic psychiatry fellowship in 2005, I have worked in juvenile corrections. That includes in detention centers but also in what are called correctional centers, so detentions before you got locked up for a short term and the correctional centers are more longer term. I did do a little bit of adult correctional work also.

Q. What did that work involve?

A. Well, all work in corrections, you get an assessment, everyone, and a child when they come into the facility gets assessed. So I would do an assessment for everyone at the facility that was under my care, or if I was the only psychiatrist, then it would be everyone. And then you treat, following up everyone on medications and then also some, you may just follow up also for psychotherapies or other stuff, too.

Q. Could you please summarize your educational background?

A. Sure. I have a BA in biochemistry from Columbia University. I graduated from St. George's University School of Medicine. I went to -- I did my adult or general

psychiatry residency at UMDNJ at Newark which is now called Rutgers, so they have changed the name. So that would be Rutgers Newark.

I did a child psychiatry fellowship at LSU Health Science Center in New Orleans. I was chief resident during that time. And then I also did a forensic psychiatry fellowship.

Q. Have you authored any peer-reviewed publications?

A. I believe I have ten peer-reviewed publications.

Q. Have you served as a reviewer for any journals?

A. Yes. I probably can't remember the names of all of the journals, but I know for Pediatrics and Adolescent Health, I think it is. So probably for maybe about four journals I have done reviews.

Q. Are those journals listed on your CV?

A. Yes, it should be all on my CV.

Q. Are you member of any professional associations?

A. Yeah. I'm a member of the American Academy of Psychiatry and the Law. I'm a member of the American Psychiatric Association. And for the American Academy of Child and Adolescent Psychiatry, I was a co-chair of the media committee there from 2013 to 2021.

I was the liaison between the American Academy of Child and Adolescent Psychiatry and the American Academy of Pediatrics, I believe from 2015 to 2022. And I'm also a distinguished fellow at the American Academy of Child and

Adolescent Psychiatry, which was awarded in 2016.

Q. Have you received any awards for your work as a psychiatrist?

A. Yes. I was two years out of my residency in 2007, was the first time that I both a Best Doctors' award which is a peer recognition award for physicians. So I've continually received Best Doctors since then. So every year I've continued to get Best Doctors.

And I consider it a recognition that I was elected to office within what's called the Louisiana Council for Child Psychiatry. That is the state branch of ACAP, which is the American Academy of Child and Adolescent Psychiatry. I was the secretary-treasurer for a few years, but I was elected president also for two years.

Q. Do you have any clinical experience with gender dysphoria?

A. Yes, I do.

Q. Could you explain what that is?

A. Gender dysphoria is a condition where there is an incongruence between someone's gender identity or sense of self and their biological sex. It's a condition where they have intense distress related to that, and that distress causes a problem in functioning somewhere, at work, school, somewhere in their life. It has to be around for at least six months in order to meet criteria.

Q. I was really asking: Can you explain your clinical experience?
A. Yeah. I can see or treat patients with gender dysphoria in any of the places where I work which would include the adult psychiatry clinics at the University of South Florida. It would include the child clinics at the University of South Florida. It would include within juvenile corrections or in any of my consultation work.
Q. And do you keep up with the scientific literature regarding treatments for gender dysphoria?
A. Yes, I do.
Q. Why is that?
A. Well, it's essential, because I see patients, for one, so it's important for me to provide the best care to anyone who comes and sees me. So, of course, I want to be up to date on everything that I do. So I've following it in that regard.
Also, as a faculty member who does a lot of teaching, I have residents, you know, medical students, child psychiatry fellows, they all work underneath me, and so I need to be able to know what the literature is and teach them while we're seeing patients.
Q. Dr. Kaliebe, did you attach a copy of your curriculum vitae to your expert report in this case?
A. I believe I did.
Q. Is that a complete and accurate description of your

professional experience?
A. It may a little dated at this time; but, yes, I believe I submitted one.
MR. PERKO: Your Honor, I believe that is on the stipulated exhibit list as Exhibit DX30, and I'd ask it be admitted at this time.
THE COURT: DX30 is admitted.
(DEFENDANTS' EXHIBIT NO. 30: Received in evidence.)
MR. PERKO: And, Your Honor, at this time, we tender Dr. Kaliebe as an expert in psychiatry.
THE COURT: Questions at this time?
MR. GONZALEZ-PAGAN: Just briefly some questions for voir dire, Your Honor.

VOIR DIRE EXAMINATION

BY MR. GONZALEZ-PAGAN:
Q. Good afternoon, Dr. Kaliebe. Nice to you see you again.
A. Uh-huh, good to see you, too.
Q. Dr. Kaliebe, you have not published any literature regarding gender dysphoria; is that right?
A. That's correct.
Q. Or you have not published any literature regarding transgender people; is that right?
A. Correct.
Q. You have not done any original scientific research with regards to gender dysphoria?

A. That's correct.
Q. Nor have you done any original scientific research with regards to transgender people?
A. Correct.
Q. Or gender identity?
A. Correct.
Q. And you do not provide medical treatment for gender dysphoria?
A. Are you saying I do not administer hormones or surgeries? That is correct.
Q. And you were deposed in this case, if you recall?
A. Correct, yes.
Q. Previously you testified that, throughout your career, you have only diagnosed approximately a dozen patients with gender dysphoria.
A. Correct.
Q. And you have previously testified that some of these dozen patients have gone on to receive gender-affirming medical treatment; is that right?
A. Correct.
Q. You also testified that you would not be providing any treatment directly addressing this patient's gender dysphoria but rather providing treatment for their comorbidities; is that correct?
A. Well, I'm not sure exactly what the question was last

time, but I do believe that providing psychotherapy can also help with gender dysphoria. So usually when you have a patient come in, you're just trying to get to know them as best you can and provide the best care that you can. I wouldn't rule out that providing psychotherapy to them helps them also with their gender dysphoria, but I just come in and treat a patient as I see them and try to do the best care that I can.

Q. Understood. Thank you.

You actually, for regular psychotherapy, you refer your patients out; is that correct?

A. Well, I actually do do a lot of psychotherapy myself, and I am quite experienced and well-trained in psychotherapy. It is a tradition in psychiatry that we do export out because we have a lot of patients and only so much time for psychotherapy. It depends what setting and in what situation.

So I do do a fair amount of psychotherapy, but I'm also often -- more often referring people out for psychotherapy because there is only so much time that I have and ability to follow up.

Q. Dr. Kaliebe, I'm just showing a transcript of your deposition in this case.

Do you recall that it was taken on March 20, 2023?

A. Yes.

Q. And specifically you stated:

I don't know that what we would say we were giving therapy for gender dysphoria.

Those are your words, correct?

A. Correct. Yes; that's correct.

Q. So I guess, are you saying now that you treat gender dysphoria as part of your practice?

A. Well, I think when you are giving psychotherapy, you are treating the whole person, and that would include the mix of mental health concerns that they have, and I think that does include gender dysphoria, plus anxiety, depression, ADHD, autism, whatever else are comorbid.

So I think -- how I read that question before, are you like particularly -- when you see a patient with gender dysphoria, are you particularly honing in on the gender dysphoria as the thing that you are going to talk about in psychotherapy? I think you do therapy open to whatever will be most helpful. It may delve into issues related to gender dysphoria or it may not, depending on what happens with the patient.

Q. Okay. With your dozen patients that you have diagnosed or so, have you specifically sought to address their gender dysphoria with psychotherapy?

A. Well, I would say -- I would say, yes, in that, when you are doing general therapy with a patient, especially a

younger person, and you're talking to them about all of the issues in their life and exploring what's going on, that that would be and could be addressing their gender dysphoria. Although, when someone has a number of comorbidities, I'm not directly going at their connection between their body and their gender identity and the distress. If it comes to that, and they are willing to talk about that and they want to talk about it, I'm open to do that.

Q. But you previously testified that providing treatment for comorbidities doesn't necessarily address a patient's gender dysphoria?

A. Correct. It may or may not, yes.

MR. GONZALEZ-PAGAN: Your Honor, at this time we would posit that Dr. Kaliebe may be able to testify as to the diagnosis and assessment of gender dysphoria, and otherwise not speak about treatment of gender dysphoria, certainly not medical treatment of gender dysphoria.

THE COURT: Well, if we get to particular questions that you think he doesn't have the expertise to address, then object to them.

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

THE COURT: I did have one question along those same lines.

Dr. Kaliebe, you treated 12 patients who have gender identity issues. How many of those were adults and how many

children?

THE WITNESS: I would have to also add that I have treated a number of patients since then. So the number is now -- that is what I gave at the deposition. But I did pick up that adult clinic, so I have a number more. So I have, you know, maybe four or five adult patients that I have now at least seen or overseen. Mostly it has been child -- I mostly functioned as a child psychiatrist and my child psychiatry clinic has been longer, so it's been mostly child.

THE COURT: So most of the 12 were children and --

THE WITNESS: And in the child clinic, you age out at 18. Sometimes we keep them on if there is something going on. And then in juvenile corrections, you know, I have had people who have aged into being 18 but came in before 18.

THE COURT: In talking with the children in the group of 12, I understand you're treating the whole patient. So you are trying to figure out what's going on. And do you sometimes talk specifically about gender identity?

THE WITNESS: I would like to get to a place where we are able to talk about it, and I would like to have openings to do that. It kind of depends on how close you are with the patient and what's going on. And I'm often working with others. It's multi-disciplinary team.

Like in juvenile corrections, all the patients I work with also have a therapist. So I'm working with their

therapist and seeing the person myself. So I will -- I'm willing to open those doors, but if that is a door that the therapist who does see them more often than me -- although, in reality, within a lot of the places I work, I'm actually the most experienced therapist there.

So they depend on me to sort of understand what's going on with the patient and make some suggestions where therapy may or may not go. So, yes, I think it would be great to explore those things. I think you don't want to push hard on things that are going to be overly sensitive.

THE COURT: That answer was kind of how you ought to do it. I was really asking what you actually did.

THE WITNESS: Okay.

THE COURT: So of the however many of those 12 children, how many did you actually talk about gender identity with?

THE WITNESS: Well, when you say "talk about," are you saying -- you know, because there's different depths of talking. Obviously, you do some reviews and find out what's going on. You're talking like more in depth. Is that the question? You're going to just ask questions about those things, just as diagnostically, that's a different --

THE COURT: Fair enough. More than just -- I don't know what that distinction would be in real life. You are talking to a patient, and the patient is, say, male assigned

at birth and says, "I'm really a girl," I'm guessing you don't just move on. That seems to be a show stopper, and surely you talk about that little bit, right?

THE WITNESS: Correct.

THE COURT: So I don't understand the differences. Did you really talk about it? Well, yeah, I assume if the child says that, then you really talk about it at least a little bit.

My question: Did you talk at least a little bit with how many of those 12 on the subject of gender identity?

THE WITNESS: Yes. So I would probably say that, you know, obviously, like I'm saying, we are doing superficial work some of the time, because we are just assessing, they are coming in, I'm working with other people. So I would say four of the group that I know well or have known for years even, so there's four that I have had more in-depth type. If that is what you're saying, more exploratory-type work, yes.

THE COURT: So real discussion about gender identity for children.

THE WITNESS: Correct, yes.

THE COURT: You may proceed.

MR. PERKO: Thank you, Your Honor.

DIRECT EXAMINATION

CONTINUED BY MR. PERKO:

Q. Dr. Kaliebe, what were you asked to do in this case?

A. I was asked to review the evidence-base regarding gender dysphoria. I was asked to speak about the increase in patients presenting with gender dysphoria. I was asked to talk about the scholarly and scientific dialogue related to gender dysphoria, and I was asked to talk about psychotherapy and other treatments for gender dysphoria.

Q. When you said evidence-base for gender dysphoria, did you mean evidence-base for gender-affirming treatments?

A. Treatments, yes.

Q. What did you do in order to assess the evidence-base supporting gender-affirming treatments?

A. Well, I have been actively involved in trying to figure out what is the evidence-base and what the best treatment is. Obviously, it is very complex science. I would say I have reviewed at least 50 papers that are directly related to gender dysphoria treatment. I go to conferences, and I particularly have been trying to see all of the presentations at APA, or the American Psychiatric Association, so that I'm up to date.

I have done the online review. I did an online review from the American Psychiatric Association.

In terms of reviewing the literature, I, of course, specifically looked at the systematic reviews and some of the other forms of coalescing the research to get a good idea of what the overall evidence-base is.

Q. Can you name some of the systematic reviews that you reviewed?
A. Well, there were systematic reviews done by Finland, by Sweden, they were done in England, and the Endocrine Society relied on reviews when they were making their recommendations, and then there was the review in the Florida report.
Q. What did you conclude about the evidence-base supporting gender-affirming treatments?
A. Well, overall the evidence-base is low quality, and that is consistent with all of the reviews.
Q. Did you review the report by Brignardello-Petersen and Wiercioch attached to the GAPMS report?
A. I did.
Q. And what did you conclude from that?
A. Well, it was similar to the other reviews in that it looked at -- it used a systematic method to review the evidence, and it did come to the conclusion that the evidence-base was overall low quality.
Q. Does the fact that the Brignardello-Petersen report is not peer-reviewed give you any pause for concern?
A. No, because for one, the -- one of the authors is a clinical epidemiologist from McMaster University, which is one of the premier, you know, where they developed the GRADE system. And for, two, the conclusions were similar to the

other reviews. So it wasn't really much different in terms of the conclusion.

Q. You mentioned that you were asked to discuss the recent increase in gender dysphoric diagnosis.

Can you please elaborate on that?

A. Yes. So the DSM-5, which was published in 2013, rated the incidents of gender dysphoria as 2 to 14 per hundred thousand, in 2013, right? So that's a very low number compared to what the current amount is. And that's consistent with my career. When I was medical school for four years, three psychiatry residences, and 11 years of practice in Louisiana, I didn't have a single patient present, complaining of gender dysphoria.

And I worked in multi-disciplinary teams. I consulted with pediatricians. I had medical students, psychologists. No one was seeing patients presenting with gender dysphoria, other than the very rare patient, and it just happened that I didn't get one of those rare patients.

And then now more recently, we have patients all of the time coming with gender dysphoria. So something has really significantly changed, and it's quite a puzzle. I had a clinic. I saw two patients with gender dysphoria yesterday. I had a clinic earlier in the year with three patients with gender dysphoria. So after years of not seeing patients with gender dysphoria, now we're seeing a huge increase.

Q. What are some of the --

THE COURT: I'm sorry. We just went through this, and it was 12 patients and four or five since then. And I asked you some more questions, and you had had a real discussion with four children. And now you say you see them all of the time. I don't get it. If you see them all of the time, how did we not get to more than 16 or 17?

THE WITNESS: I was comparing the incidents of what we are seeing now, compared to my whole career up -- for my first 20 years of not seeing a single patient, and now in one clinic seeing two patients or three patients, that's a huge increase from what it was. Maybe the way I said it, it wasn't as eloquent as it could have been, but that's a significant change.

THE COURT: Look, I'm going to be the least eloquent guy in the room. I'm not worried about how eloquently you said it. I just didn't seem to understand that. I thought, after the initial questions about your background, when I asked questions, I thought I had nailed this down. Twelve patients until recently. When you took over the adult clinic, you saw four of five more. So that seems to me 16 or 17 lifetime.

THE WITNESS: Correct.

THE COURT: But just a minute ago in response to Mr. Perko's question, you now said -- you didn't say

avalanche, but that was sort of it. We are now seeing something along those lines. We're seeing them all of the time. I just thought something you are seeing all of the time, if you have seen 17 in your life, that didn't seem to square. So that's why I stopped to say, what did I miss? I either misunderstood the prior testimony or I misunderstood what you just told me, or I'm misunderstanding something. So what is it?

THE WITNESS: Well, when you have a busy, busy career -- I mean, as a resident you see a ton of patients, in medical school you see a lot of patients. You work for a long time not seeing these patients, and then now you're seeing them, something has changed. Now, I don't know --

THE COURT: You are seeing them as what, four or five people?

THE WITNESS: Well, from a diagnosis that you didn't see at all for 20 years within medicine, it's a significant difference, yes.

THE COURT: All right. Got it.

THE WITNESS: Twenty years is a lot of time to be practicing psychiatry.

THE COURT: Look, I started to tell you when you started, it was evident to me, even before the other side started asking questions about qualifications, you have done a lot of stuff. You are a high energy guy, and I respect that.

I was going to tell you -- I was going to bring it up because the court reporter would appreciate it if you slow down a little bit; and, frankly, you are high energy guy. So got it.

THE WITNESS: I'll try.

BY MR. PERKO:

Q. Doctor, what are some of the potential reasons for an increase in gender dysphoria diagnoses?

A. Well, as we heard earlier today, any kind of psychiatric diagnosis -- and I think this included -- is a combination of, like, individual factors in the person. But also it's subject to, like, social, family, cultural factors. And, obviously, our genes have not changed in the last 30 years, but our society has quite a lot.

And so when you look, when you this rise in patients during that time, you also can see some parallel rises. For one, we just have more kids with depression and anxiety, and I think things have gotten harder for our kids. And so there are more kids that are struggling. We have an opiate epidemic and all sorts of other things that are contributors to kids having problems.

Then, in addition, it is clear, if you look at the literature with how stuff spreads through things like social media, there are social factors even with health, even with like heart disease, who you're around, who you spend time

with, that very much affects what kind of health you have and what kind of psychiatric or psychological problems.

There is even data going back to the Victorian era about how culture and the effects of society and how medicine characterizes illnesses changes how people present their suffering. And so that has changed through the years in different ways based on our diagnoses and views at the time.

In addition, we know that these media and social related, what some people would call contagions, have been shown for tic disorders and movement disorders, dissociative identity disorders, eating disorders, self harm, suicidality, all that stuff is in the literature, that those can spread through electronics. So there seems to be some mix of culture and stuff spreads more easily and more these days than it did before. That's my best guess.

Q. Doctor, you said you were also asked to comment on the status of the debate about gender-affirming treatments. Could you elaborate?

A. Yes. In my opinion the debate is quite dysfunctional. It's become very different from any type of debate that I have ever seen in the medical literature. At some point it seems like the major medical organizations, and I would say in particular the American Academy of Pediatrics, American Psychiatric Association, American Academy of Child and Adolescent Psychiatry, and the Endocrine Society, at some

point they decided that gender-affirming treatments were -- had a very strong evidence-base and that they also were morally or ethically the right type of treatment.

And it seems that since those organizations have come to that conclusion, that they have been really pushing that idea. And when they come out with press releases and when they are in the news promoting that type of treatment, clearly, the editors of their journals know what the major organizations are doing, and it seems that that has shut down the normal -- I mean, a lot of these proclamations from the professional organizations, I keep up with the literature and read it. I didn't see a back and forth in the journals about, well, this is the benefits of this going forward, this is the risk of this going forward. But all of a sudden we were presented with gender-affirming treatments as the only treatment.

In addition, like Dr. Levine was saying before, I attended his APA meeting, and I've never seen presenters treated as badly at a medical conference. I mean, it was quite unbelievable. The people who got up to ask questions afterwards were all, you know, heaping negativity and invective on the presenters rather than just asking -- it was a very thoughtful presentation, and it would give you pause to ever want to present at a conference when you see that.

Furthermore, you just see that the -- I myself have been

trying to get presentations in the -- especially in the child psychiatry realm, and I had one rejected last year. We had a research symposium, which I think in a highly unusual manner was rejected last year.

This year I had one of the high up, an M.D. and researcher from Finland, an M.D. and researcher from Sweden, I had a handpicked clinician who is a specialist in gender care from England, and I had the past president of the American Academy of Pediatrics, and I submitted to do a panel at the Child Psychiatry Conference, who says they love to have international work and international presenters, we got rejected.

I also asked to present from Sweden the same researcher, from Finland the same researcher, a researcher from England. Again, as a discussant, the former president of the American Academy of Pediatrics, again, shot down.

So it just seems that somehow if you're not -- anything is skeptical in your request to be on stage or get to be heard, you get shot down.

Q. Dr. Kaliebe, what are the types of psychotherapy and other alternative treatments are there for gender dysphoria?

A. Well, I think that, as we heard earlier, there's -- psychotherapy is a classic mental health approach. We've been doing psychotherapy for a very long time for all sorts of problems with people.

Psychotherapy, such as cognitive behavioral therapy, has been shown to be helpful for anxiety disorders of all types, trauma-related disorders, depressive disorders, personalities disorders, you know, eating disorders.

So we have a long history of success with psychotherapy for those disorders. Until recently, there wasn't as large of a population base with gender dysphoria and -- because it's hard to do studies and for many multiple other reasons. It seems like we don't -- we have not yet developed specialized treatments that are psychotherapies or they're kind of in their infancy for gender dysphoria compared to some of those other things that have been shown to be effective. But I don't see any reason that we couldn't come up with effective psychotherapies for -- for that.

In addition, there are modern twists on therapy that we could add that I think would make therapies even better. There is a very good evidence-base for mindfulness as a treatment for a number of mental health conditions, and mindfulness is just a mediation where you tune into your body, you get out of the future, you get out of the past. And when you spend time with that type of meditation, it helps you calm. It has very good evidence for depression, anxiety, a number of things. And there are moving mediations, I think Yoga was a particularly good one, that help you get more in touch with your body. And many trauma

experts actually really recommend those.

So I think we could add on some of these more modern techniques to some of the classic therapies in order to treat gender dysphoria.

MR. PERKO: Thank you, Your Honor. I have no further questions.

THE COURT: Cross-examine?

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

CROSS-EXAMINATION

BY MR. GONZALEZ-PAGAN:

Q. Dr. Kaliebe, you would agree that gender dysphoria is a real condition that requires treatment?

A. Correct.

Q. You provided some testimony just earlier about the number of people presenting for care. Do you recall that?

A. Correct.

Q. You previously testified that the fact that more people have been showing up at clinics could be, could be explained by, (a), that the care is more available; and, (b), that more people feel comfortable seeking care; is that correct?

A. Yes.

Q. You were just discussing some more modern techniques to possibly consider for treatment for gender dysphoria; is that right?

A. Yes.

Q. Gender dysphoria has been an established diagnosis in 2013; is that correct?
A. Yes.
Q. And gender identity disorder was an established diagnosis from 1980 to 2013; is that correct?
A. Yes.
Q. And so are you saying that over the last 43 years nobody has studied the use of psychotherapy to treat this diagnosis?
A. Correct. I mean, there is some case reviews or minor -- I mean, there is some literature, but there is very little literature out there.
Q. And with regards to mindfulness, you previously testified -- well, you discuss as part of mindfulness the possible use of yoga in your report as a treatment for gender dysphoria; is that right?
A. Yes. It could be a component of treatment, yes.
Q. And you have previously testified that yoga has not been shown to effectively resolve any mental health conditions; is that correct?
A. Well, I just actually read -- we had a grand rounds presentation last week at USF, and he cited multiple systematic reviews on yoga. And they were quite positive actually. So I could revise my answer that the evidence-base for yoga is actually more impressive than I thought, and those are specifically for depression and anxiety.

Q. And they were studying yoga as a treatment for depression and anxiety?
A. Correct.
Q. And what's the name of the study?
A. Well, I don't have it in front of me, but there's two -- there's more than one, but there were two systematic reviews that were presented at the grand rounds last Thursday.
Q. I'm sorry. I was a little confused. Was it one or was it two?
A. There were two different studies that were systematic reviews of yoga that were presented. One of the residents did grand rounds, and he presented. So I don't have the names in front of me. I can easily find them for you, but it was two different systematic reviews that both found quite good results actually.
Q. And you had reserved the opportunity to supplement your opinions in this case, right?
A. Yes.
Q. You did not provide a supplemental report discussing these studies; is that correct?
A. No.
Q. Okay. You previously testified about social contagion as a possibility to explain the rise in gender dysphoria as you consider it?
A. Correct.

Q. You've also previously testified that you are hypothesizing on this point; is that right?
A. I think the evidence is pretty compelling, but I think it is -- how should I say -- there is -- everything is multifactorial. So I don't know that it's a complete solution, but it seems consistent with the evidence.
Q. I'm just asking if it's a hypothesis or a proven phenomenon.
A. Well, social contagion itself does seem to be a known and proven phenomenon, and it does -- in my opinion, it is in play in this situation.
Q. But is social contagion a proven phenomenon for gender dysphoria?
A. Proven?
Q. Yes.
A. I think that it's debatable. I think it's debatable.
Q. So you don't know?
A. I believe it to be a component of the rise in gender dysphoria. I think that's consistent with the evidence.
Q. I understand that's your belief, Dr. Kaliebe. I'm not trying to be difficult. I'm just asking: Is it a proven thing? Are there any studies documenting it?
A. Well, actually, if you look at the most recent Psychiatric Times, Paul Weigle just wrote an article on social contagion. So it's the Psychiatric Times that just

came out. And he talks about psychiatric contagion in a number of disorders, and he actually mentions the polls that were done at the American Psychiatric Association where 80 percent of doctors at the American Psychiatric Association said that either often or very often they thought that social media had influenced their patients' presentation of gender identity.

So I think it's not just me. I think a lot of practicing child psychiatrists believe that.

Q. And the Psychiatric Times, that's not a peer-reviewed scientific publication, right?

A. No, it's not.

Q. You previously testified that --

THE COURT: Let me -- let me tell you for -- just a comment in general.

I've listened to this again and again, and nobody is objecting, and I usually just sit here quietly. If there was a jury in the box, I wouldn't say a word.

If you are going to impeach a witness with what the witness has said previously, first, you have to ask the question. So if he's testifying, and he has not said anything about color the traffic signal is in a case involving a wreck, and he previously told you in a deposition that the light was green, then what you have to do to do this properly is say, what color was the light? And when he says red, you can trot

out the deposition where he said green. The right way to do it is not to say, didn't you previously testify that the light was green?

Now, I bring that up only because I take it you are trying to impress me. You would do much better if you just asked the witness -- and a lot of times he will tell you the same thing today that he told you at the deposition.

MR. GONZALEZ-PAGAN: Understood, Your Honor. I ask for your forgiveness on this.

BY MR. GONZALEZ-PAGAN:

Q. Dr. Kaliebe, would you agree that in particular small populations that tend to be isolated and/or discrete, tend to turn to social media actually as a way to connect and find one another?

A. Yes, I can -- I can definitely concur.

Q. During your direct you discussed a little bit some of the opinions and even during our exchange some of the opinions of -- your discussions with regards to other psychiatrists and their experiences. Do you recall that?

A. Yes.

Q. Would you agree that those conversations are not representative -- are not a representative sample of all childhood adolescent psychiatrists?

A. I believe my interactions with child and adolescent psychiatrists is about as representative as any one could be.

So, yes, there is no one individual whose their social network or those people that they talked to would totally capture all of child psychiatry. I do know people from very different parts of child psychiatry are quite a varied group, so I believe it's somewhat representative.

Q. Dr. Kaliebe, when you were asked:

Your conversations are not a representative sample of all childhood adolescent psychiatrists. Would you agree with that?

You previously answered: *Correct.*

A. Correct, and I still agree with that, but I gave the caveat that I believe that I really know a diverse amount of child psychiatrists. So I'm as representative as you could be kind of. I mean, no one person would be representative of -- their social network could never be representative of the whole.

Q. You previously discussed the breakdown in academic debate, if you will, regarding this condition and the treatment thereof; is that right?

A. Correct.

Q. The Endocrine Society has published letters to the editor that are critical of gender-affirming care.

Am I correct on that?

A. I believe once or twice, yes.

Q. And when asked earlier about your review of the

literature, I believe you mentioned that you have reviewed 50 papers or so, and that you relied your opinions with regards to the scientific evidence for treatment on the systematic reviews that you had reviewed.

Am I understanding your testimony correctly?

A. Yes.

Q. And you cited to the reports from Sweden and Finland and the report from Brignardello-Petersen; is that right?

A. Yes. The systematic reviews are, of course, important.

Q. None of those are published peer-reviewed literature; is that correct?

A. No. That is correct, although they are -- well, I did mention -- well, I didn't mention, but WPATH themselves had commissioned a systematic review which had similar conclusions, and that is published.

Q. But with regard to Sweden and Finland and Brignardello-Petersen, those are not published peer-reviewed literature?

A. Correct.

Q. And in your report, you only cited to four original studies. Am I correct on that?

A. Correct.

Q. So you didn't review or at least discuss in your report any original studies beyond those four?

A. Well, I only cited some studies. I had read many, many

more. So I think I used all of the studies that I know about to help me form my opinion, but I don't have to specifically cite them all, so that's why there was only four.

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

THE COURT: Redirect?

MR. PERKO: No, Your Honor.

THE COURT: Dr. Kaliebe, you talked about therapy. We can probably all use therapy from time to time, and I don't doubt its usefulness. That's not the point of the questions.

I take it that a goal of therapy -- and I'm talking about psychiatric therapy, the kind of thing you do for patients. The goal of therapy or one goal of therapy is to reduce the patient's distress.

THE WITNESS: Correct.

THE COURT: And if the patient has distress over gender identity, a goal would be to reduce the patient's stress over gender identity. True?

THE WITNESS: Correct.

THE COURT: In your view, would a psychiatrist providing that kind of therapy to a person with distress over gender identity have as a goal either, one, reducing the distress by making the person comfortable with a gender identity aligned with sex assigned at birth; or, two, reducing distress by making the person more satisfied, less distressed over identifying as a gender other than the sex assigned at

birth; or, three, one of the other of those depending on the individual and the individual's own individual circumstances.

So which would be the goal, one, two, or three?

THE WITNESS: Well, I don't think the -- I think you could have different goals with different patients, so it may depend on the context of the patient and the person you are seeing.

THE COURT: That's probably answer three.

THE WITNESS: Well, yeah. And a lot of the way I would answer this question is: Are they still a developing individual? Right? Where if you are still developing, and we don't know what type of person you may eventually become, then I think getting you to come to peace with or accept or maybe even learn to love the body that you have while you are still developing is a laudable goal. And that could be a very good goal for most young people most of the time.

And I think you could be explicit about that. I don't think that -- that doesn't necessarily mean to change their gender identity, but more make them comfortable. Many kids are almost disembodied, you know, not in touch with their body.

THE COURT: I got all of that. What I'm trying to find out is: Are you okay with number two or -- look, it's perfectly okay to be morally opposed to trans treatment. You talked about the dysfunctional political debate. I don't

think I'm treading any new grounds when I say there are people engaged in the political debate who just don't believe there are trans people and don't believe that there is any real gender-identity difference.

We had somebody who had joined a brief earlier saying this is false identity. I don't have all the quotes, but they were pretty dramatic. You might have been in the courtroom.

And I'm just trying to find out whether that's your view. Are you in camp two? Is it never the proper therapy for the psychiatrist to assist the person in being comfortable with a gender different from the sex assigned at birth?

THE WITNESS: Well, what I would say is that there's a -- we don't have enough information, so it's not clear because that's just -- we don't have that science right now. And what I think for a developing person, my reading of the evidence, if you -- when we talk about the Dutch studies, I mean, they are not that impressive, honestly, because they don't map on to most of the populations that we are actually treating these days.

So they were like early onset, more male and didn't have a lot of comorbidities, when we're seeing patients with all of these comorbidities and problems. And so I think in an idealized world and in the real world that I live in, it's sort of two different things. The kids I have been seeing, I think really we need to be more --

THE COURT: All four of them.

THE WITNESS: Well, more in depth perhaps.

THE COURT: I'm sorry. I shouldn't have interrupted.

Look, I thought that was an easy answer. Yes, sometimes, number two is appropriate; or no, two is not appropriate. You launched into this long explanation, and I think what you told me is, for a developing adolescent, you don't think two is appropriate.

THE WITNESS: Yes, I do not believe that we should be doing hormones and surgeries for developing adolescents.

THE COURT: My question was therapy. And I think I take it from your answers that you don't think therapy that would make an adolescent comfortable with gender identity different from the sex assigned at birth is ever appropriate. Did I misunderstand it?

THE WITNESS: I would say a little bit. I think that we wouldn't have a goal of trying to change someone's gender identity in therapy. So I'm not trying to get to one particular result. It's more you want to -- so if that's the end result that they have a, you know, a gender identity opposite from their natal sex, I am fine with that. I'm not opposed to that.

I do think that you would have a leaning towards or it is sort of a better outcome for most kids most of the times, considering the comorbidities and everything going on,

that they come to peace with their natal sex because then they don't have all the problems that come from not having that, and the distress from not having that. But I'm okay with -- obviously, there are going to be people that are going to go on and be transgender and not be comfortable with their natal sex, so you could support that.

Is that a better answer? We were on different wavelengths, I'm guessing.

THE COURT: That's more what I was asking, exactly.

Questions to follow up on mine?

MR. PERKO: No, Your Honor.

MR. GONZALEZ-PAGAN: No, Your Honor.

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

THE WITNESS: Thank you.

THE COURT: We are probably coming up on the afternoon break. Where do we stand?

MR. JAZIL: Your Honor, we've run out of witnesses. We have Anne Dalton, Matt Brackett, and Dr. Scott left. Dr. Scott was planning on being here. She had a health issue arise, and she'll be available Monday, Your Honor.

THE COURT: My mother used to say once is a habit. You let the kid get chocolate milk one night, you are going to be giving out a lot of chocolate milk.

Remind me what Dr. Scott says.

MR. JAZIL: Dr. Scott is the neuroscientist from the United Kingdom, Your Honor. She talks about the effects of puberty blockers on the brain. I expect her to be a short witness.

THE COURT: Is she still in the U.K.?

MR. JAZIL: Yes, Your Honor. We are making Zoom arrangements.

THE COURT: All right. Tell me what -- one of the things -- when I let the plaintiffs do this, one of the things I noted was you guys are in town so they are the ones being inconvenienced. Now it's the other way around; they are the ones that travel.

MR. GONZALEZ-PAGAN: Your Honor, we are happy to accommodate restarting tomorrow with the factual witnesses, if it's okay with the Court.

THE COURT: Outstanding. For all the dysfunctional political debate -- and these kind of cases get intense on the two sides, and the fact that all of the parties have been able to deal professionally with one another at the lawyer level is to be commended all the way around. That doesn't mean you should make a habit of not having your witnesses here, but I get it. So she'll be here Monday morning?

MR. JAZIL: Yes, Your Honor. By Zoom most likely. She's trying to figure out if she can travel.

THE COURT: We're going to put her on by Zoom anyway.

Do you need to wait till Monday for the Zoom witness?

MR. JAZIL: Your Honor, she's going through a medical emergency, so she's --

MR. GONZALEZ-PAGAN: Your Honor, just to clarify, my understanding is we would have the fact witnesses tomorrow.

MR. JAZIL: Yes.

THE COURT: You don't have the fact witnesses here now?

MR. JAZIL: Your Honor, one was in the courtroom and I let him go. I didn't think we would get to him.

THE COURT: Okay.

MR. JAZIL: I apologize, Your Honor, bad timing on my part. There are two fact witnesses. One fact witness will be very short, Anne Dalton. The other is Matt Brackett, the author of the GAPMS report.

THE COURT: All right. We can make all that work. Look, if the Monday witness is a Zoom witness, you need to talk with one another on the two sides. Let's don't have people flying back to Tallahassee for a Zoom. Although -- well, let's talk about this. We were going to do closings. We are going to some argument tomorrow morning at the preliminary injunction, but that's not closing in this case. We've got closings coming up, and I really would prefer to do that in person.

I can do this. If we have people on the team that

don't want to return and be here in person, we can probably set it up so that people could monitor the argument. But anybody that's going to argue and participate, it's just better in person. Let's do it in person. If everybody wants to come, that's fine. I'm not suggesting they shouldn't. I'm just giving you the option.

So what we have is two fact witnesses tomorrow, an expert witness Monday maybe in person, maybe by video.

MR. JAZIL: Most likely by video.

THE COURT: Most likely by video. And then closing argument.

MR. JAZIL: Yes, Your Honor.

MR. GONZALEZ-PAGAN: Your Honor, if I may, I believe the only other matter is we filed last night the motion to amend.

THE COURT: Yeah.

MR. GONZALEZ-PAGAN: We were waiting for the official position from --

THE COURT: Right. What do you say about the motion for leave to amend?

MR. JAZIL: I don't oppose the motion, Your Honor.

THE COURT: I'll grant it, and would. Unique circumstances. The rules, of course, allow an amendment right up to and even after trial. I'm not sure I ever let somebody amend other than on some little technical basis during the

trial, but it turned out that during the trial the new statute was signed and so it became a statute.

I have given you a 15-second reaction the other day. Thinking about it a little more, may stressed it incorrectly, I don't think the challenge to the rule is moot. I do think standing to challenge the rule goes hand-in-hand with the challenge to the statute.

If the statute was in place and unchallenged, then the rule wouldn't make any real difference and that would create a standing issue. But with the challenge to the statute, then the standing to challenge of the rule because if the statute got struck down and the rule is still there, you would still have the same adverse situation.

So you got standing to challenge both simultaneously. I don't think nominal damages keeps you in the game, but I don't think any of that matters with the statute now having been -- become effective. It took effect immediately, true?

MR. JAZIL: Yes, Your Honor.

THE COURT: So the statute is in effect. It's properly challenged. We will deal with the preliminary injunction on that in the other case in the morning.

What else can we take care of? Everything lined up? I think we've just got the witnesses and then closing arguments.

MR. JAZIL: Your Honor, in the other case you also

have a TRO now.

THE COURT: Same.

MR. GONZALEZ-PAGAN: Your Honor, I'm not counsel in the other case, but my co-counsel, Ms. Chriss and Ms. Dunn, are counsel in the other case, so they can speak to that.

MS. CHRISS: Yes, we filed the TRO motion.

THE COURT: And let me -- while I am thinking about it, hold the thought and let me --

In the case we're are here trying, the Dekker case, when I wrote the order after the pretrial conference, I gave a specific date as of which the -- it's in the second case, the Doe case.

After the scheduling conference in that case, I wrote an order saying that both sides had agreed to accept the record in the Dekker case as of a specific time. Frankly, I didn't recall whether we said that explicitly on the record when we were talking about it. But as I was putting the order together, it occurred to me that I probably ought to have a set date so we would know exactly what the record was, and the plaintiffs in Doe wouldn't necessarily have seen the evidence that's now come in.

Now we have got a lot of evidence that's been taken in Dekker, and so what I wanted to check on was: In the Doe case, for the preliminary injunction tomorrow morning, do you agree that the testimony that's been taken in the Dekker case

is part of the record in the Doe case for the preliminary injunction?

MS. CHRISS: Yes, Your Honor.

MR. JAZIL: Your Honor, one caveat. Since Dr. Scott hasn't testified, I would simply ask the Court to consider her expert report which we attached to the summary judgment motion, because at the preliminary injunction stage --

THE COURT: And I think that report would already be covered by the scheduling order I did, because that was part of the record already as of whatever that date was. So, yes, I will consider Dr. Scott's report. And for that matter, if I don't rule before the end of the testimony in this case, I would suggest that Dr. Scott's live testimony ought to be included as well and also the two witnesses you put on tomorrow morning.

Does that work?

MR. JAZIL: It works for me, Your Honor.

MS. CHRISS: Yes, Your Honor.

THE COURT: One of the questions I'm going to ask in the morning, and since you are here, you can probably tell me the answer right now:

What's going to happen, if anything, between tomorrow morning and Monday afternoon when we have closing arguments or, for that matter, the rest of the week, if I can get a ruling out next week? Is there any reason why you need a

ruling tomorrow morning as opposed to Monday afternoon as opposed to next Friday?

MS. CHRISS: Are you specifically talking about the preliminary injunction?

THE COURT: Yes.

MS. CHRISS: I mean, the same issues that you are already aware of that we briefed in terms of our plaintiffs are not able to access care that they need right now, two of our plaintiffs have started puberty and need to be prescribed hormones, are currently on blockers and are unable to be prescribed. So the longer they wait, the more harm accrues, but I don't think Friday or Monday is --

THE COURT: You can tell me more in the morning when you check on it. Here's my understanding of meds:

Sometimes you get a prescription, and it's good for the next three months, and then you get it refilled and -- or one month and you get it refilled.

So the question is, are you going to miss a refilling between tomorrow and a week from tomorrow, or is the timing such that that seven days doesn't matter?

MS. CHRISS: With respect to the two plaintiffs who are facing the most imminent harm, it's a new prescription, so they have not yet been prescribed hormones. They have been on blockers, and their physicians have deemed them ready to start hormones. And the only thing precluding that initial

prescription which could be written any time is the rule still being in effect. But then we face the same issue with the statute codifying the rule.

THE COURT: And I take it that the time to start this is a physician's judgment, but it's not an exact science. So whether it's the 19th or the 26th is just kind of a judgment call and probably not going to make all the difference.

MS. CHRISS: I would not disagree with that, Your Honor. I just want to reiterate the harm that these children are facing.

THE COURT: All right. And I ask partly because I've got to do my schedule. I've got a lot of work to do.

MS. CHRISS: Understood.

THE COURT: And the answer is the sooner, the better. Got it.

What else?

MR. JAZIL: Your Honor, should I be prepared to argue the TRO as well?

THE COURT: I don't know that the TRO is any different from the preliminary injunction. I think it's the -- it's the same thing.

MR. JAZIL: Should I be working --

THE COURT: I was on the rules committee in Florida very briefly back decades ago when Florida went back and changed it to only a single temporary injunction instead of a

TRO and preliminary injunction.

TROs are different if they're done without notice but, of course, we are not dealing with that here. There is no reason for a TRO. We are going to have a full extensive evidentiary record, and I'm going to make a ruling on a preliminary injunction. If I called it a temporary restraining order, you'd just have to go fight about whether that made it appealable or whether it had the 14 plus 14 limit.

In all practical respects, it's a preliminary injunction up or down. So I plan to have one ruling, and it won't matter that it's cast both ways.

MR. JAZIL: Your Honor, I haven't gone back and looked at the amended pleadings yet. My understanding is that the criminal liability provision is also being challenged. I just note that I don't speak for the State Attorneys who would be enforcing that position. I hate to add another wrinkle, but --

THE COURT: That's down the list of things to worry about. The biggest thing we need to worry about is whether the plaintiffs have a right to this treatment.

MR. GONZALEZ-PAGAN: Your Honor, if I may, one question, just to clarify, given that there's the amendment that occurred and the TRO has been filed as well, is the Court still intending for trial to begin at ten? We just want to

some clarity.

THE COURT: For the trial what, to begin at ten?

MR. GONZALEZ-PAGAN: Tomorrow.

THE COURT: Is that what I said?

MR. JAZIL: I thought it was nine.

THE COURT: I thought we were going to have the argument at 8:30.

MS. CHRISS: 8:30, yes.

THE COURT: 8:30 is when we said we're going to have the argument.

MR. GONZALEZ-PAGAN: For the Doe case.

THE COURT: Right.

MR. GONZALEZ-PAGAN: So for the trial in this case, are we -- should we just get here at nine and be ready to begin? I'm just trying to get some guidance from the Court on that.

THE COURT: Well, I would think you would be interested, and it's a public hearing. Aside from that, somebody -- I guess the courtroom deputy said should she set a time limit in the notice of hearing. We didn't do that.

My off-the-top-of-my-head thought was half an hour a side ought to be fine. I'll have read the materials but, you know, we will get into this, some exchange.

MR. GONZALEZ-PAGAN: We will be here.

THE COURT: I used to tell people when they were

asking for more time that you've already had more time than you would get if this was argued in the United States Supreme Court. Then the Supreme Court went and started going on for a long time, so that doesn't work as well anymore. But it seems to me half hour a side is what we are talking about.

Mr. Jazil, you raised the question about notice to the state and all those things. I didn't look back at the rule, but I think when you've got an official capacity defendant, you're probably there. They probably have to serve the AG, Attorney General. I don't know if you've done that.

MS. CHRISS: So, Your Honor, we discussed the motion to amend -- for leave to amend the other complaint. But for this complaint, if we have leave to amend, then we can go ahead and issue the summons and serve the new defendants.

THE COURT: Do you even need leave to amend? Can't you just amend?

MS. CHRISS: This is our second amended complaint, Your Honor.

THE COURT: Ah, you do need leave to amend.

Any reason they shouldn't get leave?

MR. JAZIL: In the Doe case, Your Honor, I don't oppose the motion.

THE COURT: So leave is granted. And, yeah, you can proceed to serve it. I don't think that is going to affect anything we are doing in the morning. I assume that Mr. Jazil

will be defending that case as well.

MR. JAZIL: As best I can, Your Honor.

THE COURT: Maybe depends on the ruling, who knows.

Nobody thought that was funny. Obviously it wasn't. When the judge tells a joke and nobody laughs, it's really not funny.

MR. JAZIL: He was just reminded me, Your Honor, to do something which I've already done.

THE COURT: All right. Very good. I'll see you tomorrow morning, same place, 8:30.

(*The proceedings adjourned at 3:10 p.m.*)

(*The proceedings resumed at 3:14 p.m.)*

THE COURT: Please be seated.

I didn't handle, Mr. Jazil, your question as well as I should have, and so I -- because I didn't have the context back.

The Attorney General and the State Attorneys have just been joined. So the TRO, preliminary injunction question becomes more important as to them and who is representing them becomes more important.

We've had various ones of these cases. Sometimes I think you've represented the State, but sometimes the Attorney General has other lawyers, too. And I guess what you are telling me is you're not sure what's going to happen here.

MR. JAZIL: No, Your Honor, I'm not sure. In the

past what's happened is the Attorney General's Office approves that I speak for them, and I just haven't had those conversations yet.

THE COURT: And often somebody in the Attorney General's Office has been on the pleadings.

MR. JAZIL: Yes, Your Honor, like Bill Stafford or others from the complex litigation division.

THE COURT: I'm trying to go back quickly and recall. We have had cases with the State Attorneys or others with -- your Jacobson case now gets everybody sued all over the state. So I've probably had school boards and election cases. You get the supervisors and the canvassing boards, and many times those folks have hired their own lawyers.

MR. JAZIL: Yes, Your Honor.

THE COURT: So part of this is the State Attorneys, and sometimes it gets to be a standing case and sometimes it's just a question of what do you really need to make this happen.

You talked about getting the Attorney General served. You're not going to get -- there must be 20 State Attorneys?

MR. JAZIL: 22, I think.

MS. CHRISS: It's 20, Your Honor, looking at names.

THE COURT: And so tomorrow morning, I mean, do they know? Have you told the people?

MS. CHRISS: Not yet. I was hoping to talk to

Mr. Jazil whether they would accept service or representing them or --

THE COURT: I think in one of these cases -- I'm trying to remember what the issue was because I only had it secondarily. But I know from the Warren case that he was the State Attorney in Hillsborough. He and all the other State Attorneys had been sued for something, and they entered an agreement that they would abide by the result, and they were all dismissed from the case. I think I'm remembering that correctly.

Whether that's something that can be done here or not, what you need to do to simplify this -- I'm not suggesting it, I'm just telling you that I know that at least in one other case underlying -- or discussed in the Warren versus DeSantis case that had come up. It may have been an election case.

Mr. Jazil, do you remember what the underlying case was, where they entered the agreement?

MR. JAZIL: Yes, Your Honor. There are several. In the election cases, the trend has now been there is a subset of the 67 supervisors of elections who entered into an agreement saying we will abide by whatever the Court decides. Just don't come after us for fees under 42 USC 1988.

THE COURT: That's supervisors.

MR. JAZIL: Yes, Your Honor.

THE COURT: How about State Attorneys?

MR. JAZIL: State Attorneys have taken the position in other cases, Your Honor, saying that we will abide by whatever the Court decides. We will serve as nominal defendants and they move on.

I can't recall the State Attorneys being sued in election cases. I think --

THE COURT: That could have been an abortion-related case. Somehow it came up in Warren versus DeSantis. An abortion case in --

Oh, that's what it was. It was the challenge to the abortion statute under the Florida constitution in Florida State Court, and I think the State Attorneys must have been in agreement that they would abide by the ruling, and so they got dismissed from the case.

Different standing issue, of course, in state court than in federal court. Some of that may be down the road, but the question is tomorrow morning we're going to have a hearing. There are going to be parties to the case that will have at most about 16 hours notice of the hearing. And so that brings the TRO back into play.

You can tell me now or you can address it in the morning, but part of the question is: What are we going to accomplish here? You've got doctors in Florida who want to write this prescription, but you may need to find out what

your doctor is willing to do.

MS. CHRISS: So if I may, Your Honor, I will note that part of what we challenged in the TRO, the provision of SP-245, Section 4, there's the ban on providing the care, which basically just codifies the Boards of Medicine and Osteopathic Medicine. And in fact, it gives the authority to the -- the unfortunate authority to the Boards of Medicine and Osteopathic Medicine to create emergency rules implementing SP-254, Section 4.

Then there is a provision that, if the doctor violates that provision, they can be held criminally liable. But I may be wrong and might need to think more about this, but since Mr. Jazil represents the boards and they are responsible for one of the provisions at issue here, if that were enjoined, I don't know that the criminal penalty would come into play.

THE COURT: Do you think the crime is only violated a rule that has not yet been adopted?

MS. CHRISS: I will -- I will think more and opine on that tomorrow, if that's okay.

THE COURT: Okay. You might want to check if it's feasible with your doctor to see what the doctor is going to need; because, frankly, if the doctor is not going to do it anyway, I'm certainly not going to enter an injunction telling the doctor to do anything, and the doctor is not a party to

the case. If the doctor is not going to do it anyway, then that's a whole different problem.

MS. CHRISS: Understood, Your Honor. We can definitely speak with them.

THE COURT: All right. I came back in. I don't think I accomplished anything other than to note the issue that we will need to clean up in the morning.

MR. GONZALEZ-PAGAN: Your Honor, if I might, just for clarity of the record, I believe the entire colloquy pertains to the Doe case and not this case. But I just wanted to clarify that.

THE COURT: It did.

MR. GONZALEZ-PAGAN: We are not adding any new parties.

THE COURT: Well, you need to think through whether you have a standing issue when you don't add additional parties. I don't know if you've looked back at the Jacobson case, but Mr. Jazil was in the case and I was not. It wasn't my case, so I'm not sure I'll describe it perfectly but it does come up again and again.

Here's the brief description: It was a challenge to an election provision, I think the order of the parties on the ballot. So the plaintiffs sued the Secretary of State who is the chief election officer, probably not a precise description, and another district judge in this district

entered an injunction about the order of the candidates on the ballot. The State appealed. The State didn't raise standing in the trial court, didn't raise standing in the brief on appeal. Said in oral argument, oh, there's a standing issue. Issues an opinion vacating the injunction. No standing.

So don't go thinking because I haven't addressed standing or the defense hasn't addressed standing that that means you don't have a standing problem.

MR. GONZALEZ-PAGAN: Yes.

THE COURT: And if what you're asking for in the Dekker case in your amended complaint, and I haven't -- I have been through it but I haven't studied it. But essentially what you are asking for is an injunction that would allow the plaintiffs to get the medical care that they and their parents and their doctor think they need. If it's going to be a crime for a doctor to provide that care, you need to think about whether you have to have somebody with criminal enforcement authority like the State Attorneys as defendants. Because at least if I understand the law of the Circuit, if the injunction wouldn't compel the relevant actors to do what it is you are trying to have done, then you don't have standing.

MR. GONZALEZ-PAGAN: Understood, Your Honor. We are happy to review that Jacobson case, and we did have a motion to amend, but we're happy to review that case and provide further briefing and argument.

THE COURT: And I'll confess, I went through the motion for leave to amend pretty quickly because I anticipated -- correctly, as it turns out -- that the defense probably wasn't going to contest it. And so as I said, I did read through your order, but I'm not sure I can pass the test on your motion.

MR. GONZALEZ-PAGAN: We'll make sure we're here.

THE COURT: Very good. This time I really mean it. We are adjourned for the day. I will see you at 8:30 in the morning.

(*The proceedings adjourned at 3:26 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 *5/18/2023*

Judy A. Gagnon, RMR, FCRR
Registered Merit Reporter

Date

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DEFENSE EXHIBITS

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