UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

K.C., et al,	)	
	)	
Plaintiffs,	)	Case No.
	)	1:23-cv-00595-JHP-KMB
-vs-	)	
	)	
THE INDIVIDUAL MEMBERS OF THE MEDICAL LICENSING BOARD OF INDIANA, in their official capacities, et al.,	)	
	)	
Defendants.	)	

DEPOSITION OF DANIEL WEISS, M.D.

The deposition upon oral examination of DANIEL WEISS, M.D., a witness produced and sworn before Wendi Kramer Sulkoske, Notary Public in and for the County of Boone, State of Indiana, taken on behalf of the Plaintiff via videoconference in Santa Clara, Washington County, Utah on May 26, 2023, pursuant to the Federal Rules of Civil Procedure.

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(Via Video Conference)

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ALSO PRESENT: Zoom Moderator, Erica Harriman

EXAMINATION INDEX

EXHIBIT INDEX

DANIEL WEISS, M.D.

the witness herein, having been first duly sworn to tell the truth, the whole truth, and nothing but the truth, was examined and testified as follows:

EXAMINATION,

QUESTIONS BY MR. SELDIN:

Q Dr. Weiss, good morning.

A Good morning.

Q My name is Harper Seldin. I'm an attorney for the plaintiffs. You and I will be doing this deposition today.

Just a couple table setting things, have you ever been deposed before?

A I have.

Q How many times?

A Two times.

Q When was that?

A That is mentioned in my C.V. The last time was 2021. The time before that I believe was 1993, but the C.V. will indicate with certainty.

Q Great. So when you are referring to your C.V., you are referring to the two prior times you served as an expert witness in other matters?

A Yes.

Q Great. Okay. So some of this will be familiar to

you, but we will go over it anyway just so we are on the same page.

Today I will be asking you questions. You will provide answers. Those answers must be verbal. Head shakes will not come through. Uh-huh, huh-uh will not come through.

If you answer a question, I will assume that means that you understood my question. If you don't understand my question, let me know and we will try again.

Does that sound good to you?

A It does. I understand.

Q Now, is there any reason today, medication or otherwise, that you would not be able to understand me, understand my questions, and provide truthful responses?

A No.

Q Okay. The only other thing I will say is let's just try not to talk over each other. Even if you anticipate where I'm going, let me finish my question. I will try to let you finish your answer. That way Wendy will not yell at us, which is always my goal.

The other thing is if you need to take a break at any time, let me know. I just ask if

Page 6

there is a question pending that you answer the question and then we can take a break.
A I understand.
Q Great. Do you have anyone in the room with you today?
A No.
Q Do you have any notes with you today?
A No.
Q Do you have a copy of your declaration in this matter with you?
A I do.
Q Great. That will make it easy.
MR. SELDIN: Just for purposes of making sure we have the exhibits right, Erica, would you pull up what is marked as Weiss Exhibit 1. Great.
Q Does this appear to be the expert declaration that you submitted in this case, or the first page of it?
A It does.
Q You can see this PDF has about 113 pages on it. Does that sound about right?
A It does.
Q Is this the same document as the one you have in front of you?
A Yes.

Page 7

Q Does this declaration contain all of the opinions that you intend to offer in this case?
A No.
Q What other opinions do you intend to offer in this case?
A Other opinions might arise during the deposition.
Q Okay. So as of right now, these are all of the opinions that you intend to offer in this case?
A They are.
Q Okay. So there are no additional opinions in your mind or elsewhere that you intend to offer. As we talk you may have further opinions?
A That is correct.
Q Okay.
MR. SELDIN: Could you pull up Exhibit 2.
Q Dr. Weiss, I'm showing you Exhibit 2. You will see it has the case caption and notice of deposition and request for production of documents.
Have you seen this document before?
A I don't recall receiving this document, seeing this document, no.
Q I will represent to you that it's the notice of deposition and request for production of documents that we gave to the State Attorney General's

Page 8

office in connection with this deposition.
If you look midway down the page it says Request for Production of Documents. This is a request from the plaintiff that you produce in connection with this deposition your current C.V. first.
Starting there, do you see that request?
A I do.
Q You included a C.V. with your declaration. Is that your current C.V.?
A Yes.
Q Okay. I believe if you scroll all of the way to the back of your C.V., Page 75 it's dated May 10, 2023.
A That is correct.
Q I take it there have been no changes to this in the last sixteen days?
A Correct.
Q Great. Then, in addition, you will see back to Exhibit 2 at the bottom of the page it asks that you provide, "The declaration report, and rebuttal report the deponent has most recently submitted as an expert witness in any litigation related to the provision of gender-affirming care to minors, if such a declaration, report or rebuttal report has

Page 9

ever been submitted; if no such declaration report or rebuttal report has ever been submitted, produce any prior reports that have been submitted on the provision of gender-affirming care generally."
Do you see where that is?
A Yes, I do.
Q So I'm just wanting to confirm, have you ever issued another declaration or report or rebuttal report in a case involving gender-affirming care?
A Not an expert declaration, no.
Q Have you provided a fact witness declaration of any kind in a case?
A I provided written testimony in support of legislation, but not expert declarations.
Q Okay. Thank you for clarifying. So we will talk about that a little bit later. Thanks so much. All right.
Dr. Weiss, how did you prepare for today's deposition?
A I read the literature. I read the materials provided from the plaintiffs and I read the information available on, actually all of the plaintiffs, the four children, adolescents. And basically that's it.

And my expertise in this area comes from my experience in treating adults with gender dysphoria and reading in this area.
Q Have you treated minors for gender dysphoria before?
A I've not.
Q Okay. So I guess I will ask you two separate questions. You said you reviewed the literature and the material provided by the plaintiffs.
I take it that that is what you reviewed to prepare your declaration, is that correct?
A Well, all of the scientific literature. Also, the cases and the details with regard to the medical history of the four plaintiffs and all that material. Yes.
Q Did you review any other documents to prepare for today's deposition?
A What did I state here? Let me look.
Q Dr. Weiss, just to make sure we are understanding each other, I'm asking, like, in terms of preparing for today?
A Oh, today.
Q We will talk about your declaration in a minute. I'm asking -- let's start here. This is just a yes or no question.

To prepare for today's deposition did you speak to Ms. Youngs or any of the other attorneys at the Attorney General's office?
A Yes.
Q Okay. When did you talk to them?
A Yesterday.
Q And for about how long?
A Oh, about two hours.
Q And do you recall which attorneys were present?
A Ms. Youngs and Mr. Fisher.
Q Was there anyone else present during your preparation?
A No, there was not.
Q Other than that two hour conversation yesterday with Mr. Fisher and Ms. Youngs, did you speak to anyone else to prepare for today's deposition?
A No.
Q Okay. Did you speak with any of the other defense experts in this case to prepare for today's deposition?
A No.
Q Okay. Did you review the, to prepare for today's deposition did you review any of the expert declarations from the plaintiff experts. Dr. Shumer, Dr. Karasic, Dr. Turban?

A Yes, all three of them.
Q And have you reviewed the transcripts of their depositions in this case?
A Only Dr. Turban's.
Q Do you recall when you reviewed Dr. Turban's deposition?
A About a week ago.
Q Any other materials you can think of that you read to prepare for today's deposition?
A No.
Q Have you spoken with any of the defense experts in this case in any context at all?
A No.
Q Okay. So we know we are talking about the same folks, have you ever had a conversation with Dianna Kenny?
A No.
Q Kristopher Kaliebe?
A No.
Q Paul Hruz?
A No.
Q James Cantor?
A No.
Q I want to talk a little bit about your professional background.

Your C.V. indicates that you have several board certifications. What are your board certifications in?
A Internal medicine. Diabetes and endocrinology metabolism. There is a board for physician nutrition specialists. I'm board certified in that. I am a diplomat in the American Board of Obesity Medicine. I'm a certified diabetes education and care specialist.
Some of those boards require in order to get, in order to maintain the certification you have to pay a fee on a regular basis so some of them I've not renewed. I'm also a certified physician investigator.
Q What is a certified physician investigator?
A Someone who has expertise in the conduct of clinical trials. So they have expert knowledge in conduct and performance of clinical research in children and adults.
Q What is the process for obtaining that certification?
A There is experience and a lengthy exam.
Q When did you take that exam?
A I don't recall. It might be mentioned in my curriculum vitae.

Page 14

Q Was that towards the beginning of your career?
A Probably something like five or six years ago.
Q Okay. So within the last five or six years you obtained that certification.
Did you have to take any classes to prepare for this?
A No.
Q Any other certifications or board certifications that you have other than the ones we have just discussed?
A I might have forgotten something. If I can refer to my C.V., is that okay?
Q If it's fair to say it would be in your C.V., that is fine.
A Yes. It probably would be in my C.V. I think that is all of them.
Q Great. Who first contacted you about being an expert in this case?
A Ms. Youngs.
Q About when was that?
A Perhaps roughly, I'm not certain, maybe six weeks ago.
Q Thank you for that. If you would turn to, I guess Exhibit 1, please.
MR. SELDIN: Would you bring that up,

Page 15

Erica?
Q We will be at Page 39 of this PDF. That is the start of the C.V.
Dr. Weiss, you have your copy in front of you. We will end up on Page 2 of your C.V.
A Page 2.
Q You will see underneath Section V, Appointments: Academic and Clinical --
A Yes.
Q -- I'm looking at the portion about being a clinical assistant professor at Case Western Reserve University. Do you see that?
A Not yet. I see it now.
Q It says here that you "resigned after lengthy training was demanded for new in-hospital computer software."
Is that why you resigned?
A Yes.
Q Were there any other reasons why you resigned?
A None whatsoever.
Q What kind of software was it?
A I don't know. But I was, at that point I was an independent practitioner. I refused to use electronic medical records and I was not doing inpatient care. I saw that requirement for

Page 16

training as an unnecessary burden and completely unrelated to my management of patients.
Q Why did you not want to use electronic medical records?
A They are detrimental to patient care.
Q How so?
A They are basically a billing software. Most people don't know that.
Q Is it fair to say you had an ethical objection to being trained on the software?
A No, it's not ethical. It's not, it is not, the software was not pertinent to my management of patients.
In fact, we can get into a tangential discussion on the management, on the etiology or origin, I should say, of electronic medical records.
Basically they are a method to optimize billing. They are not good for patient care.
Q Were you seeing patients at this time?
A Of course.
Q Okay. So were you keeping paper records?
A I was keeping paper records, yes.
Q Okay. In your current practice how do you keep medical records?

Page 17

A They are electronic medical records. They are a requirement of my employment.
Q Looking lower on your C.V. on that same page you have several prior positions listed. The first one is as chief of endocrinology at University Mednet. It looks like you ended your employment there in April 2003, is that correct?
A That is correct.
Q What were the circumstances of your departure?
A This big group was disintegrated. There was poor management. There was embezzlement of funds by a physician manager. There was not optimal patient care.
Q Was there a criminal investigation related to the embezzlement?
A I think University Hospitals dropped the -- this particular physician administrator went to New York City. They left the area. They only discovered the embezzlement later. He was not a good actor.
The whole group disintegrated basically. I left a lot later than many other physicians and I just set up practice in the same area and patients followed me. I was one of 110 doctors in that group. I was the sole endocrinologist managing

Page 18

patients with endocrine disorders in that group before it deteriorated.
Q So after April 2003 that is when you set up an independent practice in Ohio?
A That is correct. I was running my own practice with a staff of thirteen people doing clinical research. I employed other endocrinologists. Then I could not maintain that financially after seventeen years of independent practice.
That is when I sold to the group Lake Health System. They were eventually bought by University Hospitals and that is when I decided to look elsewhere because then I was, I would then be employed by the same group I had originally left.
Q Looking lower on your C.V., just below that it says that until June 2007 you were the medical director at the Joslin Diabetes Center.
A That is correct.
Q What were the circumstances of your departure from that role?
A I was the first director of that diabetes center which was in another area of Cleveland, Ohio. I did that along with my role as the director of Your Diabetes Endocrine Nutrition Group, which was my independent practice.

Page 19

And the administrator of the Joslin Diabetes Center basically thought I was being paid too much and a bunch of us left at the same time.
Q And so you referred just now to Your Diabetes Endocrine Nutrition Group. That was the name of your independent practice?
A Yes.
Q I see that at Page 3, from April 2003 to December 2019. December 2019, is that when you were acquired by Lake Health?
A I sold to Lake Health, yes.
Q So it was not so much a departure so much as you sold your practice?
A Correct. I sold the practice.
Q Is that the point at which you became an employee of Lake Health Physician Group?
A That is correct.
Q Okay. I see a little lower on your C.V. it says that you were employed there from January of 2020 to January 2022, is that correct?
A That is correct.
Q Okay. What led to you leaving Lake Health?
A Well, as I said, it was principally that they were going to be purchased, they were purchased by University Hospitals. Then I looked at other

Page 20

opportunities when that became apparent that I was, that I would then be an employee of University Hospitals, which was the group I had left in 2003.
Q You say that was principally the reason you left. Were there any other reasons that you left?
A That was the reason really. And I think, I was a little bit fatigued of the thirty-six years of winters in Cleveland, you know, six months of winters. So a warmer, sunny climate was enticing.
Q So where did you go after that then?
A Now I'm in St. George, Utah. I live in Santa Clara, which is a suburb of St. George. It is a desert environment with no need for a snow shovel.
Q Makes a lot of sense to me. Is that when you became an employee of Intermountain?
A Correct.
Q I see here that also in 2022 lower on your C.V. on Page 3 that that is when you stopped being adjunct clinical faculty both at Kent State and Ohio University Heritage College of Osteopathic Medicine.
Was that because you moved to Utah?
A Yes, that was the reason.

Page 21

Q Is it a sunny day in Utah, dare I ask?
A Almost every day is sunny.
Q Good for you. So I'm looking now still on your C.V. on Page 5. You will see that there is a Section VII, Major Courses and Meetings; Continuing Medical Education.
Do you see where I am?
A Yes.
Q So this Page 5, VII. We will get to a point where I don't know what the Roman numerals stand for.
Dr. Weiss, do you see where I am?
A I do.
Q So this list of courses and meetings for continuing medical education, are these classes that you have taken or classes that you have taught?
A These are classes that I have, courses that I have taken or meetings I have attended.
Q Got it. Okay. And it looks like the first entry begins with "Review of Endocrinology" that took place in October of 1985, is that correct?
A Yes. I have been in practice many years.
Q Then by my count, if you flip to Page 10 of your C.V. you will see that the last number is 64 with Annals of Internal Medicine review from May 2021,

Page 22

is that correct?
A Yes.
Q Is it fair to say then that this has been a running list of your continuing medical education participation from 1985 to 2021?
A It's not complete because there will be continuing medical education I will do but from reading journal articles or from going online, going to an online reference called Up To Date.
So this extensive number of so-called category one credits I would obtain from that. I don't list that on the C.V.
Q So then is this list of sixty-four classes just ones that you have physically attended as opposed to done online?
A That is correct. Basically meetings that might be online meetings or more often in-person meetings.
Q Okay. So you may have done additional continuing medical education independently online --
A Correct.
Q -- but that might not be covered here?
A Correct. And you will notice it says 2021. That is the time when we happened to have a worldwide pandemic.
Q Roundabout then, yes.

Page 23

A Yeah.
Q It seems that these seem to be mostly about diabetes and metabolic disorders.
Is that about right?
A The broad area of diabetes endocrinology, yes. There are other internal medicine related topics. Correct.
Q Is any of this continuing medical education pertaining to assessing gender dysphoria?
A No.
Q Does any of it pertain to diagnosing gender dysphoria?
A No.
Q Does any of this pertain to treating gender dysphoria?
A No.
Q Does any of it pertain to providing gender-affirming care?
A I don't use that term. But treating gender dysphoria does not relate to that.
Q And why don't you use the term gender-affirming care?
A Perhaps we can defer that to later on in the discussion because it's not -- I think it's gender harming care. It's person harming care. It is a

Page 24

euphemistic term that is not appropriate to the interventions that are, that some practitioners apply to these minors. I think it's harmful. So I don't call it gender-affirming.
Q So as part of your explanation you said it's harmful to minors.
Do you also believe it's harmful to adults?
A Yes.
Q So you would not use the term gender-affirming care for a person of any age?
A Correct.
Q So when I use the term gender-affirming care I'm referring to in some part the medical procedures that are listed in Senate Enrolled Act 480 in this case.
If I refer to that broadly as treating gender dysphoria, would we understand each other?
A I think it is a better term to use the term treating gender dysphoria with hormones, puberty blockers, surgery.
I would not call it gender-affirming care. I think it is euphemistic and misleading language.
Q So just to make sure that we continue to understand each other in this deposition, I will likely use the terms gender-affirming care and

Page 25

treating gender dysphoria interchangeably.
You and I will understand that we are talking about the same kind of care. You just have a different view about whether gender-affirming care is the appropriate way to characterize it, is that fair?
A That is a fair statement.
MS. YOUNGS: And if necessary, can we specify as to what aspect because it is kind of a large umbrella and it might be confusing.
MR. SELDIN: I think we can figure it out as we go along in the context.
Q It's fair to say then that you have had no continuing medical education about treating gender dysphoria since 1985?
A No, I don't think that is fair. Because continuing medical education includes studying the scientific literature. It may not be category one credit based upon the AME designation of what category one is.
But it would be category two credit. I have had extensive category two credits, but I don't list category two credits on this C.V.
Q What is the difference between category one and category two credits?

Page 26

A It is a designation that the AMA comes up with. If you are studying a publication, analyzing it carefully and reading it, that is considered category two.

But if you are attending a meeting and they have certified it as category one, then you get category one credit. You can click on some sites and get category one credit pretty easily.

But category two credit is still very meaningful. Reading journal articles. Reading the scientific literature. I have done extensive reading on gender dysphoria that would be, that would achieve many, many credits in category two.

Q And in terms of maintaining your medical license, do category two credits count towards that?

A They do, but they are not as important. You have to have a minimum of category one for maintaining your license.

Q Is there a minimum number for category two?

A No.

Q So is it fair to say then that you could not maintain your medical license merely by using category two credits?

A That is correct.

Q Okay. I take it then when you have category one

Page 27

credits you receive some kind of a certificate or acknowledgment so when the licensing board asks if you are current you can demonstrate you have attended the requisite number. Is that fair?

A That is correct.

Q Lawyers have something similar so I'm assuming there are so many ways to track continuing education of any kind.

Do you receive similar acknowledgments for category two credits?

A No.

Q So pardon my ignorance. Is there such a thing as category three?

A I have never heard of it.

Q Is it fair to say then that you have independently researched and read about the treatment of gender dysphoria which you characterize as category two credits, but you don't have a running list of that?

A Correct.

Q Do you recall the first time that you pursued any continuing medical education about the treatment of gender dysphoria?

A I was doing some reading during a period of time when I was treating adults, which was

Page 28

approximately 2003 to 2013. So I read the literature during that period of time.

Q So you have been in practice since about 1985, is that right?

A Practice outside of Iowa since 1986.

Q Right. So from 1986 to 2002, let's say, you did not have any continuing, any medical education about the treatment of gender dysphoria. That all began in 2003?

A I don't think that is accurate to state that because there was some treatment of gender dysphoria during my training in Iowa at the University of Iowa.

There was a physician who was probably the only doctor in the state treating adults with gender dysphoria. I learned aspects of treatment from him. That would have been during my fellowship at the University of Iowa in the 1980s.

Q Who was that doctor?

A Dr. John MacIndoe.

Q I'll claim this is for the court report, but it's for me, can you spell that?

A M-A-C-I-N-D-O-E.

Q Tell me a little bit about this training that you received at the University of Iowa with

Page 29

Dr. MacIndoe?

A So he would see an occasional adult patient with gender dysphoria. I would go into the exam room and assess the patient along with Dr. MacIndoe and talk about hormonal interventions.

Q About how many of those patients do you think you encountered with Dr. MacIndoe?

A Maybe twelve.

Q Over what period of time?

A Years.

Q Two years? Four years?

A Two years.

Q Two years. Was that the length of your fellowship at the University of Iowa?

A Yes.

Q Was your fellowship in a particular specialty?

A Yes. So the training, you know, there's four years of medical school after college. And then there is residency, which is three years. And then two years of fellowship.

So the fellowship, my expertise, my fellowship is in that subspecialty of internal medicine called endocrinology metabolism.

Q So over the course of your two year endocrinology fellowship with Dr. MacIndoe you believe you

Page 30

encountered about twelve adult patients being treated for gender dysphoria?
A Yes. And keep in mind this is the early 1980s. So this was before any of the Dutch studies or any -- there was really no Endocrine Society guidelines at that point.
There were only occasional patients who expressed what was then called gender identity disorder.
Q So with these twelve patients that you saw with Dr. MacIndoe, what was your role in those consultations?
A Well, I was a fellow. So I would learn his approach and his management of the patient and discuss providing consent to the patient, discuss pros and cons of the treatment and see how he evaluated and treated these adults.
Q Did you make any treatment decisions for these adults?
A I was primarily learning at that point.
Q Is it fair to say then that you did not assess whether or not these individuals had at that time a gender identity diagnosis?
A I don't recall. I would say it's probably accurate.

Page 31

Q So you would not have been diagnosing them with --
A No, I was not.
Q And do you recall what treatments these approximately twelve adults were provided as a result of Dr. MacIndoe's care?
A It was opposite sex hormone treatment.
Q When you say opposite sex hormone treatment, what do you mean?
A So biologic males were given estrogen or androgen blockers. Biologic females were given testosterone.
Q And for these twelve patients do you recall how many times you would have seen them?
A Maybe three times for each of the twelve patients.
Q Did Dr. MacIndoe in your presence speak to these patients about how their treatments were working?
A Yes.
Q And what did they tell you and Dr. MacIndoe?
A That was a long time ago so I can't recall specifics on that.
Q Do you recall generally how these twelve adults faired on this treatment?
A My recollection from forty years ago is that they valued the physical changes that they were experiencing.

Page 32

Q Did you keep in touch with Dr. MacIndoe?
A No.
Q During your two year fellowship you would see these patients as part of learning as a fellow with Dr. MacIndoe.
Did you have any experience treating gender dysphoria between the end of your fellowship and 2003?
A I don't recall treating when I was with University Mednet, no. I think I only was treating when I was an independent practice from 2003 on. There were relatively few patients until the last decade or so. Ten, fifteen years.
Q Between the end of your fellowship and 2003 did you advertise any clinical expertise in treating gender dysphoria?
A I did not advertise at all. I didn't need to. Patients would come to me with their endocrine disorders. I was not promoting myself. I didn't need to. I was a sole endocrinologist in this group of 110 doctors. I didn't speak up or talk about my expertise in that area because there was no need to. There were patients sent to me for that.
Q So you didn't treat any patients' gender dysphoria

Page 33

from the end of your fellowship until 2003?
A Correct. They were not sent to me. I was not asked to treat them.
Q Did you have any patients who were transgender between the end of your fellowship and 2003?
A I don't recall.
Q Looking at your C.V. if you look at Page 16, Roman Numeral XII, do you see your bibliography?
A Yes.
Q You will see that this runs through Page 18. There is a Number 26 for the last publication.
Do you see that as well?
A I do.
Q Do any of these publications in your bibliography pertain to the treatment of gender dysphoria?
A None.
Q Do any of them pertain to the assessment or diagnosis of gender dysphoria?
A No.
Q Have you ever conducted any original research about gender dysphoria?
A No.
Q Have you ever conducted any original research about gender identity or transgender people?
A No.

Page 34

Q Have you published any peer reviewed articles about the treatment of gender dysphoria?
A No.
Q Have you published any not peer reviewed articles about gender dysphoria?
A No.
Q Thank you, Dr. Weiss. I'm now going to turn to Page 20 of your C.V. This is Roman Numeral XIII, Presentations to Medical Professionals.
A Yes.
Q You will see that first presentation is dated March 31, 1981, correct?
A Correct.
Q Then if we go to Page 62 of your C.V., you will see that the last entry is 564 and is dated November 9, 2022.
Do you see that?
A Say that again.
Q I'm saying do you see the last entry in this section?
A 564?
Q Yes.
A Yes, I see it.
Q Is it fair to say then this is a complete list of your presentations from 1981 to 2022?

Page 35

A That is correct. This is to medical professionals, yes.
Q Are any of these presentations regarding gender dysphoria or its treatment?
A No.
Q On Page 63 of your C.V. it says, "Note, Dr. Weiss continues to be a speaker presenting at programs across the United States. However, as of June 2007 only programs that were non-promotional in nature are listed above."
Did I read that correctly?
A You did.
Q What does that mean?
A So I have been a speaker for pharmaceutical companies and those presentations relate to their medications and teaching doctors about these new medications.
So I listed some of those. Many of those were listed early on among those presentations to medical professionals.
As of June 2007 only the programs that were not promotional, that were not pharmaceutical related were listed. So those were just didactic in nature without a sponsor by a pharmaceutical company.

Page 36

Q So why did you stop listing -- why did you change how you listed after June 2007?
A It makes the C.V. too long and it's unnecessary.
Q So can you give me an example of a promotional program that you would not have included?
A For example, there is a medication called Mounjaro. That is a one weekly injection for Type II diabetes. It is excellent for glucose control.
Most people when they are on it they also tend to lose weight. I'm currently a speaker for one pharmaceutical company that makes Mounjaro, but I don't list all those presentations. It would be too long.
Q Who makes Mounjaro?
A Lilly. Eli Lilly.
Q Are you compensated for those presentations?
A I am.
Q About how many of them do you do a year?
A It varies. It may be thirty. It may be fifty.
Q What was that first number?
A It may be thirty. It may be fifty. If the product is new they need to -- they want to promote it. They want to teach health care providers about what is available, how good it is.

Page 37

They are not familiar with it so they like to hear from an expert and so I talk to them about it.
Q And for those thirty to fifty presentations that you do a year, how much are you compensated?
A It depends if there is travel involved. If it's a web-based or just a remote, so-called remote live through the computer, then it is $1,100.
At this point for travel programs in the area it is about $3,025.
Q And so about how much money per year do you think you make doing the promotional presentations all in?
A It really varies a lot from year to year. It may be $50,000. There are some years over the last fifteen years or so it was $100,000.
Q How much do you make as part of your role at Intermountain currently?
A My current salary I think is $220,000.
Q So would it be fair to say then that the compensation for these promotional presentations has been a significant part of your income for the last five to fifteen years?
A For the last probably twenty years it has been, yes. They are all done outside of the workday. They are evening programs or maybe a lunch hour or

Page 38

morning programs so they don't interfere with patient care.
Q And you listed Mounjaro as one of the medications that you do promotional presentations for.
Are there other medications that you have done presentations for? That was a bad question.
I'm trying to ask you of the medications that you have made promotional presentations about, have they all related to the treatment of diabetes?
A No. So there have been medications for treating cholesterol. There have been medications for treating osteoporosis. There have been medications for treating diabetes. Medications related to obesity.
There are so many over the years because I have been in practice for over thirty-five years. I have been doing promotional programs since the 1980s.
Q Of the medications that you have done these promotional presentations for, have any of them been for the treatment of gender dysphoria?
A No.
Q Okay.
A Let me also spell Mounjaro for the court reporter.

Page 39

Q Thank you.
A M-O-U-N-J-A-R-O.
Q I'm turning now -- we are still on Page 63 of your C.V.
Outpatient Teaching Of Health Professionals in Training, do you see where I am?
A I do.
Q Great. And it continues onto the next page briefly.
Is any of this outpatient teaching pertaining to the treatment of gender dysphoria?
A Yes.
Q Which of these pertains to the treatment of gender dysphoria?
A So whenever I would teach a medical student or a nurse practitioner or an endocrine fellow in training or internal medicine or a family practice resident or a medical student, I would have them accompany me in my care of patients with gender dysphoria in the office so I would teach them about it.
Q So fair to say then that the teaching that you were providing on the treatment of gender dysphoria would have been the education of medical professionals in the ordinary course of treating

Page 40

patients?
A Correct. I think that is accurate.
Q As opposed to like a special seminar where there are no patients, this would be taking folks on rounds with you?
A Correct.
Q Would this have taken place from 2003 to 2013?
A That is correct. I did teaching before 2003, but I don't recall seeing patients with gender dysphoria before I, when I was in practice with University Mednet. It was only when I was in independent practice.
Q What would you tell these medical students or practitioners about treating gender dysphoria?
A I would discuss the, that particular patient and their feelings about their gender and the intervention I was offering to them. Why I was giving the hormonal treatments I was providing.
I was using opposite sex hormones or blockers. Not puberty blockers for a variety of reasons. And I talked to them about seeing the people.
The endocrinology fellows I taught often expressed an unwillingness to be, to take care of those patients when they went into practice.

Page 41

Q Why was that?
A Most endocrinologists that I have interacted with are not on board with, are not convinced that the evidence is good or they are uncomfortable treating with opposite sex hormones for those people with gender dysphoria so they don't see those people.
Q When you say uncomfortable, do you mean because of their perception of the evidence base or some other reason?
A I think it's their perception of the evidence base, yes.
Q What would you say in response to that?
A Now I would support them. I can understand their feeling that the evidence is very weak because it is both for adults and for children.
Back then when I was treating, obviously, I was not aware of how weak the evidence was.
I was offering treatment. I was the principal person in northern Ohio treating people with gender dysphoria during that ten years of time I was treating.
Q But at the time you were providing treatment to adults?
A Correct.

Page 42

Q And was your perception that the treatment was effective for them?
A I was not sure. There was an evolutionary process there with me. I felt, I evolved to the point where I saw that people were really not improving.
They had lots of other, lots of other problems. Lots of psychiatric problems. Discord in the family. There were other unresolved issues, anxiety, depression. And I thought they were inadequately evaluated when they were sent to me because they were sent to me having seen a therapist, but often those visits were one or two visits and then they were told that they were good to go. They met the criteria for hormonal interventions.
But I didn't -- so, yes, they had physical changes. But I don't think from a psychological standpoint they really improved. Eventually I, then I started to see more and more and my other patients were not getting care. I could not see new people because my practice is very busy. I declined seeing new patients.
I continued to provide care for those established patients. But as I stated in my declaration, probably seventy percent discontinued

Page 43

their care. Or I should say more specifically, they didn't follow up with me so I suspect they discontinued their care because there was no one else who could offer that care in the area.
Q When you say that you stopped seeing new patients, what year did you stop seeing new patients for the treatment of gender dysphoria?
A 2013.
Q Have you seen any patient for the treatment of gender dysphoria since 2013?
A For the treatment of gender dysphoria, no.
Q Okay. So I want to make sure I have the timeline correct. From 2003 to 2013 you saw patients for the treatment of gender dysphoria.
In 2013 you stopped seeing new patients for the treatment of gender dysphoria.
A Correct.
Q So for the existing patients that you had with gender dysphoria, the last one of those people that you saw would have also been in 2013?
A No. No. I continued seeing them until I left Ohio.
Q What year was that?
A I left Ohio in December of last year, 2022.
Q So when was the last time you saw a patient that

Page 44

you were treating for gender dysphoria?
A Around that time. December of 2022.
Q Okay. So in your declaration I think you said that you treated approximately one hundred patients for gender dysphoria, is that correct?
A Yes.
Q Does that hundred patients include the twelve you saw during your fellowship?
A No.
Q Okay. Of the hundred patients that you saw, that was from 2003 to really 2020, right?
A 2022.
Q 2022. I apologize. Well, from when you left Ohio?
A Yes.
Q Okay. So how many of those patients do you think you treated continually over that period of time?
A Well, if seventy percent left that would leave thirty.
Q So when you left Ohio in 2022 you still had thirty patients you were treating for gender dysphoria?
A Correct.
Q Okay. And what did you tell them about why you would be discontinuing care with them?
A Moving to Utah.

Page 45

Q Did you transfer their care to another practitioner?
A I discussed options with them because I felt bad about leaving. That was not just the patients with gender dysphoria, but all my patients because they had seen me for many years. Some of them thirty years.
So I offered options and asked the endocrinologist whom I hired years ago if he would continue to manage them. They were on stable hormonal treatment.
Even though he would not see people, new patients, he was willing to continue their care in most cases. I should say in all cases he was willing to continue to manage those people.
Q Okay. You believe those thirty people were appropriately continuing to receive care for gender dysphoria at the time that you transferred them to another endocrinologist?
A If I were to see them again I would not offer them opposite sex hormones and all of that treatment that I did then because I learned a lot more than I knew back then.
They are on stable regimens. They are doing as best as they can. They are getting

Page 46

psychotherapy and counseling. They are on antidepressants. Some of them have had surgical reassignment and they need their hormones. They will be maintained on those hormones by Dr. Burtch in my practice.
Q Fair to say you think your patients would have done poorly from a medical perspective if they had not been able to continue receiving the treatment for the gender dysphoria upon your departure?
A These people who had surgical reassignment certainly. They don't have their gonads. They need hormones. These are adults, of course, all of them in their thirties and forties and fifties.
Q Of those thirty patients, do you recall about how many of them had surgery to remove their gonads?
A I'm thinking here now. I don't recall.
Q Not all of them, fair to say?
A Correct.
Q Even for those who had not had a surgical intervention related to their gonads you believed it was appropriate for them to continue to receive hormones as part of the treatment for their gender dysphoria?
A I think all those patients that the endocrinologist that I hired who was going to

Page 47

assume their care, all of them have had surgical reassignment. I'm just thinking back. Yeah. All of them did.
Q They would not be producing endogenous hormones?
A That is correct.
Q I take it from a medical perspective it's not healthy to not have endogenous hormones and also not to receive them --
A Correct.
Q Okay. Now of the seventy -- so we are talking about the hundred folks that you saw between 2003 and 2022.
You say by the time you ended your practice there you were only seeing thirty of the hundred?
A Yes.
Q Do you know what happened to the other seventy folks in terms of their care?
A All I know is that they did not return for office visits. So I assume that they no longer, they discontinued treatment. They were not getting their opposite sex hormones or their blockers at all because no one else would be providing it around that time.
Q When you say blockers, you mean testosterone blockers?

Page 48

A That is right.
Q Earlier you said you don't prescribe GnRH agonists, right?
A Right. Those are not covered by insurance. They are very costly. Insurance would not tend to provide those even if we wanted to.
Q Since these patients were, had already gone through puberty they would not be candidates for puberty blockers?
A Correct.
Q But of the seventy patients, it is possible they moved away from the area, right?
A That is possible, yes.
Q It's possible that they found another provider to continue prescribing that care?
A Very unlikely. Back in 2013 there were no other providers except the Cleveland Metro General Hospital that had a clinic back then and patients preferred not to go there. It was hard to get into there.
That was the only other provider in the area. It was fairly far from where I was offering care.
Q So you suspect that, but you are not certain. Someone could have made the drive, right?
A Correct.

Page 49

Q Okay. And in 2013 when you stopped seeing new patients did you tell your existing patients that you were no longer treating new patients for gender dysphoria?
A No.
Q Okay. Do you think any of them knew that?
A I don't know. When people would call for a visit, my office would say he is not seeing new patients at this time.
Q Would they specify that you were not seeing new patients for gender dysphoria, or would they say he is not seeing any new patients, period?
A No. It was for gender related issues. I was seeing other new patients.
Q What I'm saying is if someone called you in 2014 and said I would like to make an appointment with Dr. Weiss and they didn't say why, you would take them because you were seeing new patients?
A Correct. The office would ask what it was for. Then they would clarify. If it was a gender related issue they would say I was not seeing new patients at this point. You can go down to Cleveland Metro.
Q Did you notice a drop off in your existing patients after 2013 when you stopped seeing new

Page 50

ones?
A No. I was booked out months and months. There was a great demand for our services. We had excellent reviews. Patients loved us. There were lots of referrals from other patients.
Q So there were lots of referrals from other patients?
A Yes.
Q So it's possible some of your existing patients learned you were not seeing new ones because they would refer a friend and your office would not be able to schedule them?
A Possible.
Q Okay. And in any given year, I would say in any given year about how many active patients would you have for gender dysphoria?
A It's hard to estimate.
Q It's a hundred over that 2003 to 2022 period. I am trying to figure out how many of those you saw over what period of time.
Do you have a sense?
A I would see those patients usually every three to four months. So you can do the math. I don't know.
Q I mean, do you think there was ever a point in

Page 51

time where you were actively seeing a hundred patients for the treatment of gender dysphoria all at once?
A Well, they would be spread out through the year. So I think there was a drop off over time. So maybe it was a hundred overall, but then among those hundred then there would still be those patients who would no longer follow up.
They might be initiated on hormonal therapy and then I would see them for a year or two. Then I might not see them after that. So there was attrition.
Q Okay.
A Attrition presumably from discontinuation of treatment.
Q You are not actually sure about whether they were discontinuing their treatment all together or just with you?
A That is correct. But it's highly unlikely. When I mentioned the one patient about where he could go for care, it would be, oh, I don't want to go down to the Pride Clinic. That was -- because a lot of these patients had been there. They didn't want to go back. It was a different approach that we took. It's not like that was a desired

Page 52

location for people to go to.
Q Again, you have some suppositions about what might have happened. You didn't follow up? You didn't call and say you have not come in for an appointment, what's happening?
A I did not do any systematic follow up of all hundred patients like doing clinical research, no.
Q We have been going for about an hour. Is now a good time for a five minute break?
A I can keep going if you want to. If you want a five minute break, I'm fine with that.
Q Not to put too fine a point on it, I would like a five minute break.
(OFF RECORD AT 10:36 A.M.)
(AT THIS TIME A SHORT RECESS WAS HELD OFF THE RECORD AFTER WHICH THE FOLLOWING PROCEEDINGS WERE HAD:)
(ON RECORD AT 10:42 A.M.)
BY MR. SELDIN:
Q Dr. Weiss, we are still in your C.V. on Page 64. This section is called Legal Experience.
Do you see that?
A Yes.
Q So you listed two cases in which you were an expert witness.

Page 53

A Yes.
Q Did either of these cases involve the treatment of gender dysphoria?
A No.
Q Did either case involve anyone who was transgender to the best of your knowledge?
A No.
Q Are there any other cases that you were a testifying expert that you didn't include here?
A No.
Q Are there any cases where you were a consulting expert that you didn't include here?
A No.
Q Are there any other cases where you have been retained as an expert, but have not yet testified?
A Not that I recall.
Q There are several other states that have passed laws similar to Senate Enrolled Act 480.
You are not an expert in any of those, are you.
A No. I have submitted written testimony in multiple states for legislation similar to the Indiana bill, but I've not provided any expert declarations in any other states.
Q And you have not been retained as part of

Page 54

litigation?
A No.
Q Is that something that you are interested in doing?
A I think it's important to provide the science and the facts and provide balance in this because I think a lot of harm is being done to minors.
Q On Page 64 of your C.V. it has Participation in Clinical Trials and then it goes to the next page.
For these trials what has your role been? Are you the principal investigator for all of these?
A Yes.
Q Okay. So in your declaration you talk about having been the principal investigator in about a hundred clinical trials.
Those are the ones listed here, is that correct?
A Yes.
Q Do any of these pertain to the treatment of gender dysphoria?
A No. It would be great if one did because there are no randomized clinical trials with comparator control groups for the treatment of gender dysphoria in adults or minors.

Page 55

Q And were all these trials sponsored by pharmaceutical companies?
A No.
Q Which ones were not sponsored by pharmaceutical companies?
A The second one, the efficacy of fluoxetine. That was an investigator initiated trial. I did that one without funding. There was the ACCORD trial in which I was a principal investigator. That was analogous to a health sponsored trial. That should be listed here. That is listed on Page 65. That is Action to Control Cardiovascular Risk in Diabetes. That was a National Institute of Health sponsored trial. So that was also not a pharmaceutical trial.
All of the others were pharmaceutical sponsored trials except for Page 72, 2011 to 2012 Trial-Net was an NIH sponsored trial.
Q So with the exception of those, the rest of those indicate at the end there has been a sponsor. So I take it the rest of them were sponsored by pharmaceutical companies?
A Correct.
Q Have you supervised any clinical research about the treatment of gender dysphoria?

Page 56

A No.
Q Okay. Now on Page 75 of your C.V. you will see there's a section midway through called Speakers Bureaus and Advisory Boards. Then you have Lilly on there.
Earlier you were talking about your promotional presentations for Mounjaro. Is this the same thing?
A Yes.
Q Okay. Are there any other -- other than Lilly, are there any other Speakers Bureaus or Advisory Boards that you are on currently?
A I'm a senior fellow with Do No Harm. That is not listed on my C.V. Many people view it as a politically motivated organization. It's not.
Are you familiar with Do No Harm?
Q Why don't you tell me about it?
A So basically it's an organization that attempts to eliminate ideology out of the practice of medicine to try to optimize patient care, what is best for the patient, and leave ideology, politics, religion out of practicing medicine.
So I'm a senior fellow with that organization. I do occasional, I write occasional testimony. I guess it's testimonies that I write

Page 57

in support of legislation related to gender ideology.
Q When did you first become a senior fellow in Do No Harm?
A It was something like March or so of this year. Early this year.
Q March of 2023?
A Correct.
Q And how did you learn about them?
A It's a long -- how did I learn about them? That is a short story. I just saw the, I think I saw something online with regard to what their efforts were.
The head of the organization is the former dean of the University of Pennsylvania School of Medicine. He is a nephrologist. He is just brilliant and articulate. I think his goals are wonderful. They are well -- just the motivation and the goals are really noble.
Q And do you remember where online you learned about them or what you were doing online when they popped up?
A I do not remember.
Q And so that is how you learned about them. What happened next?

Page 58

A Well, what happened was -- can you clarify that question? What happened next?
Q So you first learned about them. Then suddenly you were a senior fellow. What happened in between?
A I will explain. So there was an email sent out to request support for Florida's legislation related to treatment of minors with gender dysphoria.
I sent an email to the Florida, I think legislature's medical board or someone to support Florida's legislation. Then there was a follow-up email from Do No Harm to please send us any communication you wrote in support of the Florida legislation.
I sent them a copy of my supportive testimony. They contacted me. I think that was partly because I'm an endocrinologist who has had a lot of experience treating gender dysphoria and they were interested in my viewpoint.
Q And so thank you for that.
MR. SELDIN: Erica, if you could please pull up Exhibit 11.
Q Dr. Weiss, you will see this is an email from a DW, but it's signed by you to the Board of Medicine Public Comment.

Page 59

It's an email dated October 24, 2022. Do you see this email?
A Yes, I do.
Q And it says, "Please see my attached comments. I strongly support Florida's efforts to protect minors from experimental medical interventions such as cross sex hormones, puberty blockers, and surgery to remove normal body parts. Thank you."
Did I read that correctly?
A You did.
Q So is this the email that you sent with respect to that Florida comment we were just talking about?
A Well, no. There was probably a two-page commentary with references sent to Florida. So this is -- the attached comments are not shown here.
MR. SELDIN: Erica, if you could scroll down for us.
A Very good.
Q Is this the cover email and then the attachments that you sent that we were just talking about?
A It looks familiar, yes.
Q Okay. So in October of 2022 you send this Florida comment.
When you sent this comment did you know about

Page 60

Do No Harm?
A I don't think so.
Q Okay.
A I don't think so.
Q So --
A Wait. Excuse me.
Q Yeah.
A Yes, I must have known about Do No Harm because, as I said earlier, Do No Harm said to please send comments to Florida if you support this legislation.
That is when I sent this email to Florida. And it was only because of the Do No Harm email sent to their members, most of them who are physicians I think.
Q And when did you become a member of Do No Harm separate from being a senior fellow if those are different things?
A They are different things. I think I became a member sometime last year. I do not recall when. It may be mentioned on my C.V. I don't think so though.
Q Just so I understand the timeline, sometime in 2022 you are online. You learn about Do No Harm. Is that when you became a member?

Page 61

A Yes, when I saw the work they were doing. Yes.
Q And then you start getting Do No Harm's emails. One of them was sometime before October 24, 2022 that solicits folks to send comments into Florida.
And that is what prompted this email from you with the attached comments. Is that an accurate sort of summary of what we have been talking about?
A Yes.
Q Okay. And then did you send a copy of this to Do No Harm?
A Only when asked after.
Q Okay. So Do No Harm said to send comments. They say then thank you for sending comments. Please send us a copy of what you sent?
A Correct.
Q Then you heard back?
A Yes.
Q Do you remember about when between October 24, 2022 and becoming a senior fellow that you heard back?
A I don't remember.
Q Okay. And when you did hear back who reached out to you?
A Kristina Rasmussen, who is their kind of chief

Page 62

administrator.
Q What did she say to you?
A She said something like Dr. Goldfarb and I would be interested in speaking with you about your joining Do No Harm or something along those lines.
Q Did you then meet with Dr. Goldfarb?
A Yes. It was just online like a Zoom meeting.
Q What was that conversation like?
A They discussed their goals and how I might work with them in achieving their goals specifically with focusing on the gender dysphoria issue.
They work on other matters, too. That was not the pursuit at that point.
Q So specifically on gender dysphoria what did they say their goals were?
A Well, I think the goal is to protect minors. To protect really only minors from these harmful and experimental interventions.
Q And is a goal of Do No Harm to end the treatment of gender dysphoria for adults?
A No, not at all.
Q Is it your goal to end the treatment of gender dysphoria for adults?
A I think if adults want to undergo those treatments if they have really clear informed consent by the

Page 63

prescribing physician, I mean, they are welcome to do that. Adults are adults. It's a different story.
I don't think it's the best treatment for them if they have gender dysphoria. I think there are better approaches to their dysphoria. But if they seek to have modification in their appearance to resolve their dysphoria and the prescribing doctor thinks that's the way to go, as long as there is clear and complete consent then that's fine for adults.
Q This particular testimony that you wrote, did you write it yourself?
A Yes.
Q In the legal world it's not nearly as offensive to ask if you wrote it yourself. This was what you wrote before your involvement with Do No Harm?
A What are you referring to?
Q The Florida testimony that we are looking at right now that you submitted to the Board of Medicine, did you write this yourself?
A Yes.
Q Did you have any assistance writing it?
A No.
Q Did anyone review it before you sent it in?

Page 64

A I think I may have shown it to my wife. She is a retired physician. She is really good with grammar and clarity.
Q Good to have a copy editor in the house. What kind of physician was your wife?
A Nephrology.
Q How long did she practice?
A Oh, she is seven years older than I. She just stopped practicing about five years ago.
Q Does she also enjoy Utah and the sunshine?
A She is.
Q Okay. Glad to hear it.
Has she ever treated anyone with gender dysphoria as far as you know?
A No.
Q I want to talk more about your testimony before some state legislatures that you talked about.
Do you recall what states you offered testimony in either written or oral?
A I can check my folders and tell you. From my memory it would be Indiana, Ohio, Montana, Utah. I think that is all. That is all that I can remember. There are probably some I left out.
Q Is it possible you testified in North Dakota?
A Wyoming is in there. I think North Dakota also,

Page 65

yes. I think that is right.
Q Other than the legislative testimony that you referred to, and you listed some states just now, have you ever provided legislative testimony on another topic other than the treatment of gender dysphoria in minors?
A Another topic outside of gender dysphoria?
Q Correct.
A Yes. I have submitted video testimony in Ohio about not requiring vaccine mandates to people before -- it had to do with vaccine mandates. It was that topic.
Let's see what else. That was about two years ago I think. I can't recall any other testimony.
Q Would that have been vaccine mandates in Ohio?
A Yes.
Q What was your position on vaccine mandates?
A They should not be required by the state.
Q Why was that your position?
MS. YOUNGS: Objection. What is the relevance to the vaccines?
Q Dr. Weiss, what was your position on the vaccines? Why was that your position?
A My position at that point was that there was, it

Page 66

was a privacy issue. People's health status should not be the reason they should be excluded from businesses or governmental positions or -- basically that was it. It was a health privacy stance.
Q Is it fair to say you thought this was an inappropriate use of state power?
A Correct.
Q Have you ever lobbied?
A I'm sorry. Have I lobbied?
Q Yes.
A No.
Q You have never met with state legislators to talk about medical issues, vaccines, or treatment of gender dysphoria, nothing like that?
A No.
Q Okay.
MR. SELDIN: Erica, if you could pull up Exhibit 8.
Q Dr. Weiss, we were talking earlier about your testimony.
Do you recognize this document?
A Yes.
Q What is it?
A It's a statement I presented to Ohio's members of

Page 67

the House, Families, Aging and Human Services Committee to support the Save Adolescents From Experimentation Act.
Q Would that have been -- do you recall was that HV 454?
A That sounds familiar.
Q Was this testimony May 19, 2022, does that sound about right?
A It does.
Q Okay.
MR. SELDIN: Erica, can you pull up Exhibit 32.
Q While Erica finds that, Dr. Weiss, I have a link to the recording of that testimony.
My question will be is that you, is that the testimony?
A If it looks like me it probably is.
Q Famous last words in the court of law. We will make sure it's you.
MR. SELDIN: Erica, if you could get us to 32.
Q While that comes up, Dr. Weiss, so in May of 2022 you were not a member of Do No Harm yet?
A No.
Q You were not a senior fellow yet?

Page 68

A That is correct. I might have been a member. I don't know. But I was certainly not a senior fellow. That was just early this year.
Q So you were not a senior fellow. You are not sure if you had signed up to be a member?
A Correct.
Q When you signed up to be a member did you make a donation, or it was to join the email list?
A I think it was to join the email list. I don't think there was any monetary requirement.
Q This testimony that you provided which we just talked about as Exhibit 8, did you write that yourself?
A Yes, sir.
Q Did anyone help you write it?
A No. Again, I may have shown it to my wife for grammar and clarity.
Q Did anyone compensate you for providing that testimony?
A No.
Q What prompted you to go to that hearing?
A It is a rather long story but I will make it brief. So I was contacted by a physician who is a member of the, of SEGM, Society for Evidence Based Gender Medicine. I had joined that group probably

Page 69

two or three years ago. He, that physician, is a member of that group and he is in Ohio. He said, hey, there's this legislation coming up. Would you be willing to write testimony in support for it?
And he got me in contact with an organization that was supporting the legislation.
Q Do you recall what that organization was that was supporting that?
A CCV, I think. Center for Christian Values or something like that. I think they changed their name. But it's something along those lines.
Q You mentioned SEGM. What is that?
A SEGM. Society for Evidence Based Gender Medicine.
Q When did you join that organization? Was it maybe two or three years ago?
A Something like that, yes.
Q What prompted you to join that organization?
A So I had written a letter in support, well, actually praising an editorial or an article that Dr. Malone, an endocrinologist and founding member of the organization, had written.
And in response to my commending him on how well balanced and clear and well written that article was that he wrote about gender dysphoria

Page 70

he contacted me. He said would I be interested in just joining the organization. You know, it's basically a non-political organization that tries to provide the best science and the best evidence for taking care of people with gender dysphoria. So I joined.

There's, they have discussions online and so on. They have several physician members that are -- I'm just, I'm just connected to them. I'm really not a member of the group in that sense. They allow me to access their kind of interactive site.

Q Do you have to be a member to access the -- are you talking about -- you are on their website?

A Yes, that is all. I'm not even listed. You will not find me, if you go to SEGM you won't see my name there because I'm just -- I know about them. They have their resources basically.

Q Who was the doctor from SEGM who reached out to you about testifying in Ohio?

A Dr. William Malone. M-A-L-O-N-E. He is an endocrinologist.

Sorry. What was that question? Now repeat the question.

Q You said a doctor had reached out to connect to

Page 71

you from SEGM, the organization CCV, is that right?

A I misspoke. Okay. Right. The doctor who asked me about Ohio is Dr. Beck.

Q Who is Dr. Beck?

A He is actually one of the founding members of SEGM.

Q You found SEGM because Dr. Malone. Once you were part of SEGM Dr. Beck got in touch and asked you about supporting this bill in Ohio?

A Correct.

Q Okay. And then the organization that was supporting the bill in Ohio that you were involved with related to your testimony was CCV, is that right?

A I think that is what it's called. There are many organizations supporting the bill. CCV was the one that reached out to me and gave me a copy of the bill. They communicated with me.

Q You will see actually we have up on the screen the Exhibit 32-C which is from CCV.org.

A Okay.

Q I take it that was the organization you are talking about there. I think they have a recording of your testimony online.

Page 72

A Okay. Good.

Q Okay.

A So my recollection was accurate.

Q We love to hear that in a deposition. So during that testimony you talked about how you estimated that seventy-five percent of your patients failed to persist in their treatment with you.

Does that sound about right?

A I think I modified that to seventy percent in my statements to you earlier and in my declaration.

Q But the word "persist" is the word that you used.

A Okay.

Q I guess my question will be what does persistence mean? Like we were speaking earlier about your patients didn't return to treatment with you.

When you say didn't persist, is that what you meant?

A Yes. So when they discontinued their care with me I would equate that to lack of persistence in their treatment. Although, accurately as you stated, I can't be sure what happened to those people.

Q We have talked about other reasons that people might not have returned to you for care. It could have been that they lost their insurance perhaps?

Page 73

A Correct. Many of those people were on Medicaid. That is possible. Sure.

Q It could have been possible they were happy with the results they got and didn't feel the need for further treatment?

A That would be, that would be desistance if they stopped. They would not have discontinued hormonal, you know, to say -- well, then they would basically desist. They would say I don't really need this any more and they would stop hormonal treatments.

Q Well, I think I'm asking a different question. There are some treatments that, I mean, someone might say I want to take testosterone because I want my voice to be lower. Once their voice achieved that pitch, they might say I have achieved what I desired and I don't need more.

A That would not be the case in these people because they are all adults who have their voices. Their vocal cords will not change after the treatment. They are all post puberty.

Q As part of your testimony you have talked about a patient who had regretted the removal of their testicles.

Does that sound familiar?

Page 74

A Yes. Before I left Ohio I had two men who had bilateral orchidectomy, that is, testicular removal who regretted it within one year of treatment.
Q Were they adults when they had this surgery?
A They were.
Q Do you recall approximately how old they were?
A One was in his thirties. The other was about forty-five.
Q And were those surgeries as part of their treatment for gender dysphoria or for some other reason?
A The man in his thirties was treatment of gender dysphoria. Surgery was done in Philadelphia. He came to me for care after that.
The man in his forties was -- he should never have had that done. I was treating him for gender dysphoria. He was -- it's a complicated story. He was really autogynephilic. He basically wanted some feminine characteristics. He was married to a biologic female and sexually active with his wife. He was living as a man with long hair.
And he went -- I was seeing him for years. And he was, he seemed happy with his hair on low dose estrogen. And then I didn't see him for

Page 75

several months. He ended up going to a urologist for orchiectomy. He was evaluated by a psychologist that cleared him for surgery. He came back to see me saying I'm having problems with erections since my surgery. I said, What surgery? Because they never contacted me for his, they never contacted me before his surgery.
Then he wanted testosterone for his erections. I called the urologist. I said, How come you didn't contact me? What happened there? They said, We had a psychologist. He thought he was fine to have surgery. This just shows if two adult men can have regret it would not be surprising there would be many minors who would regret having interventions if two adult men who obviously failed to understand what they were having done to them.
That is the story on those.
Q Have you had other patients who regretted surgeries they have gotten, any kind of patient for any treatment?
A Yes. I have had patients who had complications after breast surgery. Patients who had complications after knee and hip surgeries. Yes.
Q This was not the first time you had patients come

Page 76

to you and have some regret or complications from surgeries?
A Right. But the distinction is hardly analogous because these are people who have healthy body parts and then they are being removed. They clearly don't -- they don't clearly have informed consent. When people have knee and hip and shoulder surgery they have severe pain. They have deranged, abnormal joints or breasts. They might have breast cancer.
So all these people have a disease state that can only be corrected by surgery. There is no other intervention that would be appropriate. It's quite different from people with gender dysphoria.
Q So I take it then your concern is not the regret. It is the surgery operated on what you think is healthy tissue?
A That the surgery was not the best intervention for these people's distress. There was, you know, there were interventions that they could have been offered that might have resolved their distress and they actually did not get resolution of their distress and they had worsening with the surgery in these cases of gender dysphoria.

Page 77

Q So based on those anecdotal experiences with those two patients, that is why you support laws like Senate Enrolled Act 480 which bans this care for minors, right?
A No. No. That is a terrible oversimplification. I think the evidence base is pitiful to support these interventions. It's not just my experience. It's the experience that the people didn't improve from a dysphoric standpoint, even those who did not regret their surgery.
But also the evidence base is very poor. It is really low quality. And even those -- the Endocrine Society -- that's why four, five countries have said this is not, this is not the way to go. They really should have psychological support.
And some countries have said they should only be offered -- medical interventions should only be offered in a research setting because the evidence is so poor to support it. It is not just simply my experience.
Q We will talk about the countries in a minute. I think I was asking a different question.
A Sorry.
Q Even though you had two adult patients who

Page 78

regretted their surgeries, you do not support a ban on the treatment of gender dysphoria for adults? You just support bans on the treatment of gender dysphoria for children, for minors?
A That is correct.
Q Okay. That is what I was getting at.
A I'm sorry if I misunderstood.
Q Not at all. Do you support bans on orthopaedic surgeries for minors?
A I think there needs to be informed consent for all surgeries on children. That means that informed consent involves the pros and cons, risks and benefits, alternative treatment and the parents need to be involved in the decision making process and sign off on that.
Q There are circumstances in which minors you believe can provide assent to certain types of medical care with the consent of their parents and that kind of care should be provided?
A Absolutely.
Q Okay.
MR. SELDIN: I saw a note from Erica about the video. Thank you. Can you pop that up real quick. All this for one question. Would you play the first thirty seconds or so.

Page 79

(Video Playing.)
MR. SELDIN: You can pause it.
A That is me.
Q Not the other Dr. Daniel Weiss, M.D. testifying in Ohio. Great. Thank you. Thank you for confirming that.
So during that testimony you criticized some doctors as delegating diagnosis to a minor.
Do you recall that part of your testimony?
A I don't recall the exact words, but I think there's, I think that approach is accurate.
Q Do you have any examples of a doctor failing to independently diagnose a minor with gender dysphoria before providing care?
A I think it happens all of the time in gender clinics.
Q Why do you think that?
A Well, I have heard that from parents who attended gender clinics in Ohio with their child and they are -- basically the child will just say I was born in the wrong body or I don't like my breasts and they will diagnose them with gender dysphoria and not explore any other issues.
So the person, the child comes in with this sense of what they have and that is accepted by

Page 80

the treating physicians. I think if you see what others have said in other clinics, the affidavit of Jamie Reed at the Gender Clinic in Washington, the stories of what happened at the Gender Identity Center in the U.K. and experiences from other parents of children with gender dysphoria, they will also describe the lack of exploration, investigation and psychological counseling that their children go through basically, or fail to have when they are treated.
I mean, if you just look at M.R., one of the plaintiffs, in the hospital with suicidal ideation, I think this is correct. Then a week later gets testosterone. Where is the, where is the biopsychosocial evaluation over months?
Q So based on reports from parents and other news articles, that is your basis for believing that there are minors who are being provided treatment for gender dysphoria without a gender dysphoria diagnosis?
A Well, I think, I think it's more accurate to say that there is inadequate exploration of other co-morbidities and the family dynamics and their social situation and why that child has come to reject their natal sex.

Page 81

And that is what happens in many of these clinics. And it's not just, it's not news articles. I mean, the affidavit of Jamie Reed is not a news article. The book Time to Think, which is an exploration of the very thorough evaluation of the Gender Identity Center in the U.K., that is not a news article. Also, reports from parents who, that is very powerful, very meaningful. Some of that was presented in Ohio. We hear that repeatedly.
Why are all these D tran sites coming up? There are many of them. Those people have had experiences where they were basically affirmed with minimal evaluation under two visits.
Q So it's not that you think there is not an evaluation taking place that is leading to an independent diagnosis of gender dysphoria.
It is that you believe that they should be exploring other co-morbidities?
A I think for many cases there is virtually no evaluation.
Q You said that, you know, you found compelling some of the testimony of parents.
Do you find the testimony of the parents in this case about how their children have improved

Page 82

to be compelling?
A I didn't see clear evidence that the children were improving.
Q Do you have any firsthand knowledge of a minor being provided with treatment for gender dysphoria without parental consent?
A What do you mean by firsthand knowledge?
Q Well, we talked earlier about how there are circumstances you believe where children can assent to medical treatment and their parents can consent and the provision of that treatment is appropriate based on that informed consent process.
Are you personally aware of a minor receiving treatment for their gender dysphoria where that didn't happen? Are you personally aware of that?
A I know of circumstances in which minors have gotten hormones through Planned Parenthood without parental consent.
Personally knowing them as someone I've taken care of or in my, that lives in Ohio nearby, a neighbor, no. I don't have that kind of personal awareness.
Q You said during your testimony in Ohio that it was immaterial that you had not visited any

Page 83

multi-disciplinary clinics in Ohio that were treating pediatric patients.
Do you recall saying that?
A I think so.
Q Do you still believe that to be true that it's immaterial?
A Yeah, I think it does not matter.
Q Okay. So you are comfortable relying on secondhand reports to describe what you believe is happening in that --
A They are very powerful statements by parents who attend with their child at the clinic. So when people say they have a very thorough evaluation, they do not do any of that. They don't do this. They will evaluate the child from a psychological standpoint over months and really address all of their other problems, that does not happen.
I don't believe it happens. I never hear that it happens. With my experience with adults it didn't happen. The parents don't say that it happens. The comments from the extensive evaluation, extensive interviews in Time to Think that I've referenced in my bibliography at the Gender Identity Development Center in the U.K. that has decades more experience than we do in the

Page 84

United States, and the affidavit of Jamie Reed.
And I think there will be many coming out along with many, many parental testimonies that describe how minimal the evaluation is.
And we just see the plaintiffs. We don't see extensive evaluation of these children. I mean, look at these sad stories of these children who felt terribly traumatized and they are treating them with hormones.
There was one that was physically and sexually abused by the father. Another one who has two biologic male parents. One of whom is transgender.
You wonder how much of this is pressure on the child to have hormonal treatment. That all needs to be explored. It's just not being done.
Q Dr. Weiss, I'm sorry to cut you off.
MR. SELDIN: Ms. Youngs, we will designate parts of this testimony regarding the medical records of the minor plaintiffs as confidential.
MS. YOUNGS: Certainly.
MR. SELDIN: Ms. Youngs, I believe in Dr. Weiss' declaration he has several paragraphs that we would like those designated as confidential and redacted. I just wanted to flag

Page 85

those for the court reporter and for you that that is how we would like to proceed. I assume that is not going to be a problem?
MS. YOUNGS: No.
Q Sorry for that little bit of housekeeping.
Do you think that there are any minors who are properly evaluated for gender dysphoria?
A I hope so.
Q For those minors who are properly evaluated, do you still oppose the treatment for gender dysphoria?
A The hormonal, or what you might call gender-affirming care, yes, because I think it is personally harmful and it does not help. There are safer less harmful interventions like supportive exploratory psychotherapy.
Q So it's not just the evaluations, because even if a minor were appropriately evaluated, thoroughly had a diagnosis of gender dysphoria and you agreed with that, you would still oppose the provision of the treatment of their gender dysphoria either through puberty blockers or hormones, is that correct?
A I would be more clear in stating that a thorough proper evaluation would very, very likely reveal

Page 86

factors in the family dynamics, history, sexual abuse, physical trauma, bullying, social isolation, autism spectrum disorder or depression, anxiety.

That all could be addressed and there would be no need for hormonal interventions that would be not helpful and likely harmful.

Q Do you think it's possible that there are minors who do not have any history of trauma, do not have any co-morbid conditions, do not have any social or familial pressure and, nonetheless, had gender dysphoria that would benefit from treatment?

A I think they may benefit from treatment. But the treatment is best hormonal or hormonal interventions.

So even if such children did exist and, of course, in the Dutch study they found not very many of them. They had no other significant psyhosocial issues, they treat them with these hormonal interventions and I don't think they helped them as we will discuss.

Q So you don't believe that there are any minors who had gender dysphoria period, or who have gender dysphoria?

Well, first question, do you believe there

Page 87

are any minors who have gender dysphoria?

A Sure.

Q And just gender dysphoria, no co-morbid conditions?

A Well, I think there is an explanation. They may not have obvious co-morbidities. I think with supportive therapy, one would be able to identify reasons why they have rejected their natal sex.

And those children, their dysphoria would likely resolve with that therapy. Because really what the goal is, the goal of treatment for gender dysphoria is not to make the person look like another sex. That is not the goal.

The goal is to resolve the dysphoria, the distress. Right? So if you can resolve the distress with really safe reversible interventions to addressing the biopsychosocial issues, that is what should be done.

Q So you believe there is no way to resolve gender dysphoria through physical changes, is that what I'm hearing you say?

A I don't think physical changes are helpful. This would be the only disorder listed in the DSM for which there is an intervention to modify appearance to fix the mental disorder. It's the

Page 88

only one.

Q Let's say I have a three year old child who has no history of trauma, no co-morbid conditions, nothing else going on except for gender dysphoria.

Do you believe that that child is a candidate for medical treatment of their gender dysphoria as they get older?

A So I think the diagnosis of gender dysphoria in a three year old is extraordinarily difficult. What is a three year old's understanding of gender?

If you have had kids you know that boys like to put on mommy's shoes. Girls like to wear, you know, daddy's glasses. I mean, boys have, there is just exploration and children do these things.

They might say they -- are they going to say they don't like their penis. They don't know what gender is at the age of three or four. I think that is frankly absurd, most of that.

And we know, we talk about this later, those kids, that resolves over time in most of those children. If it does not, then they need supportive therapy to help them out.

Q You can't imagine a circumstance in which a child could be accurately diagnosed with gender dysphoria?

Page 89

A In the absence of all other psychiatric or family dynamics, social causes, bullying, social isolation, influences of other children, no, I think there are other factors that explain it.

It's a symptom of something else that is going on.

Q You said they should receive supportive therapy.

What do you think the goal of that therapy should be?

A I think to resolve their dysphoria and to address their anxiety, depression. How they feel about themselves. Because it's not -- the child might come and say I really want to be a girl. Okay. Tell me more about that.

This is not conversion therapy. We are talking about just helping them out to feel less distress, less anxiety. What is going on in your life? What's happening at home? Does your dad beat your mom up? Is there alcoholism?

I mean, in the four plaintiffs we see a lot of that going on. None of these four children would have qualified for treatment based upon the only solid evidence that's claimed to be solid, it's really weak, which is the Dutch protocol.

Because the Dutch excluded those people with

Page 90

any significant psychosocial issues. All four of the plaintiffs have major psychosocial issues. They would never have been treated per the evidence that we have, which is the Dutch protocol.

Q So earlier you said that, you know, the resolution of the gender dysphoria was not going to come from changing physical characteristics.

So the goal of that supportive exploratory therapy would be to be at peace with one's assigned sex, is that right?

A Correct. I think that being at peace would come not with a focus on you have to accept your sex. Not with something that might be called conversion therapy. But really with exploring everything that is going on in the child's life.

What has happened here? What happened? How were they raised? What is going on? Have you been abused? Have you been -- how safe are you at home? What is going on at school? Do you feel isolated? Do you have friends?

All of those issues. We know that social media for all these girls has a powerful impact on their reasons for all of a sudden now when they are adolescents deciding they want to be boys.

Page 91

Q You believe that once all those issues have been fully explored and addressed if they exist, nonetheless, it's not appropriate to provide gender-affirming, to provide treatment of gender dysphoria to minors?

A To provide -- nonetheless, it would not be appropriate to provide hormonal treatment, either puberty blockers, opposite sex hormones, surgical reassignment to minors, correct. That would not be appropriate.

Q If you believe it or not, we started by talking about your testimony in Ohio. I will now turn back to that.

During that testimony in May of 2022 you were still seeing patients, adult patients who you were treating for gender dysphoria, is that right?

A Correct. Those would have been follow-up patients, but not new ones.

Q Was your provision of treatment for gender dysphoria to adults particularly lucrative?

A No.

Q During your testimony in Ohio you compared gender-affirming care to providing weight affirming care with an eating disorder.

Do you recall that part of your testimony in

Page 92

Ohio?

A Yes.

Q The term weight affirming care, does that come from somewhere or did you make it up for your testimony?

A I made it up.

Q Okay. You talked about how you provide promotional presentations for Mounjaro. That's, is that Tirzepatide?

A Yes, it is. Does Wendy know how to spell that? It's T-I-R-Z-E-P-A-T-I-D-E.

Q So my understanding is that Mounjaro has some profound weight loss side effects, is that correct?

A Yes.

Q What about a patient who came to you in your practice and said, I'm very overweight. I don't want to go outside because I'm so overweight. I don't want to see my friends because I'm so overweight. I feel like this body is preventing me from participating in society.

Do you think it would be appropriate to treat that person with weight loss drugs?

A So I, as I said, I'm a diplomatic of the American Board of Obesity Medicine. I'm very knowledgeable

Page 93

about treating obesity.

Obesity has many adverse consequences. We want to help people as best we can to help them lose weight. There are medications approved for the obesity. Yes, I treat those people.

Most of them are not dissatisfied with their, well, their appearance, but they are really struggling with knee pain, with sleep apnea and other adverse consequences, medical consequences, that derive from their weight. There is medications approved for treating weight.

Mounjaro has been studied. It works really well, but it's not yet approved for weight loss. I would not give Mounjaro to those people. I would offer them other medications which are approved for weight loss by the FDA.

Q I'm not surprised. But you could imagine a patient who said in addition to my knee pain and my sleep apnea, I want to lose weight for that, but I want to look thinner because I want to be thinner in society.

Would that be an okay reason to provide someone with a weight loss drug?

A It would depend on their body mass index.

Q Assuming it was not unsafe for them to lose

Page 94

weight?
A If their body mass index is above thirty and that is one of their concerns, sure, I would do that.
My example with the weight affirming intervention was related to a minor, a seventeen year old, who came in and said I'm too fat. And she has anorexia nervosa. Okay? That is a condition which children eat very little. It's usually females. They eat very little. They have no, their menstrual periods stop. They are really underweight, but they still see them, they see themselves as too fat.
They want to have a, they feel bad about their body. They feel they are too fat and so they want to lose weight.
So if they came to a physician and said I'm really fat. I feel bloated. I am really fat. We don't give them medication to lose weight when we as physicians judge them to be underweight.
So we would not do that. We would not affirm their self-diagnosis. Which is what is happening with gender-affirming care. The child says I want hormones. Oh, okay. I want to be the opposite sex. We will take care of that.
You just basically affirm them instead of

Page 95

having the physician make the diagnosis. In the case of anorexia you are underweight. You have a psychiatric disorder -- this may not be the way we say it -- but we will try to help you out. Let's talk about it. What's going on? What's going on at home? I will send you to a therapist.
Q So in your weight loss example, the reason that you think that that would be problematic, this prescribing a weight loss medication to a minor who was underweight and also had anorexia would be one, primarily, because it would be unsafe for that person physically to lose weight?
A There are a few reasons. One is that it's not appropriate. The person, the patient made the wrong diagnosis. I make the right diagnosis. I'm the physician. You are underweight. Your problem is not your weight problem. It's something else going on. That is why you are not eating.
The best treatment for you is not a change in your body appearance. It is therapy. We need to figure out what is going on here. Why are you not eating?
Q But to go to the other side, there are circumstances in which someone who had a BMI that was higher than it should be who wanted to lose

Page 96

weight and, therefore, change their body and it was not medically contraindicated for them to lose weight. So if their primary reason for wanting a drug was they wanted to lose weight, you could see that that would be acceptable medical practice?
A Yes. Weight loss in people who are obese is medically beneficial. No question.
Q So in your testimony in Ohio you had some criticism for advocacy groups and activist positions.
I believe you said "Most of these societies are heavily influenced and swayed by activists and by physicians who run transgender clinics who have a profit motive."
Does that sound like something you said in your testimony?
A It does.
Q Okay. I think you also said that medical societies have been co-opted by these activists.
Does that sound like something that you said in your testimony?
A It does.
Q Do you think that physicians who treat patients at clinics in academic institutions are profit motivated?

Page 97

A Some of them might be. I think the academic centers make money off certainly the surgeries and the patients. I think the physicians themselves who are treating are probably uninformed about the evidence base and how weak it is.
If they really would honestly and objectively look at the evidence base, they would see that they are really harming these children rather than helping them and they would not treat.
Q But it was your experience in providing treatment for gender dysphoria to adults in your private practice that was not particularly lucrative?
A No. I had not many patients. I think there is more -- I was not running a transgender clinic like some physicians. I think there is more money in the surgeries than there is in just prescribing medications.
But I'm not sure I -- if you have a gender clinic and that is mostly what you do, you do not want to lose those patients.
Q So when we were talking earlier about Do No Harm, you said that you didn't include it on your C.V. attached to your declaration because some people think it's a politically motivated organization.
Do you remember that we were talking about

Page 98

that?
A Yes.
Q So do you think that being involved in a politically motivated organization is detrimental to credibility?
A I don't think it is politically motivated. I think this organization is really for quality care of patients and to remove ideology from the practice of medicine.
Just do what is best for the patient in front of you. So I don't view it that way. People, you know, unfortunately this whole area of transgender has gotten, outside of medicine and science it has become like a right and left thing and Republican and Democrat.
It should be what is best for the patient. We are talking about children here. It distresses me to see that it's, you know, there's politics in there. There should not be. You can't, you can't stop people from, I mean, from their perceptions. I leave that out because I don't want to have that as a factor. I don't know if I answered your question.
Q No. You said you leave it out. Just to make sure I heard you correctly, you said you leave it off

Page 99

your C.V. because you don't want your position as a senior fellow in the organization Do No Harm to be a factor in evaluating your opinions?
A Right. Yeah. I think because of people's perception of Do No Harm. Because their perception would be, I don't know, they might perceive it as a right wing or something like that. It's really what is best for patients.
MR. SELDIN: So Erica, if you could bring up Exhibit 1, please.
Q In Paragraph 40 of your declaration you talk about -- I will wait for it to come up. You probably have it in front of you as well.
A This is in my declaration.
Q Yes. Paragraph 40. I think is on Page 9. You will see that you talk about WPATH as a U.S. based advocacy group.
Do you see that, Dr. Weiss?
A Yes.
Q Then do you see where it says that?
A Yes.
Q Okay. Then if you go to Paragraph 42 -- I'm sorry. Go back to 40.
In Paragraph 40 you say that the WPATH "guidelines have been adopted and endorsed by many

Page 100

in the health care field."
Do you see that?
A Yes.
Q So later on in your declaration in Paragraph 70, you say that doctors, like all groups, are susceptible to group think and social contagion.
Do you see that?
A I do.
Q Okay. So there is a list of organizations that have endorsed or approved the treatment of gender dysphoria for minors.
One of them is the American Medical Association which, I assume, you are familiar with?
A Sure. There are about thirty, twenty-five or thirty percent of doctors who are members of that. So the vast majority of doctors are not a member.
Q Do you think that the AMA, the American Medical Association, do you think of that as a politically motivated organization?
A Yes.
Q Do you think that that is an organization that has been overtaken by group think and social contagion?
A Yes.

Page 101

Q For the American Academy of Pediatrics, are you familiar with them?
A Yes.
Q Is that an organization that you think is a political advocacy organization?
A Not entirely. It has many political advocacy positions. I think they have adopted viewpoints that are not based upon good evidence in many respects. And gender is one of them.
Q So you think that that, in that respect that is subject, it has been overtaken by group think and social contagion?
A Absolutely.
Q I am going to ask similar questions for another couple organizations.
The American Psychiatric Association, do you consider that a political advocacy organization?
A So I would not use -- I think that it's not a political advocacy organization, but they failed to carefully look at the evidence in the treatment of gender dysphoria.
And so they have been swayed by the position that the transgender activists take in that regard. I think that is a clear way of stating it. So it's not entirely a political advocacy

Page 102

group. They have been affected by these activists and their positions fail to address the science and the evidence.
Q Do you feel the same about the American Psychological Association?
A Yes.
Q Do you feel the same way about the American Academy of Family Physicians?
A Yes.
Q And in that same regard, do you consider them as having been overtaken by group think and social contagion?
A Yes.
Q So that I understand, the organization Do No Harm that you belong to, you do not think of that as a political advocacy organization?
A No. It is very difficult for people to be outspoken and take positions that are not so popular especially when there is -- I think one can be labeled a transphobe. And, you know, you can be accused and there is a tendency of threats and violence from the other side.
So I think there are complex reasons why people might take a stance in this regard. Many of these people that are thinking the same are

Page 103

coming out and saying the same viewpoint. But group think and social contagion, fear, many people are not members of these groups. They do not want to get involved.
The Endocrine Society, which you will ask me about, a lot of the endocrinologists are not members. My group, most of them don't treat gender. They don't want to treat them. That is, you know, they just are not, they don't buy into the WPATH approach.
Q I take it then that you also think that Do No Harm has not been subjected to the same kind of group think and social contagion as these other groups?
A Correct.
Q Okay.
MR. SELDIN: So I see that it's 12:01 East Coast time. I know it's bright and early in Utah.
Ms. Youngs, how do you feel about taking a break now? Do you want to take a short break and then go another hour before lunch. What would you like to do?
THE WITNESS: We can take a short break and then take another break in other hour.
(OFF RECORD AT 12:01 P.M.)

Page 104

(AT THIS TIME A SHORT RECESS WAS HELD OFF THE RECORD AFTER WHICH THE FOLLOWING PROCEEDINGS WERE HAD:)
(ON RECORD AT 12:07 P.M.)
BY MR. SELDIN:
Q Dr. Weiss, I want to talk a little bit about your time in independent practice between 2003 and when you left in 2022.
During that time about how many patients did you see per year for all conditions?
A I have to do the math on that. That's -- I don't know the answer. I had thousands and thousands of patients I was seeing over the years, of course. I would see, let's see, I would see fifteen patients a day roughly five days a week.
So that is seventy-five times probably about, including vacation, forty-five weeks. Seventy-five times forty-five.
Q I will get my calculator out. So 3,375 a year. I assume some of these were repeat customers?
A Yes.
Q You would call them something different. Patients that had continuing care with you?
A Yes.
Q So thousands, if not tens of thousands, over the

Page 105

course of your almost twenty years in Ohio?
A I was in Ohio since --
Q I asked that poorly. From 2003 to 2022 during your independent practice, you saw thousands of patients?
A Okay. To clarify, my independent practice was stopped when I was employed by Lake Health. That was the end of 2019.
Q Okay.
A So 2003 to 2019 I was independent. Then I was employed. You know, if you do multiply those years times the 3,000 you will get that. That is a lot of patients.
Q And so of that large number, about one hundred during that whole time you treated for gender dysphoria?
A Correct.
Q So a very small part of your overall practice?
A Correct.
Q And I believe in your declaration you describe yourself as the principal physician in northern Ohio offering hormonal treatment for adults with gender dysphoria, is that correct?
A Correct.
Q And that was based on those patients during that

Page 106

time?
A It was, that statement derives from not the number of patients I was treating, but that during that period of time up until 2013 the patients who came to me indicated, and the website that was available as a resource as to what physician they could go to for their gender-affirming care, as you put it, was me.
So I was the principal physician on that Be All website. Essentially that is what it was called. That website indicated that I was the doctor in northern Ohio to see for hormonal treatment.
Q That was the basis of that statement, was your inclusion and description?
A Correct.
Q Not the number you were seeing?
A Correct.
MR. SELDIN: Erica, could you pull up Exhibit 3, please.
Q Doctor, Exhibit 3 is a printout from the website called TransFamily. I know you said the website was called Be All, but does this bear any resemblance to the website?
A This is along the same lines. So the doctor there

Page 107

that is mentioned, Thomas Murphy, that was the site that, that was the other location that was doing hormonal treatment during that period of time that I was treating.
Q If you look down it says the LGBT Pride Clinic. That was the Pride Clinic that some of your patients didn't want to go to?
A Correct.
Q Why didn't they want to go there?
A I don't know the specifics. That particular patient or a couple of patients who expressed that, they didn't like the way they were treated there. I can't give you details on that.
Q For those hundred people that you treated did you treat other conditions for them other than their gender dysphoria?
A Occasionally. I might do, I might have treated on a few of them high blood pressure. Most of them they were just seeing their primary care provider for their other care.
Q When patients would come to you for treatment for their gender dysphoria, did you ask them to provide a diagnosis prior to you providing care?
A Yes.
Q What did you require?

Page 108

A A letter from a therapist.
Q Did you require the therapist to have any particular kind of background or licensure?
A Well, they had to be a licensed therapist.
Q Okay. You didn't require a psychiatrist, for example?
A No.
Q A letter from a therapist. What would you look for in that letter?
A I would look for a statement that that person met criteria for gender identity disorder, which was a DSM criterion or term at that point. And that they were an appropriate candidate for hormonal intervention.
Q You would require a letter from a therapist saying that they had been diagnosed with gender identity disorder in the DSM 4?
A Right.
Q And that they were an appropriate candidate for treatment for their gender dysphoria using hormones, correct?
A Yes.
Q Okay. And did you require anything else in the letter?
A No.

Page 109

Q Did someone ever give you a letter and you said this is not enough, I need something different?
A Some patients came without a letter. I asked them for a letter. But they would, all those patients I treated did have some confirmation by a therapist that they were appropriate candidates for treatment.
Q You stopped seeing new patients in 2013, is that correct?
You stopped seeing new patients for the treatment of gender dysphoria in 2013, is that correct?
A Correct.
Q I believe that is right when the DSM 5 came out about that time, is that your recollection?
A Yes.
Q Did you ever treat anyone who had come to you with a letter with gender dysphoria?
A Oh. Based upon the DSM 5, no.
Q Okay.
A You know, they are basically, I mean, the distinction between the two is really not a major distinction. One is they have to have dysphoria. They would like -- the goal has been to demythologize this disorder.

Page 110

So there is movement towards changing the terminology. But in gender dysphoria they have to have significant distress associated with the gender identity.

In either case, the people who would come to me wanted hormonal treatment. Whatever you called it, gender identity, gender dysphoria, they wanted hormonal treatment to modify their appearance so they would feel better.

Q Did the move from the DSM 4 to the DSM 5 have any bearing on your decision to stop seeing new patients?

A No, it did not.

Q Did you do any independent evaluation of the diagnosis for, at the time, gender identity disorder in your patients?

A Yes, I would question what their story was on their feelings about their gender. When did it start? What else was going on?

I was not treating depression, anxiety. I did not address, you know, their childhood upbringing and whether they were abused sexually and those kinds of things, you know.

My hope was that the therapist would be providing that.

Page 111

Q Did you have a particular evaluation or set of questions or was this more general patient history?

A There would be questions. I would ask about the onset of their symptoms. I would go through the whole history of when they started to reject their natal sex.

It kind of went -- it was open with no, you know, it was with open-ended questions so they can talk to me about that like a therapist might but, you know, in a forty-five minute session. I would explore again on the next visit how they were doing emotionally.

Q So someone comes to your office. They have a letter. You have an initial appointment of forty-five minutes.

At the end of that appointment would you prescribe any medical treatment or would you require them to come back?

A In most cases I would prescribe in these adults. Occasionally I would ask them to come back. One person who was eighteen who had a letter, but I was really uncomfortable, there was a lot of stuff going on with her. She was going off to college. She wanted to have -- and I would not, I would not have been able to evaluate her for quite some time after.

So I said I don't feel comfortable giving you hormones at this time. I think you need to come back. She was one I declined to prescribe. I didn't really feel that she was adequately evaluated.

Q Did that patient come back to you for treatment or did you see that patient?

A I did not see her again. That was around probably 2012, 2013.

Q So right when you were going to stop seeing new patients anyway?

A Yes.

Q And were there any other patients who you did not treat in a similar way based on your assessment?

A There were a few people that I wanted to have come back and discuss further. But most people I would initiate therapy on the first or second visit in these adults.

Q Were there any patients -- what was the youngest patient who you prescribed hormones or other medication to?

A Probably twenty-one, twenty-two.

Page 113

Q So you saw one potential patient who was eighteen and you ended up not providing treatment.

Then the next youngest patient you actually prescribed to you believe was twenty-one or twenty-two, is that accurate?

A Yes.

Q For the folks that came to you with a letter, were most of them just starting hormones or had they been getting hormones from someone else?

A Most of them had not been on any hormones at all.

Q So you would have been starting them on hormonal treatment?

A Yes.

Q Of the hundred patients that you saw, what percentage do you think you were starting new as opposed to continuing someone else's prescriptions?

A Probably ninety-five percent.

Q Typically what medications would you prescribe?

A So I would give testosterone to females. I would give spironolactone, which blocks androgen action. I would give estrogen along with that to those males, biologic males. So biologic males would get spironolactone and estrogen. It was Estradiol usually.

Page 114

And biologic females would get testosterone --
Q Did you ever refer patients for surgery?
A I had patients that had surgery. I did not direct them to a surgeon. In the patients that sought out surgeons on their own some went to Thailand. Some went to a surgeon at Metro. Some went elsewhere for surgery for mastectomy, genital reconstruction.
In terms of referring a person, directing them to a particular surgeon, patients would often seek those surgeons out on their own.
Q Did you ever write letters for them to bring to their surgeons?
A I probably did. I have been seeing this person for so long and they have been on this therapy. Yes.
Q Do you recall of the hundred patients about how many of those letters you may have written?
A Maybe five. Something like that.
Q Earlier we talked about which of your patients had had a hysterectomy or had gonads removed.
In terms of the timeline of care, do you think most, maybe ninety-five percent of the people who came to you had not been on hormones

Page 115

before, right?
A Correct.
Q So had any of your patients when they started care with you already had some kind of surgery to treat their gender dysphoria?
A No. No one.
Q Okay. They would have had those surgeries while you were treating them, right?
A Let me clarify that. There was one person who had the orchidectomy who I saw last year who had had his treatment, all of his treatment, hormonal and other stuff, before he came to me.
I saw him because the office didn't know what he was coming from. He was one who had the orchidectomy in Philadelphia after being evaluated there.
When he came to me as a new patient, he wanted testosterone. He was one of the two who had an orchidectomy that regretted it. Otherwise, no one else had had surgery before they came to me.
Q So then I guess of the ninety-nine remaining patients, how many of them during the course of your treatment of them do you think had surgery of any kind? Then we will talk about which kind.

Page 116

A Probably about maybe fifteen or so. Fifteen to twenty. Something like that.
Q Had had surgery of any kind?
A Yes.
Q Of those fifteen to twenty do you recall which surgeries they had?
A Most of them had mastectomies. Bilateral mastectomies.
Q You said most of those fifteen to twenty. Do you have an estimate of --
A So I would say -- yeah. So maybe five or so had other surgeries besides mastectomies. So general reconstruction or augmentation, mammaplasty. That kind of thing. Breast implants.
Q Did you follow any guidelines or standards of care in your practice regarding the treatment of gender dysphoria?
A During that period of time I was following Endocrine Society guidelines.
Q Do you recall which ones?
A Well, it would not have been 2017 because I stopped in 2013. So it was 2009.
Q Okay. And then did you use the WPATH guidelines at all?
A No.

Page 117

Q So we talked earlier about your fellowship with those twelve patients that you had seen with the supervising physician.
Then after that you think the next patient that you saw would have been in 2003 when you started your independent practice.
How did it come to be that you were providing treatment for gender dysphoria in 2003?
A Well, I wanted to help people. People called my office. I wanted to relieve their distress and do what is best.
I mean, the goal, the reason I went into medicine, I like to help patients. So they would call my office. And I thought -- and there was no one else treating in the area during that time or they chose not to go to Metro. There were closer to my office or they were unhappy with Cleveland Metro.
And so I said okay. I will treat you. I looked at the Endocrine Society guidelines. I did what I thought was best for them at the time.
Q In terms of how you then went from no patients to one hundred over the course of your time in independent practice, was that primarily through word of mouth and your presence on that website?

Page 118

A Yes.
Q Okay. Did you independently advertise that you provided these services? Or no?
A No.
Q What prompted you to stop seeing new patients in 2013 for the treatment of gender dysphoria?
A Well, I had a gradual realization that I was really not helping people. Yes, they had these physical changes, but they still had a lot of psychiatric stuff going on.
Lots of them had anxiety and distress and depression and sleep problems. They felt bad. They were -- I was urging them to follow up more regularly with a therapist. And there was an increasing number coming out. I should not say -- I should say calling the office to be seen.
I would give priority over the years to get those people in promptly to the practice even though there was a delay, you know, my next opening might be three months and I would try to find a spot for the people with gender dysphoria. I felt then that my other patients were suffering.
So the combination of that and what I was doing was not helpful and my other patients were losing out. I said that's okay. I'm not going to

Page 119

be seeing new people. I will take care of the patients that I have. Those other patients can go down to Metro.
Eventually other centers emerged. University Hospitals started providing care. Cleveland Clinic opened up a transgender clinic. They promote theirs. Both of them are promoting their practices.
Q So I think in your declaration you said you realized the lack of benefits and the potential harm these treatments caused, is that correct?
MS. YOUNGS: Can you point to where that is?
Q Yes.
MR. SELDIN: Erica, can you bring up Exhibit 1.
Q In Paragraph 8 you will see in the last two or three lines, "I stopped seeing new patients with gender incongruence when I realized the lack of benefit and the potential harm these treatments caused."
Did I read that correctly?
A Yes.
Q Okay. Great. And how were you measuring or observing this lack of benefit?

Page 120

A It was really just from an open dialogue discussion with the patients when they come back. How are they doing? Asking what their emotional state is. Mood. Are they feeling down or sad? Have they lost pleasure in things? You know, are they nervous or anxious a lot? How is their sleep? So on.
Q Did you encourage those folks to seek other additional medical treatment when you were here about this?
A Yes. Therapists.
Q In the same paragraph you talk about the potential harm.
What do you mean by potential harm?
A Well, I think I detail that in my declaration.
Q I mean, specifically with the adult patients that you were treating from 2003 to 2013, what potential harm were you talking about?
A Well, so given that the lack of long-term evidence of benefit, even in adults, and the potential harm with these opposite sex hormone treatments, I didn't -- and I was not apparently achieving the goal of relieving their distress, and potentially these were -- giving estrogen to a man might be harmful.

Page 121

There is thrombotic risk with it. You know, clots in the veins and arteries. What harm am I doing by giving testosterone to a female? So there were a lot of unknowns and potential harms.
Q You said potential harms. Did anything bad happen to one of your patients in that regard, or were you concerned it might in the future?
A There were some concerns with some treatment. There is some evidence that there is worsening in a condition called sleep apnea.
There was a person I was giving -- a biologic female I was giving testosterone to. That person's sleep apnea got worse. That was a potential harm. That is one that comes to mind.
The others might have been apparent with longer follow-up. Not that I saw.
Q Did you treat any patients from 2003 to 2022? Did you have any that you saw that whole time?
A With gender dysphoria?
Q Yes.
A From 2003 to 2013 was a period of ten years of when I was treating the hundred patients.
Q I'm asking you a different question. Is there any patient who you treated for gender dysphoria that you saw in the first, you know, one or two years

Page 122

of your practice who you then treated for the next twenty years?
A Oh, yes. There is one that comes to mind. There may have been others.
Q So you think you had one patient that you treated for possibly that whole range of time?
A Yes.
Q Okay.
A Probably longer actually. Maybe I treated him even before. Well, at least during that period of time.
Q Over those twenty years did you see any of these potential harms come to fruition?
A Yes. That person with the perhaps worsening sleep apnea given testosterone, yes.
Q So that sleep apnea person is the same person?
A No. That is a different person. That was not twenty years. That person I treated for probably, actually I was seeing that person even in 2022. That person, that was a follow-up person. That person I probably treated for ten years.
Q What I'm trying to get at is you had at least one patient that you saw for twenty years and other patients that you saw for ten or more.
Did you see any of these sort of long-term

Page 123

potential harms come to fruition in those patients?
MS. YOUNGS: For clarity, that's gender dysphoria?
Q Yes. Just for gender dysphoria treatment.
A I would say no.
Q You also said in Paragraph 8, the last sentence, "I also found that these persons had minimal psychological evaluation for their psychic distress."
Did I read that correctly?
A You did.
Q So when you say that do you mean -- what do you mean?
Do you mean prior to them initiating treatment with you?
A Prior and even after.
Q But at the time that you provided treatment you thought their evaluation had been sufficient for you to start them on hormones?
A That is what I thought at the time. In retrospect I would say no, that it was inaccurate.
Q Today what would you consider an appropriate psychological evaluation for an adult prior to providing treatment for gender dysphoria?

Page 124

A I would say long-term exploratory supportive psychotherapy.
Q How long-term?
A As long as necessary to really sort out and help the person with their psychic distress. It varies with the individual. No time limit.
Q I want to talk about your current role at Intermountain Health.
What do you do there?
A I'm an endocrinologist seeing adults and adolescents with endocrine, diabetes, metabolic disorders.
And because I'm board certified in internal medicine I will address internal medicine related issues outside of the purview of an endocrinologist.
Q What are those things that you see that are outside of the purview of an endocrinologist?
A It might be hypertension. It might be high blood pressure. It might be fungal infections. It might be kidney stone prevention. Things like that.
Q Is that because folks come to you for that? Or is it, hey, Doctor, I know I'm here for my diabetes, but I've also got this foot thing?

Page 125

A Yes. It's usually the latter.
Q Not to put too fine a point on it. I'm not saying that's what I say to my doctor, but it has been known to happen?
A Absolutely. No. I like to look at the whole picture. Oh, what's going on? Okay. You're having problems with hives. Has your doctor tried this? You might consider that. Here, I will send him a note.
How about your high cholesterol? Well, I know I am asked to address your thyroid, but here is a medication for your cholesterol you might try because these others didn't work.
Q You said you treat adolescents. Do you see anyone under eighteen?
A Yes.
Q What percent is your practice of people under eighteen?
A About five percent.
Q How old are they generally?
A Sixteen. Seventeen.
Q Do you see anyone fifteen or younger?
A Sure. I'm open to that. So my practice is open. I only really started seeing people February 1. So but the office knows I will see those people.

Page 126

Q Okay. So you will see -- do you see anyone who has not gone through puberty?
A Yes. In my practice in Ohio I was seeing five years Olds.
Q Okay.
A Not for gender dysphoria.
Q Okay. So in Ohio your overall practice where we talked about the several thousand patients, what percentage of that was people under eighteen?
A Less than one percent during the time I was independent and after. When I saw children it was before 2003.
Now in Utah I'm seeing children again because there is really no practitioners who are seeing minors in the area so I'm providing that care.
Q You are not a pediatric endocrinologist?
A No. I had training in pediatric endocrinology as part of my fellowship. I have knowledge in that area.
I will treat not all disorders that pediatric endocrinologists treat, but many of them for those people who I'm seeing now in Utah.
Q Would it be fair to say then that your practice includes people under eighteen largely because of an insufficient number of pediatric

Page 127

endocrinologists in the area?
A Correct.
Q Okay. So rather than them having no care they see you?
A Or they have to travel far.
Q Just to be clear, none of your patients are treating for gender dysphoria?
A Correct.
Q Do you have any patients who are transgender?
A I have a couple of questioning patients. They are non-binary or they are questioning.
Q And have they come to you for any kind of hormonal treatment for gender dysphoria?
A No.
Q How many of those patients do you think you have?
A Two.
Q Okay. Out of how many total patients?
A I have to do the math again.
Q I know you have been seeing patients since February.
A February. Yes.
Q Is it a couple hundred? Is it dozens? How many people --
A A few hundred.
Q Do you prescribe puberty blockers in your current

Page 128

role?
A No.
Q Do you prescribe testosterone or estrogen in your current role for anything?
A Testosterone, yes. Estrogen I leave to the OB/GYN doctors.
Q What do you prescribe testosterone for in your current role?
A People who have low testosterone. Men, biologic males who are low on testosterone.
Q So I understand, you provide testosterone prescriptions to patients who were assigned male at birth?
A Yes. Biologic males and they have -- their testosterone was found to be low at some point. So I am replacing their deficiency in testosterone.
Q The two non-binary or questioning patients that you have, have you told them about your perspective on the treatment of gender dysphoria?
A No. Because it was not appropriate for what I was seeing them for.
Q What were you seeing them for?
A A thyroid problem.
Q Are those adults or are they under eighteen, those

Page 129

two patients?
A I think one of them was seventeen. The other one was twenty or twenty-one.
Q Does Intermountain have a pediatric endocrinology practice?
A They do.
Q At the location where you work or is it somewhere else?
A No. Up north. It's three or four hours away.
Q So I should take a step back. Your employer Intermountain has multiple locations in Utah?
A Yes. They are in multiple states, too.
Q Which location do you work at?
A I'm in St. George, Utah. It's the southwest part of the state.
Q What is the nearest -- what is the next closest office for Intermountain?
A Gee, I don't know. I think probably in Ogden or Logan. That's something, like, four hours away.
Q All right. So Intermountain has a pediatric endocrinology practice, but it's not in st. George. It's some distance from you?
A Correct.
Q And in the pediatric endocrinology practice at Intermountain's other locations, do you know if

Page 130

they treat early onset puberty?
A Central precocious puberty, it's very likely I'm sure.
Q Delayed puberty, would they treat that?
A Very likely.
Q Turner Syndrome?
A Sure.
Q And how about growth hormone deficiency or short stature?
A Yes.
Q Would you agree that those are conditions that should be treated by a pediatric endocrinologist when available?
A Yes.
Q Dr. Weiss, this is a page from Exhibit 17. This is from Intermountain called Additional Resources.
MR. SELDIN: Erica, could you scroll down a little bit for the text.
Q Have you seen this website page before?
A I don't recall.
Q You will see -- in the Transgender Care Section do you see where I am in the middle of the page?
A Yes.
Q Do you see that it links to the UCSF Primary Care Guidelines for Transgender Individuals?

Page 131

A Yes.
Q Do you see a little bit down it links to WPATH? Do you see that?
A Yes.
Q It also links to the Endocrine Society guidelines?
A Yes.
Q As well as the Report for the U.S. Transgender Survey in 2015?
A Yes.
Q Have you spoken to your employer about their link to these resources?
A No.
Q Do you think it is a mistake they link to these resources?
A Yes.
Q Do you think it's ill advised?
A Yes.
Q If you scroll all of the way down you will see under Referrals it says, "Please direct any questions or comments to Associate Medical Director of LGBTQ Health, Matt Bryan." Then there is an email.
Do you see that?
A Yes.
Q Have you ever reached out to Matt Bryan?

Page 132

A No.
Q Have you spoken to him? Do you know who he is?
A I'm not sure whether he is -- there's a social worker who was hired to run some of their things. That may be him. I've not spoken to him. I see no reason to.
Q Do you think it would be relevant to tell him that you think it's a mistake to link to these resources?
A Absolutely not.
Q Why not?
A Because I think most people have a viewpoint that is fairly -- in this area they are not open minded. They are not interested in seeing the evidence.
They made their -- they have confirmation bias. So by confirmation bias I mean that anything that they see that challenges their strongly held belief, they are not interested in seeing or they dismiss.
And if I brought this up, they would call me transphobic. They are not interested in seeing what is best for them based upon the evidence because they made their decision. They hire people based on their viewpoint in promoting the

Page 133

WPATH approach.
All these resources are affected by activists and it's not scientifically based. It's not based upon really good evidence. It's based upon their conviction that this is the way to go.
As I have stated in my declaration, I think the evidence and the science does not support hormonal interventions for minors, nor does it support it for adults.
They give you these resources that this is the way to go.
Q Just to circle back to something we talked about earlier. Not withstanding your feelings about the evidence, you don't support banning care for gender dysphoria in adults?
A No, not at all. If adults want to do it, that is up to them. They are free to do so.
MR. SELDIN: Can you pull up Exhibit 18, please, Erica.
Q You will see this is another page from Intermountain on the telehealth services offered to LGBTQ+ Patient Care.
Do you see that?
A Yes.
Q Have you seen this page before?

Page 134

A I don't think so.
Q Okay. You will see on this page there are several sessions on various topics that are offered.
Did you attend any of these?
A No.
Q Okay. And I take it you didn't present at any of these?
A That would not be taken well if I did.
Q And I take it that is because of your position on this care?
A Because of what I previously stated, I think this is not people -- they throw out science and thinking when they have their strongly held beliefs and they fail to see the evidence that kind of challenges that belief.
Q There is an expert clinical panel listed here at the bottom. There are several various names of practitioners.
Have you spoken to any of these practitioners?
A No. This is -- the second person, Ejay Jack, he is the social worker who I think runs the transgender program. You know, I have not spoken to him.
Q You don't know any of the other providers that are

Page 135

there either?
A No.
MR. SELDIN: Can you scroll up to the top again, Erica.
Q Dr. Weiss, you will see under LGBTQ+ Patient Care a block of text. I'm going to skip straight to the acronym. It says, "LGBTQ individuals often experience disparities in health care access and outcomes due to several factors, including social issues such as bias and prejudice, marginalizing laws and policies, and a lack of LGBTQ+ friendly practices in all areas of care."
Did I read that correctly?
A Yes.
Q Do you agree with that statement?
A I think we are talking mostly about T here now. Not all of the other stuff, all of the other letters or the plus. I'm not sure what the plus is.
But I think there is truth to that statement. But I think we are focusing on transgender dysphoria issues right now.
Q You would generally agree with that statement?
A Yes.
Q You would generally agree with that statement as

Page 136

to lesbian, gay, bisexual and transgender people?
A Yes.
Q Would you consider Senate Enrolled Act 480 to be such a marginalizing law or policy?
A Not at all.
Q Why not?
A I think it's a policy that aims to protect minors from harmful interventions, such as one might have laws to protect or exclude minors from, you know, we don't let thirteen year olds drive.
We don't want them to smoke, to use tobacco. We don't want them to use alcohol. It's along the same lines, but it's protecting them.
The medical community has failed to do so and has continued to promote harmful interventions. And they are not stopping. It's just increasing for whatever reason even though in our countries they have realized these are harmful interventions. We need to hold off here. We need to stop. Let's go back. Let's see what is the best approach to treating minors with gender dysphoria.
So it's really the state trying to protect minors because these other institutions, which ought to have done that, are not. They are just

Page 137

increasing their number of children they are harming.
Q Dr. Weiss, you have referred to other countries and what they are doing.
MR. SELDIN: Erica, can you pull up Exhibit 26, please.
A Florida is not another country.
Q We will get there.
A Okay.
Q Dr. Weiss, this is an Amicus brief that Do No Harm, your organization, filed in a case called Dekker v. Weida.
Do you see the document that I'm looking at?
A I do.
Q Have you seen this brief before?
A No.
Q Did you work on this brief?
A No.
Q Were you asked about this brief?
A No.
Q And were you aware that Do No Harm filed this brief?
A No.
Q Okay.
MR. SELDIN: So Erica, if you can scroll

Page 138

to Page 4, please, Page 4 of the text.
Q Dr. Weiss, I'm in the middle of the page. You will see, "Florida is not alone."
A Yes.
Q It says, "Just last year, Sweden's public-health body barred puberty blockers for adolescents in all but 'exceptional cases' because 'the efficacy and safety, benefits and risks of treatment are not proven'."
Did I read that correctly?
A You did.
Q So in Sweden it's not that the puberty blockers are banned entirely. It's that they are restricted, is that right?
A I would like to look at the Swedish statement so that I don't quote it out of context. That is one of the references in my bibliography.
Q Do you have a reason to believe that Do No Harm would mischaracterize Sweden's approach here?
A No.
Q Okay. And so to the best of your recollection, puberty blockers are still being provided in Sweden under specific requirements, right?
A I think I would still want to look at the wording of the Swedish document.

Page 139

MS. YOUNGS: Can we pull up the originals as exhibits?
MR. SELDIN: We will do a little more on this first. I think we will probably get there.
MS. YOUNGS: Okay.
A Sweden is 102.
Q Let's look at 102 in your declaration.
MR. SELDIN: Erica, can you pull up Exhibit 1, Paragraph 102.
Q We will probably come back to this exhibit as well.
A I have it.
Q Great. Are you looking at Paragraph 132?
MS. YOUNGS: 132?
Q Dr. Weiss, where are you?
A I am sorry. I pulled up the original hard copy of the reference 102 in my declaration. I do have that.
Q Dr. Weiss, do you have other documents in front of you other than your declaration?
A I just have all my references. That's all. They are all on my declaration.
Q You have the full text of all of the items that are listed in your bibliography?
A Yes.

Page 140

MR. SELDIN: Ms. Youngs, could we get copies of all those?
MS. YOUNGS: Yes.
MR. SELDIN: The witness is relying on them in front of him in his deposition. I think we are entitled to see them.
MS. YOUNGS: Okay. I don't think he is using them right now. I think he has them printed out in a pile.
MR. SELDIN: He had them printed out and he pulled up the original.
A I have it for the paper copy because that is easier to look at that for the reference.
MR. SELDIN: We will have to take a housekeeping pause here. If the witness has hard copy documents and he is using them in the deposition I believe that we are entitled to receive them. Is that a problem?
MS. YOUNGS: It's not a problem. It will take a while.
A This is the first document I've used a hard copy with since we have spoken.
Q Do you have other hard copies on your desk?
A On my desk, but I've not referred to them at all. They are just in a pile in the corner.

Page 141

MR. SELDIN: Maybe at a break we can sort this out, Ms. Youngs. We might need copies of those.
MS. YOUNGS: I presume it's just everything that is in the bibliography.
A It is.
MR. SELDIN: I have no reason to doubt that. I think we are entitled to see them.
MS. YOUNGS: Well, I don't know that we can produce them at this moment.
MR. SELDIN: I don't need them today. I will need them eventually.
MS. YOUNGS: Okay.
MR. SELDIN: I suspect with FedEx from Utah to here we will get them next week or the doctor can scan them.
Q Let's start from the beginning. Dr. Weiss, at the beginning of your deposition I asked you what you had in front of you. You confirmed you had your declaration, which included your C.V., is that right?
A Right.
Q Okay. And you also have hard copies of the references in your bibliography on your desk, is that right?

Page 142

A Well, it is on my desk. It would be in front of me. It's there.
Q Are there any other documents related to this case that are on your desk whether you have touched them or not?
A There is this book.
Q Okay. Have you referred to that book?
A During this deposition, no.
Q Okay. All right. Anything else on your desk related to this case or this subject matter that we have not discussed?
A No.
Q Okay.
MR. SELDIN: So Ms. Youngs, I would like to request that we have the -- we don't need the book, but the title of the book, and then copies of whatever is in front of him as they sit on his desk. We don't need them today, but we will need them.
A The title of the book is in one of my references.
Q Great.
MS. YOUNGS: Okay.
MR. SELDIN: We have been going about an hour. I'm just going to finish up this line. Then we will go for lunch if that works for you?

Page 143

MS. YOUNGS: That would be great. Do you have any indication on how long we will be going today?
MR. SELDIN: I think we might go the full seven hours.
MS. YOUNGS: Okay.
MR. SELDIN: I will know more after the break for lunch. Let's finish this line real quick. Actually, you know what, now is probably a good time to break.
Does that work for you?
MS. YOUNGS: Yes.
(OFF RECORD AT 1:05 P.M.)
(AT THIS TIME A SHORT RECESS WAS HELD OFF THE RECORD AFTER WHICH THE FOLLOWING PROCEEDINGS WERE HAD:)
(ON RECORD AT 1:45 P.M.)
BY MR. SELDIN:
Q Dr. Weiss, I want to ask you about your position as a senior fellow at Do No Harm. We were talking about that a little earlier today.
Do you receive any compensation as part of being a senior fellow?
A Yes.
Q What is that compensation?

Page 144

A An hourly rate.
Q What is that hourly rate?
A I think $325.
Q What activities are you compensated for?
A For my efforts to prepare expert testimony for those legislative bodies.
Q You became a senior fellow in March 2023, this year?
A Approximately early this year.
Q So we will talk through the testimonies since then. But fair to say you believe Do No Harm would have compensated you for your time involved in some of that?
A Yes.
Q Do you receive compensation from Do No Harm for any other activities?
A No.
Q Do you know who provides the funding for Do No Harm?
A No.
Q Have you discussed this case with anyone at Do No Harm?
A No.
Q Have you discussed your declaration with anyone at Do No Harm?

Page 145

A No.
Q Is Do No Harm aware that you are an expert in this case?
A Part of my knowledge has been what has accrued over the years and more recently, which was writing testimony for my statement in Ohio and subsequently for the statements in affiliation with Do No Harm.
Q I'm sorry. I must have misspoken.
Is Do No Harm aware that the state of Indiana has employed you as an expert in this particular case?
A I do not think so.
Q All right. We talked earlier about your testimony in Ohio. That was before you became a senior fellow at Do No Harm, correct?
A Correct.
Q I think earlier you said that you testified in Utah, is that correct?
A Yes.
Q Dr. Weiss, this Exhibit 10 is the minutes of the House Health and Human Services Standing Committee. It is a long agenda for Tuesday, January 4, 2023.
Is that the date that you testified in Utah?

Page 146

A I don't remember.
Q On Page 2 you will see midway through there is an Agenda Item 3.1st Sub S.B. 16, Transgender Medical Treatments and Procedures Amendments. Do you see that, Dr. Weiss?
A I do.
Q Do you see the second name is "Dr. Daniel Weiss, M.D., Do No Harm, spoke in favor to the bill"?
A Yes.
Q Based on this agenda, is it fair to say you spoke on or about January 24.
A Yes. My recollection of when I became a senior fellow with Do No Harm was off a bit. My recollection of when I started with Do No Harm, I could not recall with certainty and it was obviously before this date of January of this year.
Q So you would think then that sometime in 2022 you became affiliated with Do No Harm?
A Must have been. Yeah.
Q And who asked you to testify at that hearing in Utah?
A I don't recall.
Q Were you compensated for your testimony at that hearing?

Page 147

A If I was with Do No Harm, yes.
Q And did you have to travel to testify at that hearing?
A No.
Q Who wrote your remarks for that hearing?
A Daniel Weiss. Me.
Q Did anyone review them other than your wife maybe for grammar?
A No.
Q And would anyone at Do No Harm ever have read them?
A Only after they were submitted.
Q I think you mentioned earlier that you testified in Montana, is that correct?
A I believe that is correct.
MR. SELDIN: Erica, could you pull up Exhibit 22.
Q These are minutes from the Montana Senate. If you will scroll down to Page 3, the third from the bottom you will see your name, Dr. Daniel Weiss, Do No Harm. Do you see that?
A Yes.
Q Would this have been the January 27, 2023 hearing that you testified at in Montana?

Page 148

A Correct.
Q Who asked you to testify at that hearing?
A Likely Do No Harm.
Q Were you compensated for your testimony at that hearing?
A Yes.
Q Did you have to travel?
A No.
Q Did you testify live or was it just written remarks?
A I don't remember.
Q Did you write your remarks?
A I did.
Q Did anyone other than your wife review them?
A No.
Q Would Do No Harm have read them before you gave them?
A No.
Q Would they have read them after?
A I'm sure after they were submitted.
Q Then we will pull up Exhibit 21. Dr. Weiss, in addition to your testimony in 2022 did you testify again this year in support of a bill to ban care?
A For minors with gender dysphoria?

Page 149

Q Yes.
A Can you clarify your question?
Q Sure. I have up here remarks that appear to be from you. We will scroll down to the end and it ends with, "Please help protect the children of Ohio" on Page 4 of the PDF. You will see right above your signature, Dr. Weiss, it says "Please protect the children of Ohio" and your name and the date.
A Yes.
Q Was this written testimony in support of House Bill 68 in Ohio?
A I don't recall the number of the House bill. There was the Safe Act Save Adolescents from Experimentation Act this year. I submitted written testimony in support of that.
Q Did you testify live or provide oral remarks?
A No. It was only written testimony.
Q Were you compensated for providing that written testimony?
A I don't recall.
Q If you had been, would anyone other than Do No Harm have compensated you?
A No.
Q Then did you write these remarks yourself?

Page 150

A I did.
Q Would anyone have reviewed them other than your wife?
A No.
MR. SELDIN: Erica, take us to Exhibit 24, please.
Q Do you recognize this document?
A Yes.
Q Is this your testimony in North Dakota in support of House Bill 1254?
A Yes.
Q Do you recall whether you provided these remarks live or just submitted them in written form?
A I believe it was just submitted in written form.
MR. SELDIN: Erica, could you pull up Exhibit 25, please.
Q Dr. Weiss, on Page 6 of this document all of the way at the bottom you will see there is a line that says 3/28, 11:30 a.m. and then Daniel Weiss.
A It must have been live.
Q Okay. I will represent the link is to your written testimony. I was not sure if you testified or not.
A I don't remember. To my surprise, if you have a video then it was live.

Page 151

Q This was not a gotcha. I was really asking for the answer on this one. It was not a trap.
You provided testimony in support of this bill in North Dakota, right?
A Yes.
Q And were you compensated for providing this testimony?
A I believe so, yes.
Q Would that have been by Do No Harm?
A Yes.
Q And then, again, did you write these remarks?
A I did.
Q Yourself?
A Yes.
Q Okay. I believe that we have talked about your testimony in Ohio twice.
Dr. Weiss, when I say testimony, I mean live or written remarks. You have provided testimony in some form in support of bills that would ban the treatment of gender dysphoria in minors in Ohio, Utah, North Dakota, Montana, and earlier we spoke about your letter to the Florida Board of Medicine.
Does that all sound correct to you?
A That treatment we are talking about is -- sorry.

Page 152

I think Ms. Youngs is trying to jump in.
MS. YOUNGS: Dr. Weiss was just trying to clarify that by treatment you mean certain, what procedure -- can you say what you mean? Dr. Weiss is not against treatment.
Q For all of these bills, Dr. Weiss, that we have been talking about, these are all bills that would ban medical care that treated gender dysphoria in minors. Is that your understanding as well?
A These bills would ban interventions that were medications, hormonal interventions and surgery as proposed treatment for gender dysphoria.
Not any treatment. Not medical care. But only treatment that was intended to improve the dysphoria and that treatment that would be banned would be hormonal interventions and surgery.
Q In the states in which you provided such testimony were Ohio, Utah, North Dakota and Montana, is that correct?
A Sounds correct.
Q You also submitted the letter we spoke about to the Florida Board of Medicine, is that correct?
A That was correct. That was an email.
Q Right. And earlier when we were chatting I think you had mentioned that you thought you had

Page 153

testified in Indiana and Wyoming.
Did you testify in those places?
A I believe so.
Q Okay. Do you recall anything about your testimony in Wyoming?
A Just it was similar written testimony. I think that was live in Wyoming. I'm pretty sure it was live. I'm pretty sure.
Q Do you recall when?
A Sometime this year. This spring.
Q Did Do No Harm compensate you for that testimony?
A I believe so.
Q Did you testify in support of Senate Enrolled Act 480 in Indiana?
A There was a bill in Indiana that I did support. I submitted written testimony. It was not in person. I don't remember the bill number. It had to do with gender dysphoria care in minors.
Q Do you recall when that was?
A I think it was sometime this spring.
Q You don't think it was Senate Enrolled Act 480?
A I don't know. I don't recall.
Q Are there any other states where you provided testimony on this or a similar topic that we have not talked about?

Page 154

A Not that I recall.
Q Dr. Weiss, do you keep a running list anywhere of the places in which you have provided this kind of testimony?
A Yeah. I have a list of folders that have testimony that I submitted. I have one for the different states.
Q That would be the list that you would refer to in trying to determine where all you have testified?
A That would be the closest to a list, correct.
Q Roughly do you know how much in total Do No Harm has compensated you for all of your legislative testimony?
A Maybe about $8,000.
Q Earlier we talked about why you don't include Do No Harm on your C.V. as one of your affiliations.
I'm curious why you don't include any of your legislative testimony on there either?
MS. YOUNGS: Can you clarify? Don't include what where?
A I don't understand.
Q The legislative testimony that we just spoke about, that does not appear on your C.V., is that

Page 155

correct?
A Correct. I don't see any reason to mention that on a C.V.
MR. SELDIN: Erica, could you pull up Exhibit 26.
Q We will look at Page 2 of the document or Page 8 of the PDF. If you go to 8 of 25, that is where it is.
Dr. Weiss, do you see that?
A Yes.
Q Do you see where I am at the top? I will just read this.
"Amicus Do No Harm is a diverse group of physicians, health care professionals, medical students, patients, and policymakers whose goal is to protect health care from a radical, divisive, and discriminatory ideology."
A Yes.
Q Did I read it correctly?
A Yes.
Q And what is that ideology, do you know?
A Well, I would consult the Do No Harm website in that regard. My focus is on gender dysphoria.
MR. SELDIN: Erica, could you please pull up Exhibit 28.

Page 156

Q This is from the Do No Harm website. It says, "Protecting Minors from Gender Ideology."
Is that the ideology that you believe is being referenced there?
A Yes.
MR. SELDIN: Erica, can you please pull up Exhibit 27.
Q Dr. Weiss, these are the FAQs from Do No Harm's website. You will see that the first two are "What is Critical Race Theory?" and "What is anti-racism?"
Do you see those two?
A Yes.
Q Do you do any work for Do No Harm regarding critical race theory and anti-racism?
A No.
Q So your sole focus in your work with Do No Harm is gender ideology?
A Yes.
Q Are you on social media?
A No.
Q No Twitter? No Facebook?
A None at all. In fact, I eliminated a Facebook account about a decade ago. Never used Twitter. They are dangerous.

Page 157

Q Have you given any media interviews of any kind regarding your work with Do No Harm?
A No.
Q Have you spoken at any conferences?
A No. On this topic?
Q On this topic?
A No.
MR. SELDIN: Erica, can you pull up Exhibit 1.
Q I'm going to look at Paragraph 6 of your declaration on Page 2.
Let me know if you can see that?
A Yes.
Q Do you see you say, "I have been a member of the Endocrine Society since 1990 but I canceled my membership in 2022 after the repeated failure to respond to my concerns about its promotion of hormonal interventions in children with possible gender-related distress."
Did I read that correctly?
A Yes.
Q When you say "repeated failure to respond to my concerns," how did you indicate your concerns to the Endocrine Society?
A Emails.

Page 158

Q About how many emails did you send?
A Four.
Q Do you remember to whom you sent them?
A I sent them to the president of the Endocrine Society, a couple of committee people, and someone else that I don't remember.
Q Did you do that in your personal capacity or as part of your membership in Do No Harm?
A This was well before Do No Harm. It was in my personal capacity.
Q When about do you think you sent these emails?
A Well, probably early 2022.
Q Did you ever hear back?
A No.
Q The substance of these emails, would they have been similar to your legislative testimony?
A It was really more brief and focused on my concerns about their promoting this practice with little evidence.
It was not as extensive with references. I also directed it to a person who was in a fellowship with me, a year behind me at the University of Iowa so I knew her. I still know her. And there was no response.
Q Do you still use the Endocrine Society Clinical

Page 159

Practice Guidelines in your practice?
A On what particular disorder?
Q Any disorder?
A Some of them.
Q Okay.
MR. SELDIN: Erica, could you pull up Exhibit 12.
Q Dr. Weiss, what I'm about to show you is from the Endocrine Society website. It's a list of their clinic guides by topic area. I'm going to ask you for these topics that are listed, whether you practice in this space and whether you use any guidelines.
So going from the top, do you treat adrenal conditions?
A Yes.
Q Do you use the Endocrine Society guidelines to treat those?
A Some of them.
Q How about for hypoglycemia?
A Yes.
Q Do you treat that condition?
A Yes.
Q Do you use the Endocrine Society guidelines for those conditions?

Page 160

A Yes.
Q Okay. Then just looking through the rest of this, you will see there are several other conditions listed.
How about for bone health and osteoporosis?
A I treat that.
Q Do you use these guidelines?
A Some of them.
Q And then for male reproductive endocrinology?
A Yes.
Q Are you a reproductive endocrinologist?
A No.
Q How about for diabetes, mellitus and glucose metabolism, do you use the guidelines?
A I don't know what they are. I don't tend to refer to them because I'm an expert. They are probably outdated by the time they are written. I see so much diabetes and I'm very current on the literature on that.
I treat many people with diabetes. I don't care about the Endocrine Society guidelines for that.
MR. SELDIN: Erica, could you pull up Exhibit 31?
Q Dr. Weiss, this is clinical guidelines from the

Page 161

Endocrine Society on the Management of Individuals With Diabetes at High Risk for Hypoglycemia: An Endocrine Society Clinical Practice Guideline.
Do you see what I'm referring to?
A Yes.
Q Is this a clinical practice guideline that you have used?
A I don't refer to it because I'm so knowledgeable in this area. By the time it's written -- it was published in 2022. We have actually enhanced knowledge from that time.
So it's, these are often outdated by the time they were written. These are usually fairly well evidence based when they do come out. They get outdated shortly thereafter.
But I follow, when I do check these guidelines I'm doing -- my care is consistent with them.
Q And so we will scroll down to the section that says Methods on Page 1.
Do you see where I am, Methods?
A Yes.
Q You will see it says, "Methods. A multidisciplinary panel of clinician experts, together with a patient representative, and

Page 162

methodologists with expertise in evidence synthesis and guideline development, identified and prioritized 10 clinical questions related to hypoglycemia in people living with diabetes."
Do you see that?
A Yes.
Q Do you think a multidisciplinary panel with a patient representative is a good way to develop a guideline?
A Those are a couple of elements. There's much more than that though.
Q Then at the bottom of Methods it says, "The Grading of Recommendations Assessment, Development and Evaluation (GRADE) methodology was used to assess the certainty of evidence and make recommendations."
Do you see that?
A I do.
Q Do you agree with the use of GRADE?
A Yes.
MR. SELDIN: Take us to Page 9, please.
Q Dr. Weiss, Recommendation 1, do you see where I am?
A I do.
Q It says, "We recommend continuos glucose

Page 163

monitoring (CGM) rather than self-monitoring of blood (SMBG) glucose by fingerstick for patients with type I diabetes receiving multiple daily injections (MDIs)."
Do you see that?
A I do.
Q Do you agree with that recommendation?
A Yes.
Q Is that something that you use in your practice?
A Absolutely.
MR. SELDIN: Erica, can you take us to Page 11.
Q You will see where it says Justification For The Recommendation.
Do you see that?
A Yes.
Q It says there, "The panel justified a strong recommendation despite the low quality of evidence, based on recognition that iatrogenic hypoglycemia is the limiting factor in the glycemic managment of diabetes and is a major concern for individuals with diabetes and for their family members."
Do you see that?
A I do.

Page 164

Q You see that they use low quality of evidence here.
Does that give you any concern about this particular guideline?
A No. Because I think it's true. No concern.
MR. SELDIN: Erica, can you take us back to Page 2.
Q At the top of Page 2, Dr. Weiss, it says Conclusion and there it says -- do you see where I am?
A Yes.
Q Then it says, "The recommendations are based on the consideration of critical outcomes as well as implementation factors such as feasibility and values and preferences of people with diabetes."
Did I read that correctly?
A Yes.
Q Do you generally agree with that statement?
A Yes.
MR. SELDIN: Erica, can you take us back to Exhibit 1?
Q I'm going to Paragraph 9 of your declaration. That is on Page 2.
You say at the end, "Unlike most pediatricians, my care and follow up of patients

Page 165

does not stop when the person turns 18."
Do you see where you said that?
A Yes.
Q I take it that is because you generally treat patients that are over eighteen so they don't age out of your practice, right?
A Pediatricians stop care for people when they are eighteen. For example, people with Type I diabetes who might have hypoglycemia related to that guideline, the pediatrician stops seeing them when they are eighteen and they turn them over to me.
Q Do you know pediatricians who will see patients after they turn eighteen?
A Very few.
Q Generally or in pediatric endocrinology?
A Both. There are a few disorders where they might see them beyond eighteen like cystic fibrosis. Like most disorders, chronic conditions, they turn them over to a person who is board certified in internal medicine.
And in the case of endocrine disorders, an endocrinologist.
Q And that is because pediatric medicine is different from adult medicine, right?

Page 166

A I think it's, a lot of it is tradition. I think there are a number of reasons.
Q Well, they are different specialities, though, right?
A They are.
Q So there are differences in how to treat pediatric patients versus adult patients?
A True.
Q And how do you know that most pediatricians stop care at eighteen?
A Thirty-six years of practice.
Q Then, Dr. Weiss, in Paragraph 10 of your declaration you say that you have training in diagnosis and treating patients with some mental health disorders including depression.
Do you see that?
A Yes.
Q What training have you received in diagnosing and treating patients with some mental health disorders?
A Some of it is from during residency in internal medicine. Some of it is from reading. Some of it is from online conferences. Some of it is from in-person conferences.
Q And depression is a DSM 5 diagnosis, is that

Page 167

right?
A Yes.
Q Is that a diagnosis that you make in your practice?
A Yes. Depression is common with diabetes, for example.
Q Why is that?
A It's not known.
Q Do you have a theory?
A No.
Q So endocrinologists can sometimes be qualified to make a mental health diagnosis then?
A Absolutely.
Q So not just psychiatrists can make these kind of diagnoses, but other clinicians can?
A Most people who treat depression are primary care people.
Q Have you ever received any training in diagnosing gender dysphoria using the DSM 5?
A The DSM 5 came out in 2013 and that's when I stopped treating.
Q So you would not have received training in specifically how to use those criteria to diagnose?
A It does not take a lot of training. That is why

Page 168

WPATH recommends that primary care people do it. WPATH even excludes, does not, it states that you don't even need dysphoria now.
Q Dr. Weiss, in Paragraph 17 of your declaration you say, "Any well-trained" -- let me know when you are there.
A I am.
Q You say, "Any well-trained practicing physician must be able to analyze evidence with a careful reading of published literature. Doctors who are unable to do so cannot provide good care for their patients."
Did I read that correctly?
A You did.
Q What is a well-trained practicing physician?
A That is a good question. One of the criterion are to be able to analyze evidence with a careful reading of the published literature.
And many physicians don't have that. They just look at guidelines. They say okay. They don't critically think about it. They don't look and do literature searches. They don't analyze the methodology of studies.
They say I will follow the guidelines. That is why there are now more and more physician

Page 169

assistants and nurse practitioners doing care. They can just simply follow the guidelines without much thought or critical analysis.
Q Do you consider yourself to have expertise above that of a well-trained practicing physician?
A It depends on the area you are referring to.
Q With respect to the treatment of gender dysphoria in minors?
A Yes, I do think I am more knowledgeable in that area. Most physicians have actually not, have studied the literature in this regard. They are not knowledgeable and they are not interested in treating.
Q So you believe that your expertise in that regard comes from your ability to read the studies that are used behind the guidelines, is that accurate?
A That is part of it, yes.
Q Dr. Weiss, go to Paragraph 21 of your declaration on Page 4.
You say, "While hormonal and surgical procedures may enable some individuals to appear to others as the opposite sex during some of their lives, no procedures can enable an individual to perform the reproductive role of the opposite sex."

Page 170

Did I read that correctly?
A Yes.
Q So if someone cannot perform the reproductive role of being male you would consider them not to be male?
A There might be exceptions with intrasex -- disorders of sexual differentiation, which are exceedingly rare.
Q But you believe there could be some males who cannot perform their reproductive role because of an intrasex condition, but are nonetheless male?
A Right. If someone was born without testes, but is XY and otherwise a male, he is still a male, but he is born without testes.
There are women that are born without uteruses. They have disorders where that is how they are born.
So those are really rare exceptions and that would be a person that would still be that same biologic sex. Otherwise, no. I'm not talking about these people here though.
Q Would you consider chromosomes to be definitive in determining sex?
A Examine the external genitalia. And then if there is a question, chromosomes.

Page 171

Q So you agree that a visual inspection of an infant's external genitalia does not provide information about the reproductive capacity as an adult, right?
A It does in almost all instances. There are very few instances in which it does not. So we don't have to assign sex at birth. You examine the child and you can determine what their sex is in all likelihood.
Unless they have some unusual disorder, they will be -- they might be infertile. Yes, there are some infertile people, but otherwise they would have the potential for reproductive capacity. But that is not all it is.
I think you are kind of changing the wording of this because we are changing the topic because what I have said here was that those changes, those hormonal changes to a person with gender dysphoria do not enable them to have reproductive capacity.
And now you are asking what is a boy or a girl? What is a male or female? That is a different question.
Q And so using your definition of men and women or boys and girls, you believe that there are some

Page 172

men who are born infertile, but are nonetheless still men, right?
A Correct.
Q There are some women who are born infertile, but are nonetheless still women, correct?
A Correct.
Q In Paragraph 24 you have a quote from Dr. Levine about twelve year olds. Then you make some reference to the plaintiffs in this age when they were four.
My question is just, have you ever done a biopsychosocial assessment of a child of any age?
A No.
Q So for that statement about four year olds and twelve year olds are you just relying on your common sense there?
A Common sense and being a father.
Q Then in Paragraph 25 you say, in the second sentence you are talking about adolescents. You say, "One series of 1,655 youth, mean age of 15.7 years, reported that 55% had friends who also 'came out' as transgender around the same time."
Do you see that?
A Yes.
Q As a general matter does it surprise you that

Page 173

adolescents would go online and find people with whom they had common traits or interests?
A This is not speaking to that. It's not that they, they said they were gender dysphoric or transgender and then they found the people.
It's that they found these people online and then they came out. Or they found these, they had these friends and they all came out and said that they were transgender at the same time.
That should raise concerns that that might be some element of social contagion or peer influence.
Q So imagine an adolescent who has never been on the internet. They have parents that keep them away from screens entirely. They come to believe or realize that they are transgender. would it surprise you when they went online and they would look for other people who were transgender?
A That would not surprise me at all. But there are no adolescents that don't go online.
Q Dr. Weiss, in Paragraph 26 of your declaration in the third sentence, second line, you say, "There are no standards of care accepted by most practitioners, either internationally or within the United States."

Page 174

Do you see where you said that?
A I do.
Q What do you mean when you say "most 'practitioners"?
A That is what I said. Most practitioners.
Q How do you know that most practitioners don't accept those guidelines?
A During my thirty-five years of experience of teaching many of those in the health care field and interacting with hundreds and hundreds of physicians, I know that most are not supportive of the so-called WPATH or Endocrine Society guidelines. And for that reason they chose not to treat.
From seeing the statements and evaluation by other countries they don't endorse the treatment that we are doing in the U.S. These other countries have had many years of experience above and beyond the United States.
So it's not, it's kind of -- it is a fiction that it's some kind of universal, you know, or that it's endorsed around the world, this particular approach to care. There's a lot of disagreement.
Q You believe that based on your conversations over

Page 175

your career with folks about this topic that you have accurately ascertained that most of them do not agree, not withstanding what the major medical associations have said?
A Some of those organizations have made those statements and many physicians are not members of those organizations.
And it's not just my conversations with physicians. It is also what is seen and what other countries have concluded, as we will talk about I'm sure.
Q Then, Dr. Weiss, in Paragraph 26 you say, "The goal of treating children with gender dysphoria is to resolve their gender related distress."
Do you see that, the first sentence of Paragraph 26?
A Yes.
Q When you say that, do you mean pre-puberty children?
A All children.
Q How are you defining children?
A Anyone under eighteen.
Q So you mean both children who have not hit puberty and children who have hit puberty?
A Correct.

Page 176

Q What is that statement based on?
A Well, it would be based upon the approach of most physicians including Dr. Shumer and Dr. DeVries and Dr. Cohen-Kettenis, the people who started the Dutch protocol, and other treating physicians.
The goal is not to modify the appearance of the body. The goal is to relieve the psychic distress related to the gender incongruence. That is what they say. That is what -- the Dutch protocol initially started with that goal in mind.
Q So when you say that the goal is of relieving, resolving gender related distress, you are referring to resolution through non-hormonal interventions?
A No. That should be the goal. That should be the goal of all treatments. The goal, the reason that hormonal treatments have been implemented is not because they want to create these people who are looking like the opposite sex, but really to help the child's psychic distress.
That is the initial reason for the whole Dutch protocol. That is the basis -- that is the best evidence that the Endocrine Society invoked for the management of children and adolescents

Page 177

with gender dysphoria, is the Dutch protocol.
The Dutch said the reason to treat these children and to treat early is to relieve their gender related distress.
Q You believe that relief should not come in the form of bodily changes?
A That is correct, because it does not work.
Q In paragraph, that same Paragraph 26, you say at the very end, "Psychotherapy can be very beneficial in patients with gender dysphoria and lead to their desistance."
Do you see where you said that?
A I do.
Q Based on your prior statement do you mean patients of all ages?
A Yes.
Q What is desistance?
A Desistance would be, could be defined -- people define it differently.
I would define it as no longer rejecting your natal sex.
Q Is that a term that you would use for both children who have not hit puberty and also adolescents?
A Yes.

Page 178

Q Okay. Is detransition a term that you are familiar with?
A Yes.
Q What does that term mean to you?
A That term relates to those who took therapies, hormonal therapies, blockers, or opposite sex hormonal therapies, to appear as the opposite sex and after a period of time decide -- or maybe even surgery, underwent surgery -- then changed their mind and wanted to return to their natal sex.
Q What is the difference then between desistance and detransition?
A Desistance is just discontinuing the efforts to appear as the opposite sex. Detransition is already, those children or adolescents or adults who made the change to the opposite sex, the change in the appearance, took those therapies or interventions and now they want to return to their natal sex.
Q So when you say desistance, do you mean the resolution of gender dysphoria, or an identification to the sex assigned at birth?
A It would be the identification with the sex assigned at birth. What their psychic state is, that does not speak to that other than they are

Page 179

returning to their, accepting their natal sex.
They might have depression, anxiety, who knows.
Q So in your mind, desistence then is the resolution of gender dysphoria by identification with the sex assigned at birth, is that what you mean by desistence?
A There is more work that needs to be done in this area to study this. Unfortunately, little has been done.
Desistence would be defined as no longer having dysphoria related to your gender.
Q Okay. And is that different from identifying with your sex assigned at birth?
A No, I would say it was the same. You are now returning and identifying with your natal sex.
Q If a patient is receiving psychotherapy but continues to have severe gender dysphoria, do you think medical intervention is ever appropriate?
A No. By medical intervention you are talking about to change the appearance of the child and giving them opposite sex hormones? Is that what you are referring to?
Q We have been talking about treatment with hormones --

Page 180

A I think it's never appropriate.
Q Is that true, it's never appropriate for a person of any age?
A We are talking about children and adolescents right now. I don't think it is appropriate for any age because I don't think any evidence supports those hormonal interventions as being beneficial.
Q So, Dr. Weiss, say that you have a patient who has gender dysphoria and receives the interventions that we have been talking about to treat that in the form of hormones and that fully resolves their gender dysphoria.
They are back to zero gender dysphoria. Would you consider that a successful outcome?
A I think that hypothetical case is merely hypothetical. It just does not happen. You are implying causation from the intervention. I think there is no convincing evidence that those hormonal interventions are the key to, or are causal in improving any gender dysphoria.
I think it is very unclear and it actually may worsen it. And, remember, so are you going to -- are you telling me that that child has no psychotherapeutic intervention during that period

Page 181

of time?
You are just applying hormonal intervention and then they get better? I think that is very interesting. I've not seen any reports of that. And I don't think that exists. I would wonder whether the child would have desisted otherwise without your harmful interventions.
Q So let's say you have two patients. One who receives both psychotherapy and the medical interventions that we have been talking about in the form of hormones. That completely resolves their gender dysphoria.
Then you have another patient who only receives psychotherapy and their gender dysphoria resolves because they desist and begin to identify with their sex assigned at birth.
Do you think one outcome is better than the other?
A Yeah. I think the intervention that is least invasive, least potentially harmful is always the best intervention.
So not giving hormonal treatments to these children with normal bodies that might lead to irreversible effects is always best to minimize harm. The harm is minimized if it's just a

Page 182

supportive psychotherapeutic intervention.
Q So you think that desistance is the better outcome?
A Oh, sure. Because that means the child is no longer dysphoric and that is the goal. The goal is not to modify their body. We want to help them so they are no longer in distress.
So the goal should be relieving their distress with the least harmful intervention.
Q Is there any point at which you would agree that medical intervention would be warranted?
A For?
Q Well, for an adolescent. Let's say we have an adolescent who has been in therapy since they were three and their gender dysphoria has not improved. It's now thirteen years later. They are sixteen.
Do you think that that person is a candidate for hormonal treatment?
A If that hormonal treatment is intended to improve their gender dysphoria, absolutely not. It would likely worsen.
That child has been gender dysphoric since the age of three. What else is going on with that child? Do they have autism spectrum disorder? Are they feeling -- do they have a family

Page 183

environment that is really in chaos?
There are other things going on. Hormones will not help that child with gender dysphoria.
Q Let's say you have someone who is forty years old. They have been in some kind of psychotherapy for twelve years for their gender dysphoria. It has not abated.
Do you think that person at forty or -- I can't do math -- let's say they are thirty. So it's eighteen plus twenty-two. Do you think that person is a good candidate for a medical intervention like hormones?
A I don't think any person is a good candidate. And if they had not improved with psychotherapy, maybe they need to find a different therapist.
You know, there are good mechanics and bad mechanics. The same thing with therapists. There are different therapeutic approaches, you know. And some people have serious psychiatric problems that may not be remedied with therapy.
But you can make them much worse if you start giving them hormones that are not going to help them. There may be doctors who will be willing to treat that person, that adult, but it would not be me because I don't want to hurt them.

Page 184

Q In Paragraph 27 of your declaration you say in the second sentence, "But Clinicians who without question 'affirm' the child's self-diagnosis will fail to address psychiatric co-morbidities that may underlie the rejection of their sex."
Do you see where you say that?
A Yes.
Q Do you have any examples of a clinician failing to use the DSM 5 criteria to diagnose gender dysphoria?
A How is that related to that statement? I don't know why you are asking me that in reference to this statement.
Q Regardless of that statement, do you have an example of that?
MS. YOUNGS: Does he have an example of? State that again.
Q I'm asking, Dr. Weiss, do you have an example of a clinician who failed to use the DSM 5 criteria to diagnose gender dysphoria in a minor?
A Let me give that some thought. No.
Q Do you have an example where a clinician declined to treat a co-morbidity once they found a gender dysphoria diagnosis?
A I think there are examples in these plaintiffs,

Page 185

yes.
Q Other than the plaintiffs, do you have an example?
A Yes. The patients I was seeing, I think some of those adults had co-morbidities that I was not treating. I was giving them these opposite sex hormonal interventions that were not helpful. They needed really primarily psychotherapy. I would say also if you read Jamie Reed's affidavit from the Washington University Gender Center it seemed to be the pattern, the consistent pattern that they ignored all other co-morbidities and just focused on gender.
Q Let's go to Paragraph 28 of your declaration.
MR. SELDIN: Ms. Youngs, I know we talked about this earlier, but I want to confirm about designating the portions of the deposition pertaining to the plaintiffs' medical records, we will treat those as confidential?
MS. YOUNGS: Yes.
Q So in that respect, Dr. Weiss, in Paragraph 28 you said that, "I reviewed the records of A.M., K.C. and M.W., all plaintiffs in this case. All had multiple serious psychiatric co-morbidities including anxiety, depression, and self-harm behavior. The health care providers did not

Page 186

address these problems. All care has been focused on gender affirmation."
Do you see that?
A Yes.
Q What do you mean by gender affirmation here?
A Hormonal interventions, either puberty blockers or opposite sex hormones.
Q What do you base that definition on?
A So-called gender-affirming care is hormone interventions, either blockers or opposite sex hormones. Some people call them cross hormones.
Then surgery after that as so-called gender-affirming care or gender affirmation.
Q So I'm showing you a document, Exhibit 13, with the caption to this case. It says Plaintiff's Responses and Objections to Defendant's First Requests for Production to Plaintiffs.
Do you see that?
A Yes.
Q Have you seen this document before?
A I don't remember. Scroll further. That looks familiar. That came along with the records. Right? Is that correct that it came with the records?
Q I will represent this was a document provided by

Page 187

plaintiff's counsel to counsel for Indiana in connection with the discovery in this case. I don't want to hear what your counsel gave you. We will represent that is what the document is.
A Understood. I believe I saw this, yes.
Q Okay. I will head that problem off at the pass. You believe you may have reviewed this document in connection with that?
A Yes.
Q On Page 5, Dr. Weiss, do you see there is Request 1 and the response. At the end it says, "Moreover, this request is vague, overbroad, and unduly burdensome to the extent it requests records for 'a related condition' because there are no conditions inherently related to gender dysphoria."
Do you see that?
A No. I don't see it yet. Where?
Q So do you see Request Number 1?
A Yes.
Q Then you see Response?
MS. YOUNGS: Can you zoom in? Do you see it?
A Okay.
Q That is four lines down.

Page 188

A Yes.
Q So you see where it says, "Moreover, this request is vague, overboard, and unduly burdensome to the extent it requests records for 'a related condition' because there are no conditions inherently related to gender dysphoria."
Did I read that correctly?
A Yes.
Q Would it surprise you to learn that the medical records that have been produced in this case all pertain to the treatment of gender dysphoria?
A I think that statement that there are no conditions inherently related to gender dysphoria is ridiculous. It's absurd.
The whole patient psychiatric psychosocial status is related to gender dysphoria. Their family situation. Whether they were sexually abused. That is related to gender dysphoria. Whether they are physically abused. Were they bullied. All those.
So there are no conditions related to gender dysphoria, that is a ridiculous remark. It's antithetical to any psychological care that that person might require.
Q Earlier we were talking about diabetes. You said

Page 189

a lot of your patients with diabetes also have depression, correct?
A Yes.
Q Do you consider depression and diabetes to be related conditions?
A There is more depression in people with diabetes and that is perhaps in part because of the burden of the diabetes care. But that is just an association.
Q Other than that case, have you ever evaluated the medical records of a minor?
A Yes.
Q When?
A Over my thirty-five years of practice I have. I took care of children down to the age of five.
Q We talked about you thought that was less than one percent of your practice overall, correct?
A Maybe a little more earlier then and then it became less later. Yes.
Q You have interacted with the records of your minor patients, correct?
A What is the question?
Q I'm asking, we are talking about when you treated minor patients as a small part of your practice you interacted with their medical records as their

Page 190

physician?
A Yes. I also would have reviewed previous records when I was assuming care for that child.
Q How long did your review of the medical records take in this case?
A I don't remember. Hours.
Q Can you estimate approximately how many hours you spent reviewing the medical records in this case?
A The medical records of the four plaintiffs, maybe five hours.
Q Who did you discuss your review with, if anyone?
A I just reviewed them on my own.
Q Did you discuss, this is a yes or no question, did you discuss your review with the attorneys for the state of Indiana?
A Yes.
Q Did you discuss your review of the medical records with any other physician?
A No.
Q Did you discuss them with your wife?
A No.
Q Then I assume I know the answer to this, have you shared those medical records with anyone else?
A Absolutely not.
Q In Paragraph 29 you say one of the plaintiffs had

Page 191

been abused and that "Puberty blockers are not a treatment for post-traumatic stress disorder."
Do you see that?
A Yes.
Q Do you recall a physician prescribing blockers to treat PTSD in that plaintiff's medical records?
A I recall puberty blockers being prescribed. The prescription was for gender dysphoria, but the gender dysphoria diagnosis was made in the context of major psychosocial factors that ought to have been addressed.
And per the Dutch protocol guidelines or the Endocrine Society guidelines, those should have been addressed. Failing to address those is not optimal care if you just jump to treating and introducing a new problem like treating with puberty blockers.
Q In Paragraph 30 you are talking about a different plaintiff here.
You say that another child was socially transitioned at age four by the parents, both of whom are biologic males and one who identifies as transgender.
Do you see that?
A Yes.

Page 192

Q What was your basis for saying that that plaintiff's parents are biological males, one of whom identifies as transgender?
A It was in the records.
MR. SELDIN: Erica, can you pull up Exhibit 19.
Ms. Youngs, this is a medical record. Again, we will talk about how to designate this as confidential. I took the one page as opposed to a whole set so we don't have a larger number of documents to deal with.
MS. YOUNGS: Okay.
MR. SELDIN: Can you scroll down to the bottom of this document, please. It is IUH821. I didn't think it was necessary or appropriate to bring in the entire medical record from IU Health given what we are dealing with.
MS. YOUNGS: We will reserve the ability to object if there is more information that we need to review to answer the question.
MR. SELDIN: Of course.
Q So, Dr. Weiss, I want to direct you to the bottom. Or rather I'm sorry. Scroll up. You will see at the top right there is a name which I will not say so we don't have to redact it from the record from

Page 193

the persons whose medical record this is.
The first initial is K and the last is a C.
Do you see that?
A Yes.
Q That is the K.C. you are referring to in Paragraph 30?
A Yes.
Q We will scroll down to the bottom. Dr. Weiss, in the bottom left do you see under Social History where I am?
A Yes.
Q Then Home/Environment. Lives with parents. And I will skip the names and ages of the siblings. It says, "Mom had menarche at 11 and Dad was shaving in the sixth grade."
Do you see that?
A I do.
Q Is that consistent with your statement that both K.C.'s parents are biologic males?
A That is not consistent. There is elsewhere in the record that I derived that statement from.
Q Do you recall where in the record?
A No. Also, I believe this was K.C. who there was a restraining order from the biologic father to stay -- I believe that is correct -- to stay away

Page 194

from the -- I believe I'm not confusing. No. No. That is A.M. I'm sorry.

With K.C. there is somewhere in the record where that was apparent about a transgender parent. I don't recall.

Q If it's not K.C.'s parents would you need to revise your declaration?

A It's possible I am mistaken with regard to that. That is what I saw, that there was a parent who identified as transgender and was a biologic male.

Q And why was the sex of the parents notable to you?

A How they identify is notable because I would be curious as to whether there was pressure on the child from the age of four to socially transition.

That is unusual. So that ought to have been explored by any biopsychosocial evaluation in this child who has multiple medical problems.

Q In Paragraph 31 of your declaration you say, "The mother of M.W. questioned the rapid onset of gender dysphoria in her," you use the term "daughter."

You said, "However, after a telephone call with a health care provider, she no longer expressed concern, though the file does not explain."

Page 195

Do you see that?

A Yes.

Q Why was it notable to you that the clinicians addressed the mother's concerns?

A That is not what was notable. What was notable was the mother had those concerns. What happened to those concerns? How were they addressed?

Q I mean, in general it's a good thing when clinicians express concerns of parents in the care of their children, right?

A Yes.

Q Doesn't that mean there was not immediate affirmation here if, in fact, the mother had questions that were strong enough that she followed up with the clinician?

A They rate parents on their degree to which they affirm. You know, so they are really evaluating parents on an ongoing basis if they do any questioning of them, of the gender issues that the child has.

So I would wonder what happened here. We don't know what the conversation was and whether was the parent told if you don't affirm M.W. she will kill herself. Was it that kind of a threat which we often hear occurs in these kind of

Page 196

settings. I don't know. I wonder about that because this later onset expression of gender dysphoria in this sixteen year old suggests it has not been an ongoing gender issue for years with the child.

Q So it raises concerns in your mind when gender dysphoria begins to appear in a later adolescent, is that what I'm hearing you say?

A Yes.

Q You also don't believe that a three year old can accurately express gender dysphoria, is that right?

A Yes.

Q So there is no age between three and sixteen where you think a child can accurately report gender dysphoria?

A Well, they can mistakenly report it, but that does not mean there are not co-morbidities or reasons why they are feeling dysphoria that could be addressed without hormonal interventions.

They can be dysphoric and attribute it to their gender. But especially for a new, rapid onset in this setting there is usually factors. Like I think she had just broken, she had a relationship that just broke up. She had a bad

Page 197

experience in school. Yes, that was M.W.

So there was a stabbing at the school. So that needed to have been explored. This feeling of gender incongruence, why did it come up all of a sudden? But it is not clear to me from the records that there was any exploration of that and they moved right onto testosterone at the second visit with the first visit being a video visit.

Q In your practice do you do telehealth visits?

A Yes. That is with established patients.

Q During the pandemic did you have any new patients that started with telehealth?

A No.

Q Were there doctors in your practice who did?

A Not new patients, no. We only did televisits for a short period of time. Then we were seeing them in the office.

Q In Paragraph 32 of your declaration you are discussing an informed consent sheet. In the last two lines you said, "Among the potential undisclosed harms are infertility, baldness, and an increased risk of heart attacks and stroke."

Do you see that?

A I do.

Q This was for M.R.

Page 198

MR. SELDIN: Erica, can you please pull up Exhibit 20.
Q This is another medical record where I have the one page.
Dr. Weiss, do you see this says, "Informed Consent for balancing hormones in Gender Diverse people" with the Mosaic logo in the top right and the plaintiff's name in the top left?
A Yes.
Q Is this the informed consent sheet that you are talking about in Paragraph 32 of your declaration?
A Yes.
Q Okay. And your question about this form is that there are undisclosed harms of infertility, baldness, and increased risk of heart attacks and strokes, is that right?
A Yes. Undisclosed or minimized.
Q To read back the sentence from your declaration you said, "Unknowns and potential harms were minimized on this form. Among the potential undisclosed harms are infertility, baldness, and an increased risk of heart attacks and strokes."
Do you see that?
A Yes.
Q So do you see on this form the part where it says

Page 199

midway through, "People whose bodies are at higher concentration of testosterone have higher risk of heart disease, high cholesterol and high blood pressure."
Do you see that?
A Yes. It's followed by the sentence, "These are all modifiable by diet, exercise and medications."
Q It would be fair to say this was a risk that was disclosed, but you believe minimized?
A Correct.
Q So it is not an undisclosed harm?
A I agree.
Q And then if you move up a little bit you will see under Not Permanent changes it says, "Hair loss on head (sometimes permanent)."
Do you see that?
A I will follow up on the statement I said, increased risk of strokes. She does not mention and this form does not mention strokes. So that is not disclosed.
Q Heart disease, high cholesterol, and high blood pressure are?
A Yes.
Q Now, do you see the part on this form where it discloses, "Hair loss on head (sometimes

Page 200

permanent)" as a potential side effect?
A Yes.
Q And so that would be a disclosed harm, is that right?
A It is expressed hair loss on head. I call it baldness. It's a different way of expressing it. Yes.
Q And then do you see at the bottom of this sheet it says "What we don't know."
The second bullet point is, "What testosterone does to fertility."
Do you see that part?
A Yes.
Q So, in fact, concerns about fertility are disclosed on this form.
MS. YOUNGS: Was there a question?
Q Potential fertility issues is a disclosed potential risk on this form, is that correct?
A Maybe. What we don't know is what testosterone does to fertility.
Q Well, then it says, "Some trans men come off T and get pregnant and birth babies, have no long-term data on these humans."
All together would you agree that is a disclosure of some risk to fertility?

Page 201

A Yes, I would agree.
MR. SELDIN: We have been going for a little bit. Is now a good time for a five minute break?
MS. YOUNGS: Thank you.
(OFF RECORD AT 3:12 P.M.)
(AT THIS TIME A SHORT RECESS WAS HELD OFF THE RECORD AFTER WHICH THE FOLLOWING PROCEEDINGS WERE HAD:)
(ON RECORD AT 3:17 P.M.)
BY MR. SELDIN:
Q Dr. Weiss, I'm on Exhibit 1, your declaration. Paragraph 34.
Do you see that?
A Yes.
Q In Paragraph 34 you say, "With gender identity issues, open, exploratory supportive psychotherapy or talk therapy is too often dispensed with entirely."
Do you see that?
A Yes.
Q There is no citation for that, is that correct?
A Correct.
Q Do you have any examples of children or adolescents who were not offered therapy as part

Page 202

of their treatment for gender dysphoria?
A Just in speaking with parents and hearing of cases. Not patients under my care. I was not treating minors.
Q Dr. Weiss, what do you mean when you say open exploratory supportive psychotherapy?
A It's talk therapy without the goal of changing the child's view on their gender. It's really exploring their whole family dynamics. What's going on. How is school. Just trying to understand what, how the child feels overall. Their mood. Their outlook. Their interest in things. That kind of approach.
Q How is that different from a gender-affirming approach?
A A gender-affirming approach would be an approach that says, okay, your problem is you are not the right -- you don't appear the right gender. We are going to give you hormones and we will give you -- or puberty blockers -- and we will fix your appearance and you will feel better.
Q So you would agree that pre-pubertal children who have not yet hit puberty are not offered medical interventions in forms of blockers or hormones, correct?

Page 203

A What is the question?
Q For the treatment of gender dysphoria that we have been discussing in minors, that treatment is not even on the table until a minor hits puberty and the -- right? Because puberty blocker, by definition you have to be going through puberty?
A Right. They would initiate a puberty blocker at stage two, which is early onset puberty.
Q When you say stage two you mean Tanner Stage Two, is that correct?
A Yes.
Q So for a child who has not yet hit puberty, what is the difference between the open exploratory supportive psychotherapy that you just described and the gender-affirming that you just described since there is no medicine on the table?
A Well, gender-affirming therapy might be, okay, your main problem is your gender dysphoria. They might institute social transition at that point, which is a treatment.
Q So your open exploratory supportive psychotherapy would not include social transition?
A Correct. Because there is evidence that social transition is a powerful intervention that may change outcomes.

Page 204

Q And what does institutional social transition mean?
A It means that the child adopts a different name and pronoun and lives as the opposite gender.
Q So you don't think that is an appropriate intervention?
A Correct.
Q And in your view of gender-affirming therapy, is the therapist pushing that or just merely not opposing it?
A The therapist would push it.
Q What about a therapist that does not push it, but says this is an option. How do you feel about it?
A I think that hypothetical situation is not one that is realistic or meaningful.
Q So in your open exploratory supportive psychotherapy would social transition be discussed at all?
A It might come up.
Q What do you think the therapist's response should be when it comes up?
A It really depends on the situation and the child. It's so complex. It is an interplay of so many factors.
Q Do you think there is ever a situation where the

Page 205

therapist and patient might come to the conclusion that that would be helpful to socially transition?
A Not a therapist who knows the evidence base.
Q And so in your mind, open exploratory supportive psychotherapy, is the goal of that therapy identification with the sex assigned at birth?
A The goal is to help the child's distress.
Q How do you believe that that distress can be ameliorated using that kind of psychotherapy?
A That is how therapy often works. There is no age below which you can't have that kind of therapy for children. So five year olds, six year olds, four year olds can all benefit from those kinds of therapies without drugs.
Q So the goal of that open exploratory supportive psychotherapy that you feel is not being provided is resolving the gender dysphoria because the patient comes to identify or be at peace with their sex assigned at birth, is that right?
A I think the goal is to really relieve their anxiety and depressed co-morbidities. And if gender dysphoria is part of that, that hopefully will resolve, too.
Q Is there any evidence for the open explorative supportive psychotherapy that you are talking

Page 206

about?
A Yes. I referenced some papers.
Q Is there anything other than the papers that you reference in your complaint -- I'm sorry -- in your declaration?
A Yes. Yes. There are therapists who use it all of the time and children and adolescents benefit from it.
Q Which therapists do you know that are providing the kind of open explorative supportive psychotherapy that you are talking about?
A What do you mean by "know"?
Q You said you know there are therapists that provide this kind of therapy. I am asking who is it?
A Someone like Dr. Kenneth Zucker. Dr. Steven Levine. Dr. Cantor. James Cantor. Dr. Marcus Evans. There are others.
Q The same Dr. James Cantor who is a witness for Indiana in this case?
A Yes.
Q Were you aware that both Dr. Zucker and Dr. Levine have treated adolescent patients with gender-affirming care?
A I'm not aware that they prescribed hormonal

Page 207

therapy for those people.
Q Are you aware of whether or not they recommended hormone therapy for those people?
A No.
Q Would your view of their practice change if you learned they had, in fact, prescribed gender-affirming care in the form of hormones for these patients?
A What was the question again?
Q Well, you told me that you think Dr. Cantor and Dr. Zucker were providing the kind of open exploratory supportive psychotherapy that you think should be happening. Right?
A Right.
Q And I asked were you aware that they prescribe or have recommended the prescription of hormones for their patients with gender dysphoria. You said you were not sure. Is that correct?
A I'm not aware that they, themselves, prescribed it or that they recommended it.
If they did recommend it or prescribed it I think they were doing, that recommendation was inappropriate and not based upon good evidence. Maybe they were not aware of the evidence at that point when they prescribed it.

Page 208

Q So I will represent to you that Dr. Zucker's clinic did treat adolescents with hormones.
Does that give you pause as to the psychotherapy that he is providing?
A No.
Q So you think it's possible to provide the kind of psychotherapy you think is appropriate while also prescribing hormones to adolescents?
A I don't think it's appropriate to prescribe the hormones.
Q In Paragraph 39 of your declaration, I believe that takes us to Page 9, you say, "No other mental disorders listed in the DSM are treated with medication or surgery with the goal of altering body appearance or function."
Do you see that?
A I do.
Q There is no citation for that, correct?
A Correct.
Q Would you agree the brain is part of the body?
A Yes.
Q So psychotropic meds do change bodily function to the extent that they change brain function. Would you agree with that?
A I agree that they do change brain function. Yes.

Page 209

Psychotropic medications are not intended to change body appearance.
Q Would you want to revise that statement to say that the goal is altering body appearance then as opposed to function?
A That might be better.
Q Dr. Weiss, in Paragraph 58 of your declaration, which takes us to Page 13 -- the heading is Gender Dysphoria and Associated Psychosocial Conditions.
Do you see where that is?
A Yes.
Q What is a psychosocial condition?
A What is the question?
Q What is a psychosocial condition?
A Social conditions would be the environment the child is living in. So that is the family, friends, school.
The psychological status has to do with their mood, their interest in things, their sleep. Are they anxious. All those factors.
Q So in Paragraph 58 say, "Most current data show that 70% of children with gender dysphoria have had recent trauma, history of abuse, autism spectrum disorder, homosexual orientation, depression, anxiety, or bullying."

Page 210

Do you see where you said that?
A I do.
Q Why is homosexual orientation worth remarking on here?
A It is really important. If a parent has expressed or discussed an objection to be homosexual and the child has some homosexual orientation, that child might find it more acceptable to identify as transgender than to express their homosexual sexual orientation. That would be one example.
Q Are there other examples where homosexual orientation would be notable?
A Well, there might be some so-called internalized homophobia if the child feels bad about being gay or lesbian. But it's more acceptable and it is kind of considered cool to be transgender. They come out as transgender, but they really have a homosexual orientation, gay or lesbian.
That is apparent with some of those people who end up detransitioning. They really realize they were gay or lesbian and that it was a mistake for them to transition.
Q Do you think as a general matter it's more socially acceptable to be transgender than it is to be gay currently?

Page 211

A Yes.
Q Why?
A I don't know. Mores and cultural. Things change.
Q So it's your belief that currently in the United States it is more socially acceptable to express being transgender than to express being gay, lesbian, or bisexual?
A In many environments, yes, I do believe that. And really, it's really the child's perception. It's not what I think. It's what the child perceives. If the child perceives that it's more, that it's more acceptable in his or her environment to be trans rather than to be gay or lesbian, they may kind of reject their homosexual sexual orientation and express a transgender identity.
Q I guess we are talking about two different things.
One is your perception and then a child's perception. So it's your perception that it's more socially acceptable to be transgender than it is to be gay, is that correct?
A Yes. But I don't think that is important. What is important is the child's. We need to evaluate each child to see what is going on from an intrapsychic standpoint that leads them to feel dysphoric, have gender dysphoria.

Page 212

And for some of these children it's a homosexual orientation that needs to be explored. They need to be accepted and affirmed that if they are gay or lesbian that that is okay. That is good. We don't have to give you hormones and blockers and all this stuff.
It is not for them. We can be treating their condition with the wrong intervention if we give them gender-affirming care.
Q So from your perspective, it is preferable for an individual to be gay or lesbian as opposed to transgender?
MS. YOUNGS: I think that is a mischaracterization of his testimony.
A I would agree with that. I'm not placing any judgment on it. I'm saying that from the standpoint of what we are talking about here, which is treatment of gender dysphoria, that it's important to understand the basis for that child's feelings.
And for some of those children it's a homosexual orientation. They need to be affirmed from that standpoint and that will help them. It will be really -- that will come out with open exploratory supportive psychotherapy and you don't

Page 213

need to give them hormones.
Q So in your view then after a period of open exploratory supportive psychotherapy, as you have defined it in your declaration, you think as a medical outcome it would be better if the patient subjected to that therapy concluded that they were, in fact, gay or lesbian as opposed to suffering from gender dysphoria that required treatment through hormones?
A Well, hormones are not required. And I would not use the word "subjected." It is not a harmful intervention, talk therapy. It is kind and caring and supportive and open. And, you know, it's everything that children should be getting that they might not get from mom or dad. It depends on the household.
The outcome would be wonderful if they could avoid irreversible harm from hormonal interventions or even surgical reassignment.
Q You expressed concern earlier that co-morbid conditions were not being adequately addressed in minors with gender dysphoria.
Is that a fair characterization of what we have been talking about?
A Yes.

Page 214

Q Are there other medical treatments that you think are inappropriate for adolescents who are currently experiencing depression or anxiety?
A Not that I can think of.
Q Are there other medical treatments that you think should not be provided to adolescents because they have been bullied or have experienced trauma or abuse?
A Medical treatments other than hormonal interventions for gender dysphoria?
Q Other than that?
A No.
Q Would you agree that someone can have more than one condition that might require two different kinds of treatment?
A Yes.
Q But it is your position that even if an adolescent has no other diagnosis other than gender dysphoria they are still not a candidate for hormonal intervention or puberty blockers?
A That is my view because there, because the evidence does not support benefit from those interventions.
Q So in that case it would not be the existence of co-morbidities. It would be your view of the

Page 215

evidence base that would cause you to believe that?
A Right. The evidence does not support benefit from hormonal interventions for gender dysphoria even in the absence of major co-morbidities.
Q In Paragraph 60 of your declaration you say at the end, "When the GRADE score is 'low,' the true effect is likely to be markedly different from the estimated effect."
Do you see that?
A I do.
Q Can you give me an example of that?
A Can you be a little more specific in what you are asking?
Q Sure. You say when the GRADE score is low that the true effect is likely to be markedly different from the estimated effect.
And there is no citation there, right?
A Well, the citation relates to GRADE. That is what GRADE, that is what -- the citation still relates to citation 42, which is on GRADE.
Q Okay. So that is how you believe GRADE characterizes low in terms of quality?
A Yes. That is right out of the GRADE criteria.
Q All right. And can you give me an example of

Page 216

that?
A An example of what?
Q A place where the GRADE score on research is low and so the true effect is likely to be markedly different from the estimated effect?
A The hormonal treatment for gender dysphoria.
Q Any other treatment other than that where you believe that applies?
A The GRADE score.
Q Okay.
A I don't -- not that comes to mind.
Q So earlier today we were talking glycemia and we were looking at the Endocrine Society guideline. It talked about the recommendation for continuous monitoring versus fingerstick.
It said we recommend this even though it's low quality GRADE score.
Do you recall that?
A Oh, yes.
Q So do you have the same concerns about that intervention as you do with gender-affirming care?
A Oh, my goodness. Absolutely not. It is so different. We see immediate real time ongoing clear-cut evidence of benefit with continuous

Page 217

glucose monitoring daily, multiple times a day. We see evidence for that even though there might not be a study, you see that the patient has -- you are preventing a serious outcome every day, which is hypoglycemia. That is easily measurable and people get alerts from their continuous glucose monitoring system.
There is no parallel. There is no comparison to an intervention for hormone therapy for gender dysphoria.
Q So I will represent to you in this case and in other places there have been self-reports from minors with gender dysphoria that have received gender-affirming care that they on a daily basis feel better psychologically. They are more comfortable in their bodies. They are better able to participate in society.
You would not consider that self-report to be credible in this instance?
A It's worthless. It means that there are so many confounders. That is an anecdote from one or two people. But what else is going on in that patient's life? Have they had psychotherapy? You know, it could be the placebo affect.
It's nothing like continuous glucose

Page 218

monitoring in patients with diabetes. There's just no comparison whatsoever.
Q Is that because you don't believe we should give credence to the self-report of the minors who receive this care who say this is making me feel better on a daily basis?
A I think the patients can't diagnose themselves. Glucose measurements on a continuous glucose monitoring reader or an iPhone app, glucose measurements are very different from, I feel better and I think it's from that shot. There is no comparison.
Q You have patients with diabetes.
A Yes.
Q Are they able to tell based on how they feel in their body that maybe their blood sugar is getting low?
A Often no.
Q Is there a point at which they can?
A Sometimes. But often no. They need a measurement tool.
Q If you had a patient who came in and said I just, I'm not feeling particularly well. Would that be something that you would want to explore further in your treatment of them with diabetes?

Page 219

A Sure. Why are they not feeling well?
Q So you do believe that patient's self-report has some role in medical diagnosis?
A Oh, of course. Part of that, the most important part of the engagement is the history, what is going on. The patient can't diagnose their own condition. They can't -- they will come in and say I think that pill is giving me this problem, but they are on twelve pills.
Well, how do we know which pill? We can't rely on the patient to make the diagnosis.
Q In Paragraph 64 of your declaration you talk about, you know, essentially what would be a randomized control study.
Is that a fair summary of what you are talking about in Paragraph 64?
A Yes.
Q Is there any evidence that supportive psychotherapy alone can treat gender dysphoria?
A Yes. It's low quality evidence, but there is.
Q Would you expect people to sign up for a study where the intervention only had low quality evidence?
A It depends.
Q What does it depend on?

Page 220

A How well the informed consent process is. And I think if people were clearly informed of the weakness of the evidence for hormonal interventions and the potential harm, they might sign up for it. It might be difficult to do the study.
Q You think that the low quality evidence for the supportive psychotherapy that you are talking about, there is a form of informed consent that could be sufficient that you could ethnically sign people up for that group?
A For that group and the comparative group, it might be this would be an experiment, a clinical research trial where people were fully informed.
As you know, I'm an expert in clinical research. They would be fully informed from the outset with what is called equipoise. Not the doctor convinced that the best approach is hormones. But the doctor unsure of what the best approach is.
And then be able to convey that to the person who signed up and say these are your two options. We can see how you do. Then they randomly are assigned to one group or the other.
Q So the other group in your study, they would be

Page 221

receiving hormones, is that right?
A That is part of clinical research.
Q So you think this kind of study would be a good idea?
A Well, if the physicians in the United States continue to push these interventions which are so, I think, unhelpful and potentially harmful, perhaps this would get them to back down and say, look, this is what needs to be done and this is what is recommended.
Some other countries have said we need to put a stop to this right now. We need to evaluate it further. This would be a means to evaluate it.
Q You are aware that Senate Enrolled Act 480 bans care all together even in a research setting, correct?
A No, I was not aware of that.
Q Are you in favor of a law that bans care entirely without a research exception?
A I think I would have to see how -- what the research would be. You can call it research and have no control group. We are doing research.
There are publications where they call it research and I don't think it adds meaningfully to the evidence base. So it has to be a really well

Page 222

designed study prospective, randomized with a good comparator group.
Q So that kind of study then, the one you just described, you would be in favor of that kind of study taking place?
A I would.
Q In Paragraph 69 of your declaration, it says in the second sentence, "A Cochrane Review was performed of hormonal interventions in females with gender dysphoria. They found 'insufficient evidence to determine the efficacy or safety of hormonal treatment approaches in transgender women in transition.'"
Do you see where that is?
A Yes.
Q I'm a little confused. Is this review that you are talking about, was it addressing transgender men or transgender women?
MS. YOUNGS: Can he refresh his memory by looking at the study? Do you have the review of the study?
Q Before we get there, Dr. Weiss, do you know just from reading this whether the study was about being assigned male at birth or people assigned female at birth?

Page 223

A Let me look at the reference. This was biologic males.
Q Thank you. Then in Paragraph 70 in the second sentence you say, "Doctors, like all groups, are susceptible to group think and social contagion."
Do you see that?
A Yes.
Q Other than the treatments for gender dysphoria that we have been discussing can you give me another example of that?
A The treatment of post-menopausal women with estrogen and progestin in the hope that it would reduce heart attacks. The treatment of primary aldosteronism with surgical intervention. The treatment of high blood pressure in persons with Type II diabetes. I can go on and on.
Q And for all of those you believe that is group think and social contagion that were at fault?
A I think much of that is group think and doctors not thinking for themselves and not critically questioning the evidence.
Q In those cases was it further research that turned the tide?
A Yes.
Q So it was not debate. It was new research

Page 224

studies, is that fair to say?
A Yes.
Q Okay. In Paragraph 78 of your declaration you say, "At a minimum, one must conclude from these studies that persons with gender dysphoria continue to have significant psychiatric issues despite hormonal and surgical interventions."
Do you see that?
A Yes.
Q For people who have gender dysphoria, if they have other co-morbidities, why not treat all of the conditions as opposed to stopping the treatment for gender dysphoria?
A So one of the principles of treatment is to initiate treatment that is least harmful. And so the least harmful interventions would -- a harmful intervention, potentially irreversible, or definitely irreversible if surgery is involved, would be hormonal interventions for those persons.
So you could treat depression through various approaches and maybe the gender dysphoria would resolve. But if you are doing multiple interventions at one time you will not know what is helping.
Clearly in these citations in these reports

Page 225

focusing on treatment of gender dysphoria, it didn't seem to really help much in terms of the suicide and depression and so on.
Q Okay. So if someone has both diabetes and a heart condition and you are treating their diabetes and it is being effectively treated but their heart condition does not improve, do you stop treating the diabetes?
A So we are talking about mental disorders when we talk about gender dysphoria. So not chronic medical conditions that are outside of the brain.
So people can have multiple sclerosis and depression and you can treat both. You can treat both of those. But multiple sclerosis is not thought to be a psychiatric disorder.
So you are mixing apples and oranges, I think.
Q What if someone has depression and ADHD and you are effectively treating their ADHD but they continue to be depressed, would you stop treating the ADHD because the depression did not resolve?
A So I don't know that much about ADHD, but it may be that when you are treating the depression they will have less in the way of ADHD.
But, no. I think the psychiatrist who is

Page 226

treating needs to know the interaction between those two and treat both of them and maybe taper off on one of those medications. Your depression is much better. Maybe we can drop back on your meds for your ADHD or vice versa.

You can't do that if you were doing hormonal interventions and you have already transitioned the person. That is not something that you can go up and down on.

Q In Paragraph 80 of your declaration you are talking about a quote and then you say at the end, "Elsewhere this author writes that there are 'numerous gaps in knowledge' in transgender medicine."

Do you see that?

A Yes.

Q Are there gaps in knowledge in other areas of medicine?

A Not as much as in transgender medicine. And the gaps are so large in transgender medicine that practitioners are inclined to treat with these interventions that I think are harmful.

Q So when there are gaps in knowledge in medicine do you believe that we should withhold care?

A No. The care just continues to improve and change

Page 227

over time. But we always want to have the care be the least harmful possible.

Q And so you would agree then that the way you close those gaps to get to a place of care that is more effective and less harmful is through research?

A Correct.

Q In Paragraph 86 of your declaration you say that GnRH analogs are approved for use in children with a relatively rare disorder called central precocious puberty.

Do you see that?

A Yes.

Q So would you agree that for children experiencing that condition GnRH analogs are safe to use?

A They appear to be. And there is no other treatment for those children.

Q What about a child who has both precocious puberty and gender dysphoria, would you consider GnRH analogs to be an appropriate treatment?

A Yes, for the precocious puberty. Not for the gender dysphoria.

Q But if they had both, you would still find it appropriate to use the GnRH analog to treat them?

A For the precocious puberty. I've not seen a single report of a child who has both though.

Page 228

Q In Paragraph 90 of your declaration you say, "Seizures have been reported in children receiving puberty blockers."

There is no citation to that sentence. Do you see that?

A The citation comes in the next sentence.

Q Okay. So you believe that footnote 60 applies to both those sentences?

A I think so. Let me check. Yes, it does apply to both sentences.

Q So is that the Bangalore Krishna study?

A Yes.

Q Okay. Was that study in children who are being treated for precocious puberty?

A Yes. There is very little data on children treated with puberty blockers for gender dysphoria. Very little published data.

Q So because central precocious puberty can only be treated with GnRH agonists or puberty blockers, even though there are some rare side effects it's still an appropriate treatment in your mind?

A Yes.

Q So you would agree that medical interventions can always have rare side effects?

A They can always have side effects. We don't know

Page 229

how rare these are in their use with children with gender dysphoria because the data are not there. These children -- there is no reporting. There is no collection of data. They are just being treated.

Q I'm asking you a broader question. Generally speaking, medical interventions can have side effects and some are more common, some are more rare?

A Correct.

Q And even for medications or treatments where there are those side effects, if the treatment on balance benefits the majority of patients they will continue to be prescribed, is that fair to say?

A Yes, as long as the person knows the risk versus benefit and gets full informed consent.

Q In Paragraph 96 of your declaration you say: "Children who fail to progress through puberty are infertile."

Do you see that?

A Yes.

Q Okay. So puberty blockers themselves don't cause infertility though, right?

A They should not if we look at the data on

Page 230

precocious puberty. There is no good published data in the treatment of children with gender dysphoria.
Q Would you agree once the puberty blockers stop and the child progresses through endogenous puberty we have no reason to believe that blockers have a negative effect on fertility?
A They should not. Although, there is not data published for those with gender dysphoria.
Q You would agree with that statement when it is used for precocious puberty?
A Yes, it appears that it does not impair fertility. But the data that is published in the children with precocious puberty is primarily biologic females usually.
We have very, very little data on biologic boys and their ability to conceive when puberty blockers are stopped in them.
Q And that is something that you probably would want more data on, right?
A Yes.
Q Can you think of other medical treatments that can cause infertility in children that are minors?
A Chemotherapy.
Q You believe there are circumstances in which

Page 231

children and their parents can consent to the receipt of that treatment, correct?
A Well, that is pretty clear. If they have cancer they might be infertile, but they won't die of their cancer hopefully.
Q You would agree that there are medical outcomes that are more important than fertility, or parents and their minor children can weigh whether fertility is important to them relative to the other potential conditions or side effects?
A That is the importance of the full informed consent by the parents and the assent by the child. Children have, they don't have long-term perspective often. But, yes.
Q We may have covered this. Have you ever prescribed puberty blockers for any condition?
A Not that I recall.
Q In Paragraph 106 of your declaration you are talking about hormones.
You say in the third sentence, "Pediatricians and pediatric endocrinologists would fail to recognize any of these long-term harms because they usually do not provide care to persons after the age of 18."
Is that what you said there?

Page 232

A Yes.
Q Is that statement generally true of all pediatric interventions?
A Yes.
Q So it's not specific to the provision to treating gender dysphoria in minors?
A Correct.
Q So you were talking earlier about the treatment of Type I diabetes in minors and their transition to adult endocrinologists.
A Yes.
Q Do you believe that, generally speaking, pediatric endocrinologists do understand the long-term effects of treating Type I diabetes in children?
A Yes.
Q Then in Paragraph 109 of your declaration you say, "Short-term effects of testosterone given to natal females include acne, baldness, facial hair, clitoral enlargement and pelvic pain. There may be deepening of the voice."
Do you see that?
A Yes.
Q And so for a person whose goal it is is to reduce their gender dysphoria, would you agree that some of those side effects are actually intended

Page 233

results?
A No.
Q You don't believe facial hair is an intended result of the testosterone to treat gender dysphoria?
A Well, acne is not. Pelvic pain is not. Clitoral enlargement may be painful. That is not really the goal. Maybe facial hair.
Q So at least one of those might be an intended result?
A People don't usually want to go bald.
Q Would you agree if your goal was to appear more masculine then being bald might, in fact, help you in that effort?
A It might. I agree.
Q Not to put too fine a point on it.
A Correct.
Q In Paragraph 110 you talk about infertility or rather you say, "Infertility is frequent in those females treated with testosterone even if not given puberty blockers."
Do you see where you wrote that?
A Yes.
Q Have you ever treated a transgender man for infertility?

Page 234

A Not for their infertility.
Q And you are not a reproductive endocrinologist, correct?
A No.
Q Or by practice, I guess?
A No. Reproductive endocrinologists are trained initially as obstetricians gynecologists. They really just mostly focus on infertility in biologic females.
Q In Paragraph 126 you talk in the second sentence, "Bilateral mastectomy has been euphemistically called 'top surgery' and 'chest contouring'."
Do you see that?
A I do.
Q Do you think that anyone who gets that medical procedure fails to understand that breast tissue will be removed?
A I think actually they don't, a lot of them don't understand it. So there are instances in which young women have had their breasts removed and then they regret it and they want to have them put back on.
Q Well, I'm asking a different question. The question is not about that, but do you think that the fact that a surgery is called top surgery or

Page 235

chest contouring obscures the fact to the patient that what is going to happen is they are going to have breast tissue removed bilaterally?
A I think it's inappropriate and it is obscuring. I think it is misleading and it minimizes what they are doing.
Q Would you be more supportive of that as a medical intervention if everyone agreed we will only call it bilateral mastectomy? We will not use the terms top surgery and chest contouring.
A Yes. Call it what it is.
Q Okay.
MR. SELDIN: So we have been going for a little under an hour. Is now a good time to take maybe a five minute break?
MS. YOUNGS: Sure.
(OFF RECORD AT 4:09 P.M.)
(AT THIS TIME A SHORT RECESS WAS HELD OFF THE RECORD AFTER WHICH THE FOLLOWING PROCEEDINGS WERE HAD:)
(ON RECORD AT 4:15 P.M.)
BY MR. SELDIN:
Q Dr. Weiss, in Paragraph 131 of your declaration, which is Exhibit 1, you talk about clinics in the U.K.

Page 236

Is it your understanding that the treatment of gender dysphoria using blockers and hormones is still being provided in the U.K. in some form?
A That is still an option.
Q Then in Paragraph 132 you discuss Sweden. In the second sentence you talk about, "Its new guidelines stated that the risks of hormonal interventions outweighed benefits and that hormonal interventions in minors can only be used as part of a research protocol."
Did I read that correctly?
A Yes.
Q So in Sweden they are still providing care, but limited to research studies?
A They are providing care, but it's hormonal interventions that are limited to research protocols.
Q Yes. So you would agree then that hormonal care is still being provided to adolescents in Sweden in the context of research protocols?
A Yes.
Q Okay. Which in your view might be beneficial in the United States as well in the context of a randomized control trial?
A Right. Carefully designed randomized control

Page 237

trial. Yes.
Q In Paragraph 133 of your declaration you talk about France.
Is it your understanding that care is being provided in France under some restrictions related to research?
A Specifically what do you mean by "care"?
Q Hormonal treatments for the gender dysphoria in adolescents?
A "They advised 'the greatest reserve' in the use of hormonal treatments."
That should be not an initial treatment. It's an option, but only after extended psychological support.
Q Which in your view, that would be if you were going to provide hormonal care to adolescents for gender dysphoria, that would be the correct protocol after an extended period of therapy?
A To evaluate all co-morbidities, evaluate the child very thoroughly and only in the setting of the research protocol.
Q Is it your understanding then with respect to Paragraphs 134 and 135 that similarly Norway and Finland are also providing hormonal treatment for gender dysphoria to adolescents in some form?

Page 238

A In Norway, this statement there in Norway was that there was insufficient evidence for the use of puberty blockers and opposite sex hormones in young people.
The approach that the Norwegians are taking has not been finalized. That was the guidance from their Health Care Investigation Board.
In Finland, let me refresh my memory. They recommended psychosocial support as a first line of treatment. Hormonal interventions may be considered with a great deal of caution and no irreversible treatment should be initiated.
Q But in neither place is care banned -- is the provision of hormonal treatment to adolescents for gender dysphoria banned entirely at this stage?
A To my understanding that is correct.
Q Okay. Earlier today we were talking about your employer Intermountain Health --
A Yes.
Q -- and their linking to certain resources for care of transgender people and LGBTQ health generally.
Do you remember that discussion?
A Yes.
Q Do you believe that Intermountain has been subjected to sort of group thinking and social

Page 239

contagion in the same way as the AMA and other organizations?
A Yes.
Q Do you think that there are any large medical systems in the United States that have not been subjected to that kind of group think and social contagion?
A No.
Q We were talking about your prior experience as an expert in two cases. I believe that is in your declaration in Paragraph 13.
Do you have that portion of your declaration up?
MS. YOUNGS: Paragraph 13?
MR. SELDIN: Yes.
MS. YOUNGS: Okay.
Q Okay.
A Yes.
Q For Suzanne Platz did you write a report?
A Yes.
Q Were you deposed?
A Yes.
Q Did you testify at trial?
A No.
Q Did the case go to trial?

Page 240

A No.
Q Was your expert opinion in that case challenged in the form of a Daubert motion or a state equivalent?
A No.
Q For the second case, William Blair, did you do a report?
A Yes.
Q Were you deposed?
A Yes.
Q Did you testify at trial?
A Yes.
Q Did any party file a Daubert motion as to your testimony or try to limit it in some way?
A Not that I'm aware of.
Q In either case was your testimony limited or excluded by the court in any way?
A No.
Q Have you ever had to detract a research paper?
A No.
Q Have you ever had to issue a correction for a research paper?
A No.
Q Have you ever been sued for medical malpractice?
A No.

Page 241

Q Have you ever been the subject of professional discipline?
A No.
Q Or sanctioned by the licensing board?
A No.
Q Have you ever had a professional complaint filed against you?
A No, not that I'm aware of.
Q Have you ever been arrested or charged with a crime?
A No.
Q Have you ever been the subject of a Title Nine complaint?
A No. What is Title Nine?
Q Have you ever worked at an academic research institution?
A No. The answer is no, I've not been the subject to a Title Nine complaint.
Q Have you ever been accused of any other form of discrimination or harassment?
A No.
Q Recalling earlier we were talking about your senior fellowship with Do No Harm. You also mentioned being a member of, I believe, SEGM, S-E-G-M, is that correct?

Page 242

A Yes.
Q Are there any other organizations like that that you belong to?
A Like what?
Q Like Do No Harm or SEGM?
A How are you characterizing them?
Q Are you a member of any other organizations that take a position on the provision of treatment for gender dysphoria?
A No.
Q Are you a member of any other organization that takes the position on gender ideology as to how Do No Harm uses that term?
A I will correct that statement. The answer is yes, there is one other organization. They take a position on treatment of gender dysphoria. That organization is AAPS, American Association of Physicians and Surgeons.
They have been around since the 1950s. They also have a view that is similar to Do No Harm's view.
Q And what was the extent of your involvement with AAPS?
A I'm just a member.
Q Do they have a newsletter that you read? Do you

Page 243

go on their website? What is the nature of your belonging to that organization?
A I just pay dues. I get a regular mailing and newsletter. They have, they have been involved in -- I think they filed some Amicus briefs in various cases. I don't know about gender cases. And my membership there is in my C.V.
Q So other than Do No Harm, SEGM and AAPS, are there any other organizations of which you are a member that are similar in their beliefs regarding gender ideology or the treatment of gender dysphoria?
A No.
MR. SELDIN: If we could take another break. It's possible I'm done.
MS. YOUNGS: Okay.
MR. SELDIN: Would you be amenable to ten minutes? Let's come back at 4:37 Eastern.
MS. YOUNGS: Okay.
(OFF RECORD AT 4:27 P.M.)
(AT THIS TIME A SHORT RECESS WAS HELD OFF THE RECORD AFTER WHICH THE FOLLOWING PROCEEDINGS WERE HAD:)
(ON RECORD AT 4:37 P.M.)
BY MR. SELDIN:
Q Dr. Weiss, thank you. Unless I have some

Page 244

follow-up questions from any questions Ms. Youngs might ask, I have nothing further for you today. Thank you for your time.
MS. YOUNGS: I have no rebuttal questions.
(OFF RECORD AT 4:41 P.M.)

AND FURTHER THE DEPONENT SAITH NOT.

(Signature waived.)

_____
DANIEL WEISS, M.D.

Page 245

STATE OF INDIANA)
) SS:
COUNTY OF BOONE)

I, Wendi Kramer Sulkoske, Notary Public in said county and state, do hereby certify that the deponent DANIEL WEISS, M.D. was sworn to tell the truth in the aforementioned matter:
That the deposition was taken on behalf of the Plaintiffs at the time and place heretofore mentioned, with counsel present as noted;
That said deposition was taken down in Stenograph notes, reduced to typewriting under my direction, is a true record of the testimony given by said deponent; and that the reading and signing by the deponent were waived, the witness being present and consenting thereto.
I do further certify that I am a disinterested person in this cause of action; that I am not a relative or attorney of any of the parties or otherwise interested in the event of this action, and am not in the employ of the attorneys for the respective parties.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal this _____ day of _____, 2023.

_____
Wendi Kramer Sulkoske, Notary Public

Commission Number NP0661030

My commission expires December 1, 2030
My county of residence is Boone

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Daniel Weiss MD CDECES PNS CPI FAPCR

Chair Manchester, Vice Chair Cutrona, Ranking Member Denson, and members of the House Families, Aging, and Human Services Committee

I am here to support the *Save Adolescents from Experimentation Act*, the SAFE Act.

My testimony is strictly my own and does not represent any health care organization in the State of Ohio.

I am a board-certified internist and endocrinologist. I have practiced in northern Ohio since 1986. I am also a Certified Physician Investigator. I have been the principal investigator for over 100 clinical trials involving both adults and children.

Physicians have 3 fundamental responsibilities: we must use our expertise to **diagnose** and to **care** for our patients. And we must be certain that our patients understand and fully **consent**.

Diagnosis of a medical condition is <u>not</u> delegated to the patient, because it requires expert medical evaluation. Physicians who see a child with distress, possibly related to gender, should not agree to the child's diagnosis any more than they would agree with a child who thinks he or she has diabetes or cancer.

Once the physician is confident in the diagnosis, he or she can weigh the best **care** or treatment for that patient. A cardinal principle is: "first do not harm".

Finally, physicians must obtain informed **consent**, especially for any experimental intervention. Ethical practice prohibits children from providing consent. Children cannot fully comprehend risks versus benefit, and at most can provide assent to a parental decision. Children must obtain consent from their legal guardian or parent for any medical treatment or surgery. Treatment for gender dysphoria should not be an exception to this requirement.

I stopped accepting new patients with gender dysphoria because I discovered that most had stories of traumatic childhoods and co-morbid depression. Most had inadequate psychologic

evaluation before they were “cleared” for treatment. Hormonal treatment did not resolve those underlying psychologic issues.

Parents are often told if they fail to go along with hormonal interventions for their child with gender dysphoria, he or she will commit suicide. However, the best evidence proves this to be completely false. A long-term study of adults in Sweden found that despite cross sex hormones and surgical reassignment surgery, there was a 19-fold higher suicide rate and a 3-fold higher overall mortality in transgender persons as compared to the control population.

The only study on hormonal treatment of gender dysphoria in minors is the so called the Dutch study. That study found no improvement in depression, anxiety or anger after treatment in a small group of 55 children.

To summarize, there are NO studies that demonstrate clear benefit with hormonal or surgical treatment for children with gender dysphoria.There is increasing evidence of harm with puberty blockers and cross sex hormones—damaging bone health, cardiovascular health and fertility. A paper published this year in the Endocrine Society’s key journal described the evidence on hormonal interventions for “gender diverse adolescents” as sparse, of low quality and with potentially irreversible side effects.

And GnRH analogues, so called puberty blockers, are not FDA approved for treating gender dysphoria. All these facts mean that puberty blockers and cross sex hormones are experimental interventions for gender dysphoria. The SAFE Act aims to protect children from these experimental therapies.

There are an increasing number of people who were given hormonal or surgical treatment for gender dysphoria who later regret such treatment. I estimate that 75% of my adult patients failed to persist in their treatment with me. Recently, I saw a man who regretted having his testicles removed within one year of that surgery.

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I strongly support the SAFE Act. The SAFE act is an act of harm reduction for children.

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1. Kaltiala R, Heino E, Tyolajarvi M, Suomalainen L. Adolescent development and psychosocial functioning after starting cross-sex hormones for gender dysphoria. *Nord J Psychiatry*. Apr 2020;74(3):213-219. doi:10.1080/08039488.2019.1691260

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4. Carmichael P, Butler G, Masic U, et al. Short-term outcomes of pubertal suppression in a selected cohort of 12 to 15 year old young people with persistent gender dysphoria in the UK. *PLoS One*. 2021;16(2):e0243894. doi:10.1371/journal.pone.0243894

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11. O'Connell MA, Nguyen TP, Ahler A, Skinner SR, Pang KC. Approach to the Patient: Pharmacological Management of Trans and Gender-Diverse Adolescents. *J Clin Endocrinol Metab*. Jan 1 2022;107(1):241-257. doi:10.1210/clinem/dgab634

From: D W
To: BOM Public Comment
Subject: Gender dysphoria comments from an endocrinologist who has treated many
Date: Monday, October 24, 2022 9:21:21 PM
Attachments: Dr Daniel Weiss .pdf

Please see my attached comments.
I strongly support Florida's efforts to protect minors from experimental medical interventions such as cross sex hormones, puberty blockers and surgery to remove normal body parts.
Thank you.

Daniel Weiss MD CDCES
Physician Nutrition Specialist
Board Certified: Diabetes/Endocrinology/Metabolism
Diplomate: American Board of Obesity Medicine

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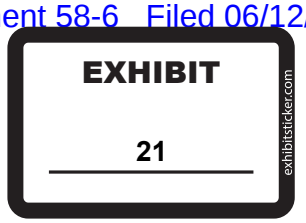

Daniel Weiss MD

My name is Dr. Daniel Weiss.

I am a board-certified internist and endocrinologist. I am also a senior fellow with the non-profit organization called Do No Harm. My commentary is mine alone and does not represent the views of any medical practice.

I practiced endocrinology in northeastern Ohio for 36 years. In December 2022, I moved to Utah and joined a medical practice there. I believe my clinical experience is meaningful in part because for 10 years I provided hormonal treatments for persons with gender dysphoria .

I no longer provide this care.

Why not? Because I discovered that most of these patients had stories of traumatic childhoods and co-morbid depression. Their psychologic evaluation was inadequate before they were "cleared" for treatment. Furthermore, opposite sex treatment did not resolve any of their underlying psychologic issues.

I later learned that there is no good scientific or clinical evidence to support hormonal or surgical interventions for minors with gender dysphoria. Instead, there is increasing evidence to show that such treatments for gender dysphoria cause harm. I will briefly summarize key data in the medical literature .

The most-cited studies of hormonal treatment in minors report the outcomes using the so-called Dutch protocol. I encourage you to look at the references I have provided.

Multiple papers detail the many scientific flaws in the Dutch studies. Here are a few. There was no comparison group. The study subjects were highly selected. The study started with 111 children but only 55 were analyzed at its conclusion. Nonetheless the small group of children showed no improvement in gender distress, anxiety, or anger after opposite sex hormone treatment. The researchers used an unvalidated measurement tool and manipulated its results.

It is little known that the series included a death as a complication of surgery. Importantly, independent UK researchers could not replicate the findings of the Dutch group.

A paper published last year in the Endocrine Society's key journal summarized the evidence on hormonal interventions for "gender diverse adolescents" as sparse and of low quality. In the key authoritative endocrinology textbook, just published in 2023, the chapter on Transgender Healthcare, written by a WPATH member, states that "long-term prospective outcome studies of the effects of GAHT (gender affirming hormone therapy) of any type are lacking. What data that do exist are mostly retrospective and have numerous limitations."

And gender dysphoria resolves in the vast majority of children without any interventions.

I have touched on the lack of data showing benefit. So, what about harm? Many studies show that puberty blockers and opposite sex hormones damage bone health, cardiovascular health, and fertility. There is emerging evidence of increased rates of breast cancer and other adverse effects.

Those who state that puberty blockers are readily reversible and harmlessly "pause" puberty can cite no published data on the reversibility of these drugs in this setting. The FDA has not approved any drug for treatment of gender dysphoria.

How about suicide? The largest study documented 4 suicides out of 15,000 adolescents being treated for gender dysphoria in the UK. It is not known whether this rate is any different than that seen in adolescents undergoing mental health treatment who do not have gender dysphoria.

The best data suggest that hormonal and surgical interventions increase the risk of suicide. The Dutch study provided no data on suicide. In contrast, a long-term study of transgender persons in Sweden found a 19-fold overall higher suicide rate, 40-fold higher in females and a

3-fold higher overall mortality despite treatment with opposite sex hormones and surgery as compared to the control population. In a study of over 8000 transgender person,two thirds of those who died by suicide were still receiving treatment at the gender dysphoria center. In an article this year in the NEJM there was a 45-fold increase in suicide with opposite sex hormonal therapy.

For more than a decade, long before opposite sex therapies became popular in the United States, European centers offered these treatments for gender confusion. Now, as increasing data show substantial harm, Finland, Sweden, Norway, France and the United Kingdom have discouraged or terminated opposite sex treatments for minors. Instead, they advise supportive psychotherapy for minors with gender confusion.

The United Kingdom's Gender Identity Development Service, started in 1989, is now closed. Hormonal interventions will only be provided as part of formal research program. They recognize the experimental nature of these treatments in those who have normal puberty.

Why haven't US physicians and surgeons learned from their European colleagues? I am uncertain but I ask how many doctors who justify this harm to minors have financial conflicts of interest? How many are employed at transgender clinics and how many perform lucrative surgeries ?

Finally, it should be noted that strict international principles prohibit children from providing consent because children cannot fully comprehend risk versus benefit. The United States is a signatory to the United Nations Convention on the Rights of the Child. The *Declaration of the Rights of the Child* states that "the child, by reason of his physical and mental immaturity, needs special safeguards and care." These safeguards are uniquely important when it comes to an experimental intervention. The Declaration of Helsinki allows individual parents to consent to an experimental treatment for their child. Usually, this choice is made in an extraordinary

circumstance, to save that child's life, and with the child's assent. Experimental treatments to change gender appearance should not be an exception to these requirements.

Please help protect the children of Ohio.

Thank you.

Daniel Weiss MD

April 24, 2023

Key References:

Lack of efficacy

de Vries A. L. *et al.* Puberty suppression in adolescents with gender identity disorder: a prospective follow-up study. J. Sexual Medicine 2011; 8: 2276-2283.

"Dutch Study." There was no change in anxiety, depression or gender distress following GnRH therapy (puberty blockers) and opposite sex therapy in children. There was no comparator control group and all received psychologic support.

de Vries A.L. *et al.* Young adult psychological outcome after puberty suppression and gender reassignment. Pediatrics 2014; 134: 696-704.

"Dutch Study." A non-validated assessment tool was used to assess dysphoria, there was no control group and the 55 patients were tested in such a way that improvements in scores would be seen even without treatment.

Carmichael P. *et. al*. Short-term outcomes of pubertal suppression in a selected cohort of 12 to 15 year old young people with persistent gender dysphoria in the UK. PLOS One 2021; 16 (2)

These researchers could not confirm any of the claims of DeVries et al in young people treated with the Dutch protocol in the U.K.

Kaltiala R, *et. al.* Adolescent development and psychosocial functioning after starting cross-sex hormones for gender dysphoria. *Nord J Psychiatry*. 2020;74(3):213-219.

This retrospective chart review showed no improvement in psychiatric status in 52 adolescents after opposite sex hormone treatments.

Abbruzzese E. *et. al*. The Myth of "Reliable Research" in Pediatric Gender Medicine: A critical evaluation of the Dutch Studies—and research that has followed, Journal of Sex & Marital Therapy. January 2023.

This paper is a comprehensive and critical review of De Vries' studies identifying the many flaws and biases in the methodology.

Levine S. *et. al*. Reconsidering informed consent for trans-identified children, adolescents and young adults. J. Sex and Marital Therapy 2022; 48: 706-727.

This paper describes the challenges in providing full and proper informed consent to children with gender dysphoria and their parents in light of the flaws in the Dutch protocol and limitations in our knowledge base.

O'Connell MA, *et al*. Approach to the Patient: Pharmacological Management of Trans and Gender-Diverse Adolescents. *J Clin Endocrinol Metab*. 2022;107(1):241-257.

This review stresses the need for improvement in the "evidence base" emphasizing that the "evidence relating to hormonal therapies in youth is low" and that "data on wellbeing in transgender persons is sparse".

Levine SB, et. al. What are we doing to these children? Response to Drescher, Clayton, and Balon commentaries on Levine et. al. 2022. J Sex and Marital Therapy 2023; 49:115-125.

In a response to comments, the authors discuss the benefits of psychotherapeutic interventions and the frequent conflicts of interest in those clinicians who promote hormonal and surgical interventions.

Deutsch, MB. Transgender Healthcare. p 1752-1757 *in* Degroot's Endocrinology. Basic science and clinical practice. 8th edition. 2023.

Dr. Madeline Deutsch, a member of the World Professional Association for Transgender Health (WPATH) writes that "long-term prospective outcome studies of the effects of GAHT (gender affirming hormone therapy) of any type are lacking. What data that do exist are mostly retrospective and have numerous limitations."

Role of psychotherapy or non-intervention

Ristori J, Steensma TD. Gender dysphoria in childhood. *Int Rev Psychiatry*. 2016;28(1):13-20.

85% of children with gender dysphoria show spontaneous resolution of their symptoms and distress without any intervention.

Clayton, A. Gender-affirming treatment of gender dysphoria in youth: a perfect storm environment for the placebo effect-the implications for research and clinical practice. Arch Sex Behavior 2023; 52:483-494.

This paper provides an overview of the poor data in support of opposite sex hormone treatment, of the harms caused by opposite sex treatment and improvement in response to placebo. For perspective, it describes historical treatments which once were popular, but eventually proved harmful to children.

Costa R. *et. al.* Psychological support, puberty suppression, and psychosocial functioning in adolescents with gender dysphoria. J Sex Med 2015: 12: 2206-2214.

This UK study found that psychological support alone lead to significant improvement in psychological function in adolescents with gender dysphoria, mean age of 15.5.

Psychiatric co-morbidities in youth with gender dysphoria

Becerra-Culquie TA *et. al.* Mental health of transgender and gender nonconforming youth compared with their peers. Pediatrics 2018: 141: e20173845.

Over 60 % of transgender adolescents were diagnosed with depression, autism spectrum disorders, psychoses, substance abuse, anxiety or eating disorders

Kozlowska, K. *et. al.* Australian children and adolescents with gender dysphoria: clinical presentations and challenges experienced by a multidisciplinary team and gender service. Human Systems: Therapy, Culture and Attachments 2021; 1: 70-95

88% of these youth had comorbid mental health diagnoses and other indicators of psychological distress and adverse childhood events. 19% had a history of sexual abuse.54% were bullyed. What is the best approach to treating these youth?

Devor, H. Transexualism, dissociation and child abuse: an initial discussion based on nonclinical data. J Psychology and Human Sexuality 1994; 6: 49-72.

In depth interviews disclosed that sixty percent of the natal females disclosed one or more types of child abuse; more than 50% of that abuse was sexual.

Harm:

Mortality:

Dhejne C, *et al.* Long-term follow-up of transsexual persons undergoing sex reassignment surgery: cohort study in Sweden. *PLoS One*. 2011;6(2):e16885.

This long-term study found an overall 19-fold higher suicide rate (40 fold in female to male) and a 3-fold higher overall mortality in 324 transgender persons at 11 years after full transition, compared to the control population.

de Blok CJM. *et al.* Mortality trends over five decades in adult transgender people receiving hormone treatment: a report from the Amsterdam cohort of gender dysphoria. *The Lancet Diabetes & Endocrinology*. 2021;9(10):663-670.

This study documented increased rates of mortality in all persons receiving opposite sex hormone therapy.

Bone:

Biggs M. Revisiting the effect of GnRH analogue treatment on bone mineral density in young adolescents with gender dysphoria. *J Pediatr Endocrinol Metab*. Jul 27 2021;34(7):937-939.

Children treated with puberty blockers showed a marked reduction in bone density in those treated with GnRH analogues (puberty blockers); this change would be expected to increase the risk of fractures.

Cardiovascular:

Nota NM, et al. Occurrence of Acute Cardiovascular Events in Transgender Individuals Receiving Hormone Therapy. *Circulation*. 2019;139(11):1461-1462.

This study found increased rates of heart attacks, strokes and blood clots in those treated with opposite sex hormone therapy.

Getahun D. *et. al.* Cross-sex Hormones and Acute Cardiovascular Events in Transgender Persons: A Cohort Study. *Ann Intern Med*. Aug 21 2018;169(4):205-213.

This study documents increased rates of blood clots as well as strokes and heart attacks in males given opposite sex hormone treatment

Fertility:

Baram S, *et al*. Fertility preservation for transgender adolescents and young adults: a systematic review. *Hum Reprod Update*. Nov 5 2019;25(6):694-716.

The authors raise concerns that opposite sex hormone therapies cause infertility, but offer no solutions to this problem.

Rodriguez-Wallberg K, *et. al.* Reproductive health in transgender and gender diverse individuals: a narrative review to guide clinical care and international guidelines. International J of Transgender Health. 2023; 24: 7-25

This paper details the likelihood of infertility "inherent in these interventions". They stress the many challenges and unknowns in fertility preservation in those receiving opposite sex therapy, especially in children. They note that many transgender persons "regret missed opportunities for fertility preservation".

Cancer:

de Blok CJM, *et. al.* Breast cancer risk in transgender people receiving hormone treatment: nationwide cohort study in the Netherlands. BMJ 2019; 365: l1652.

Males given opposite sex hormones experience a 46 fold increase in the occurrence of breast cancer.

Corso, G, *et. al.* Risk and incidence of breast cancer in transgender individuals: a systematic review and meta-analysis. European J of Cancer Preventioln 2023;

Reports a 22 fold increase in breast cancer in male to female transgender persons as compared to biolologic males.

Gurrala RR, *et. al.* The impact of exogenous testosterone on breast cancer risk in transmasculine individuals. Ann Plastic Surg 2023; 90: 96-105.

Breast cancer occurred 20 yrs earlier than expected in this population of females even though most had mastectomies before the diagnosis.

Wang, JC et. al. Factors associated with unsatisfactory Pap tests among sexually active trans masculine adults. LGBT Health 2023;

Those females who had received 1 year or more of testosterone were three and half times more likely to have an unsatisfactory Pap test, making early detection of cervical cancer much more difficult.

Breastfeeding:

Gribble, K. *et al.* Breastfeeding grief after chest masculinisation mastectomy and detransition: a case report with lessons about unanticipated harm. Frontiers in Global Women's Health 2023; Feb.

This case report describes the challenges faced by a woman who detranstions and who grieves over being unable to breastfeed her infant. Detransition is discussed and the importance of including in the informed consents before mastectomy the inability to breastfeed.

Brain:

Schneider MA, e*t. al.* Brain maturation, cognition, voice pattern in a gender dysphoria case under pubertal suppression. Frontiers in Human Neuroscience Nov 2017; 11.

This patient showed an abnormal failure to increase brain white matter. In addition the patient experienced a reduction in IQ and memory during 22 months of puberty blockers.

Gutkind NE, *et. al.* Idiopathic intracranial hypertension in female-to-male transgender patients on exogenous testosterone therapy. Ophthalmic Plast Reconst Surg 2023.

Describes 4 patients, the youngest 19, with visual impairment, headaches and other symptoms caused by increased intracranial pressure. They postulate male hormone therapy as a cause.

Post-surgical complications

Van der Sluis WB, *et. al.* Genital gender-affirming surgery for transgender women. Best Practice and Research Clinical Obstetrics and Gynecology Dec 2022.

The surgical procedures vulvoplasty and vaginoplasty typically require a 5 day hospital stay. The authors describe the risk of severe complications, the possibility of repeat surgeries and the fact that there is no accepted validated questionnaire to assess postoperative satisfaction.

Ortengren, C. et. al. Urethral outcomes in metoidoplasty and phalloplasty gender affirming surgery and vaginectomy: a systematic review. Translational Andrology and Urology 2022; 11: 1762-1770.

The authors review reports of surgical outcomes including the ability to urinate while standing after surgery. Of those reporting this result, 25% of patients were unable to urinate while standing. Up to 63% had complications including urethral strictures and infections. No description was provided of patient satisfaction after surgery.

Kamal K, *et.al.* Addressing the physical and mental impacts of postsurgical scarring among transgender and gender diverse people. LGBT Health 2023

The authors describe the "dearth of peer-reviewed research" on the "repurcussions" of postsurgical scarring and the lack of coverage by insurance for "scar treatment".

Potter, E. *et. al*. Patient reported symptoms and adverse outcomes seen in Canada's first vaginoplasty postoperative care clinic Neurourol Urodyn 2023; 42: 523-529

Pain, bleeding, sexual dysfunction and urinary symptoms were common (> 50%) in this series of 80 biologic males who had undergone surgery to create a vagina.

Wang, AMQ, *et. al*. Outcomes following gender affirming phalloplasty: a systematic review and meta-analysis. Sexual Medicine Reviews 2022; 10: 499-512.

The authors describe a 76% complication rate after attempts to create a penis in biologic females. Goals of surgery include being able to urinate with standing, having sensation, and aesthetics, i.e being similar in appearance to biologic male genitalia. The objective the authors considered did not include having a penis that can function for intromission. Only 6% of those centers reporting results aesthetic results.

Suicide risk

Wiepjes CM, *et. al.* Trends in suicide death risk in transgender people; results from the Amsterdam Cohort of Gender Dysphoria study (1972-2017). Act Psychiatr Scand 2020; 141: 486-491.

This long-term study of 8263 transgender adults, (mean age of 25 at first visit to gender dysphoria center) showed that suicide deaths occur during every stage of gender transitioning. There were 49 suicides out of 8263 persons with average follow-up of 7.5 years. This number is a rate of 40/100,000 which may be compared to 11/100,000 in the general population. Two thirds of those who died by suicide were still receiving treatment at the gender dysphoria center. The average age at the time of suicide was 41. This study provided no additional psychiatric information.

Biggs, M. Suicide by clinic-referred transgender adolescents in the United Kingdom. Arch Sexual Behavior 2021; 51: 685-90.

In this study, of the Gender identity Development Service in the UK, 4 patients commited suicide out of 15,000. This rate was 5.5 times higher than the overall adolescent population without psychiatric diagnoses. The study reached no conclusion as to the best approach to prevent these suicides.

Chen, D. *et. al.* Psychosocial functioning in transgender youth after 2 years of hormones. N Engl J Med 2023; 388: 240-250.

There was no control group in this study of children, aged 12-20 (mean age 16) treated with opposite sex hormones over 2 years in 4 US transgender clinics. Psychiatric care was not described. The biologic males showed no improvement in depression, anxiety or life satisfaction. There were no reports of adverse physical events but 2 children, on treatment, committed suicide during this short term study. The rate of suicide in this group translates into a 45 fold higher rate than CDC reported suicide rates for those of comparable age in the general population.

Jackson, D. Suicide-related outcomes following gender-affirming treatment: a review. Cureus March 20, 2023. Vol 15.

The author reviews those 23 studies that examine suicidal ideation and suicide attempts in persons before and after surgical and/or hormonal interventions. He finds various flaws in most of these studies. He points to the need for more research and informed consent for those considering these treatments.

Regret and Detransition

Littman L. Individuals treated for gender dysphoria with medical and/or surgical transition who subsequently detransitioned: a survey of 100 detransitioners. Arch. Sex Behavior. 2021; 50: 3353-3369.

This study recruited subjects with gender dysphoria and offered them a 115-question anonymous survey on several social media sites. The responses showed that 48% of the natal females had trauma within 1 year before onset of gender dysphoria. 55% felt they did not receive adequate evaluation from a doctor or mental health professional before opposite sex therapy 76 % did not tell their treating physician that they had chosen to detransition. In 23%, the desire to "transition" was a response to difficulty in accepting themselves as gay, lesbian, or bisexual. Gender dysphoria started on average at age 11 and transition occurred on average at age 22. On average, detransition occurred 4 years later.

Roberts CM, *et. al.* Continuation of gender-affirming hormones among transgender adolescents and adults. J Clin Endocrinol Metab 2022; 107: e3937-e3943.

This study used the US Military Healthcare System database to determine the adherence rates for opposite sex hormone treatment in 952 persons with a mean age 19. 66% of this cohort were natal females. Over 4 years, 36% of the natal females discontinued treatment. Of those who started opposite sex treatment below the age of 18, 26% discontinued within 4 years.

Ethics

https://www.ecfr.gov/current/title-21/chapter-I/subchapter-A/part-50/subpart-D/section-50.52

Code of federal regulations relating to institutional review board requirements for clinical investigations involving children. There must be anticipated benefit that is as favorable as other available treatments and there must be assent of the children and permission of the parents or guardians.

Declaration of Helsinki (1964) BMJ 313, 1448-1449, 1996

Gender Service Providers

Barnes, Hannah. Time to Think. The Inside Story of the Collapse of the Tavistock's Gender Service for Children. 2023.

This BBC journalist details the history of the poor care provided to over 10,000 children seen over the course of 30 years in the United Kingdom's Gender Identity Development Service. Pressure from transgender activists, concrete thinking by distressed youth hoping for a quick fix and financial issues were some of the reasons why staff failed to address important psychologic

factors in their patients. In doing so, they directed these children into medical therapies that harmed and did not help.

Cass Review Interim Report (Feb 2022)
https://cass.independent-review.uk/publications/interim-report/

This is the commissioned report written by Dr Hillary Cass, a highly respected pediatrician in the United Kingdom. She describes the failings of the Gender Identity Development Service. Dr. Cass recommends many changes to the treatment of minors with gender dysphoria. She stresses psychosocial interventions as the principal focus.

Affidavit of Jamie Reed.
https://ago.mo.gov/docs/default-source/press-releases/2-07-2023-reed-affidavit---signed.pdf?sfvrsn=6a64d339_2

The writer is a whistleblower who describes the treatment of (over 600) children at the Washington University Pediatric Transgender Center. Children were railroaded into opposite sex medical interventions without addressing adverse effects and without treating underlying psychiatric conditions.

Do No Harm

EXHIBIT

24

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North Dakota Senate

Senate Committee on Human Services

HB 1254

Daniel Weiss MD

Opening Statement

Chairwoman Lee and Members of the Committee:

My name is Dr. Daniel Weiss.

I am a board-certified internist and endocrinologist. I am also a senior fellow with the non-profit organization, Do No Harm. My commentary is mine alone and does not represent the views of any medical practice.

I believe my clinical experience is meaningful, in part, because I have provided hormonal treatments for persons with gender dysphoria in the past.

I do not do so now.

Why not? Because I discovered that most of these patients carried stories of traumatic childhoods and co-morbid depression. Their psychologic evaluation was inadequate before they were “cleared” for treatment. Furthermore, opposite sex treatment did not resolve any of their underlying psychologic issues.

I later learned that there is no good scientific or clinical evidence to support hormonal or surgical interventions for minors with gender dysphoria. Instead, there is increasing evidence to show that such treatments for gender dysphoria cause harm. I will briefly summarize key data in the medical literature.

The most-cited studies of hormonal treatment in minors report outcomes using the so-called Dutch protocol. I encourage you to review the references I have provided.

Multiple papers detail the many scientific flaws in the Dutch studies: There was no comparison group. The study subjects were highly selected. The study started with 111 children but only 55 were analyzed at its conclusion. Nonetheless, the small group of children showed no improvement in gender distress, anxiety, or anger after opposite sex hormone treatment. The researchers used an unvalidated measurement tool and manipulated its results. It is also little known that the series included, as a complication of surgery, a patient death. Independent researchers in the United Kingdom attempted to replicate the findings of the Dutch group, but, revealingly, were unsuccessful.

A paper published last year in the Endocrine Society's key journal summarized the evidence on hormonal interventions for "gender diverse adolescents" as sparse and of low quality. In the key authoritative endocrinology textbook, just published in 2023, the chapter on Transgender Healthcare, written by a WPATH member, states that "long-term prospective outcome studies of the effects of GAHT (gender affirming hormone therapy) of any type are lacking. What data that do exist are mostly retrospective and have numerous limitations."

And gender dysphoria resolves in the vast majority of children without any interventions.

I have touched on the lack of data showing benefit. So, what about harm? Many studies show that puberty blockers and opposite sex hormones damage bone health, cardiovascular health, and fertility. There is emerging evidence of increased rates of breast cancer and other adverse effects.

Those who state that puberty blockers are readily reversible and harmlessly "pause" puberty can cite no published data on the reversibility of these drugs in this setting. The FDA has not approved any drug for treatment of gender dysphoria.

How about suicide? The largest study documented 4 suicides out of 15,000 adolescents being treated for gender dysphoria in the United Kingdom. It is not known whether this rate is any different than that seen in adolescents undergoing mental health treatment who do not have gender dysphoria.

The best data suggest that hormonal and surgical interventions increase the risk of suicide. The Dutch study provided no data on suicide. In contrast, a long-term study of transgender persons in Sweden found a 19-fold overall higher suicide rate.

The rate was 40-fold higher in females and a 3-fold higher overall mortality, despite treatment with opposite sex hormones and surgery as compared to the control population. *In a study of over 8000 transgender person, two thirds of those who died by suicide were still receiving treatment at the gender dysphoria center*. In a New England Journal of Medicine article this year, suicide reportedly increased 45-fold with opposite sex hormonal therapy.

For more than a decade, long before opposite sex therapies became popular in the United States, European centers offered these treatments for gender confusion. Now, as increasing data show substantial harm, Finland, Sweden, France, and the United Kingdom have discouraged or terminated opposite sex treatments for minors. Instead, they advise supportive psychotherapy for minors with gender confusion.

Why have physicians and surgeons in the United States resisted the shift occurring among their European counterparts? I do not know the answer. However, I caution legislators to avoid all individual and institutional financial conflicts of interest while finalizing this bill.

In closing, it should be noted that strict international principles prohibit children from providing consent. This is because children cannot fully comprehend risk versus benefit. The United States is a signatory to the United Nations Convention on the Rights of the Child. The *Declaration of the Rights of the Child* states that "the child, by reason of his physical and mental immaturity, needs special safeguards and care." These safeguards are uniquely important when it comes to an experimental medical intervention. The Declaration of Helsinki allows individual parents to consent to experimental treatment for their child. Usually, this choice is made in an extraordinary circumstance, to save that child's life, and with the child's assent. Experimental treatments to change gender appearance should not be an exception to these requirements.

Please help protect the children of North Dakota.

Thank you.

Daniel Weiss MD

Key References:

Lack of efficacy

de Vries A. L. *et al.* Puberty suppression in adolescents with gender identity disorder: a prospective follow-up study. J. Sexual Medicine 2011; 8: 2276-2283.

"Dutch Study." There was no change in anxiety, depression or gender distress following GnRH therapy (puberty blockers) and opposite sex therapy in children. There was no comparator control group, and all received psychologic support.

de Vries A.L. *et al.* Young adult psychological outcome after puberty suppression and gender reassignment. Pediatrics 2014; 134: 696-704.

"Dutch Study." A non-validated assessment tool was used to assess dysphoria, there was no control group, and the 55 patients were tested in such a way that improvements in scores would be seen even without treatment. There was one post-surgical death. Only 55 of the original 111 children were included in the analysis.

Carmichael P. *et. al.* Short-term outcomes of pubertal suppression in a selected cohort of 12- to 15-year-old young people with persistent gender dysphoria in the UK. PLOS One 2021; 16 (2) *These researchers could not confirm any of the claims of DeVries et al in young people treated with the Dutch protocol in the U.K.*

Kaltiala R, *et. al.* Adolescent development and psychosocial functioning after starting cross-sex hormones for gender dysphoria. *Nord J Psychiatry*. 2020;74(3):213-219.

This retrospective chart review showed no improvement in psychiatric status in 52 adolescents after opposite sex hormone treatments.

Abbruzzese E. *et. al.* The Myth of "Reliable Research" in Pediatric Gender Medicine: A critical evaluation of the Dutch Studies—and research that has followed, Journal of Sex & Marital Therapy. January 2023.

This paper is a comprehensive and critical review of De Vries' studies identifying the many flaws and biases in the methodology.

Levine S. *et. al.* Reconsidering informed consent for trans-identified children, adolescents, and young adults. J. Sex and Marital Therapy 2022; 48: 706-727.

This paper describes the challenges in providing full and proper informed consent to children with gender dysphoria and their parents in light of the flaws in the Dutch protocol and limitations in our knowledge base.

O'Connell MA, *et al.* Approach to the Patient: Pharmacological Management of Trans and Gender-Diverse Adolescents. *J Clin Endocrinol Metab*. 2022;107(1):241-

257. *This review stresses the need for improvement in the "evidence base" emphasizing that the "evidence relating to hormonal therapies in youth is low" and that "data on wellbeing in transgender persons is sparse".*

Levine SB, *et. al.* What are we doing to these children? Response to Drescher, Clayton, and Balon commentaries on Levine et. al. 2022. J Sex and Marital Therapy 2023; 49:115-125. *In a response to comments, the authors discuss the benefits of psychotherapeutic interventions and the frequent conflicts of interest of those clinicians who solely promote hormonal and surgical interventions.*

Deutsch, MB. Transgender Healthcare. p 1752-1757 *in* Degroot's Endocrinology. Basic science and clinical practice. 8th edition. 2023.

In this authoritative textbook on endocrinology, *Dr. Madeline Deutsch, a member of the World Professional Association for Transgender Health* (WPATH) *writes that "long-term prospective outcome studies of the effects of GAHT (gender affirming hormone therapy) of any type are lacking. What data that do exist are mostly retrospective and have numerous limitations."*

Role of psychotherapy or non-intervention

Ristori J, Steensma TD. Gender dysphoria in childhood. *Int Rev Psychiatry.* 2016;28(1):13-20. *85% of children with gender dysphoria show spontaneous resolution of their symptoms and distress without any intervention.*

Clayton, A. Gender-affirming treatment of gender dysphoria in youth: a perfect storm environment for the placebo effect-the implications for research and clinical practice. Arch Sex Behavior Nov. 2022.

This paper provides an overview of the poor data in support of opposite sex hormone treatment, of the harms caused by opposite sex treatment and improvement in response to placebo. For perspective, it describes historical treatments which once were popular, but eventually proved harmful to children.

Costa R. *et. al.* Psychological support, puberty suppression, and psychosocial functioning in adolescents with gender dysphoria. J Sex Med 2015: 12: 2206-2214.

This UK study found that psychological support alone lead to significant improvement in psychological function in adolescents with gender dysphoria, mean age of 15.5.

Psychiatric co-morbidities in youth with gender dysphoria

Becerra-Culquie TA *et. al.* Mental health of transgender and gender nonconforming youth compared with their peers. Pediatrics 2018: 141: e20173845.

Over 60 % of transgender adolescents were diagnosed with depression, autism spectrum disorders, psychoses, substance abuse, anxiety or eating disorders.

Kozlowska, K. et. al. Australian children and adolescents with gender dysphoria: clinical presentations and challenges experienced by a multidisciplinary team and gender service. Human Systems: Therapy, Culture and Attachments 2021; 1: 70-95

88% of these youth had comorbid mental health diagnoses and other indicators of psychological distress and adverse childhood events. 19% had a history of sexual abuse. 54% were bullied. What is the best approach to treating these youth?

Devor, H. Transexualism, dissociation and child abuse: an initial discussion based on nonclinical data. J Psychology and Human Sexuality 1994; 6: 49-72.

In depth interviews disclosed that sixty percent of the natal females disclosed one or more types of child abuse; more than 50% of that abuse was sexual.

Harm

Mortality:

Dhejne C, *et al.* Long-term follow-up of transsexual persons undergoing sex reassignment surgery: cohort study in Sweden. *PLoS One*. 2011;6(2):e16885.

This long-term study found an overall 19-fold higher suicide rate (40 fold in female to male) and a 3-fold higher overall mortality in 324 transgender persons at 11 years after full transition, compared to the control population.

de Blok CJM. *et al.* Mortality trends over five decades in adult transgender people receiving hormone treatment: a report from the Amsterdam cohort of gender dysphoria. *The Lancet Diabetes & Endocrinology*. 2021;9(10):663-670.

This study documented increased rates of mortality in all persons receiving opposite sex hormone therapy.

Bone:

Biggs M. Revisiting the effect of GnRH analogue treatment on bone mineral density in young adolescents with gender dysphoria. *J Pediatr Endocrinol Metab*. Jul 27, 2021;34(7):937-939. *Children treated with puberty blockers showed a marked reduction in bone density in those treated with GnRH analogues (puberty blockers); this change would be expected to increase the risk of fractures.*

Cardiovascular:

Nota NM, et al. Occurrence of Acute Cardiovascular Events in Transgender Individuals Receiving Hormone Therapy. *Circulation*. 2019;139(11):1461-1462.

This study found increased rates of heart attacks, strokes, and blood clots in those treated with opposite sex hormone therapy.

Getahun D. *et. al.* Cross-sex Hormones and Acute Cardiovascular Events in Transgender Persons: A Cohort Study. *Ann Intern Med*. Aug 21, 2018;169(4):205-213.

This study documents increased rates of blood clots as well as strokes and heart attacks in males given opposite sex hormone treatment.

Fertility:

Baram S, *et al.* Fertility preservation for transgender adolescents and young adults: a systematic review. *Hum Reprod Update*. Nov 5, 2019;25(6):694-716.

The authors raise concerns that opposite sex hormone therapies cause infertility, but offer no solutions to this problem.

Cancer:

de Blok, *et. al.* Breast cancer risk in transgender people receiving hormone treatment: nationwide cohort study in the Netherlands. BMJ 2019; 365: l1652.

Males given opposite sex hormones experience a 46-fold increase in the occurrence of breast cancer.

Gurrala RR, *et. al.* The impact of exogenous testosterone on breast cancer risk in transmasculine individuals. Ann Plastic Surg 2023; 90: 96-105.

Breast cancer occurred 20 yrs earlier than expected in this population of females even though most had mastectomies before the diagnosis. Despite mastectomy, they retained some breast tissue.

Wang, JC et. al. Factors associated with unsatisfactory Pap tests among sexually active trans masculine adults. LGBT Health 2023;

Those females who had received 1 year or more of testosterone were three and half times more likely to have an unsatisfactory Pap test, making early detection of cervical cancer much more difficult.

Breastfeeding:

Gribble, K. *et al.* Breastfeeding grief after chest masculinisation mastectomy and detransition: a case report with lessons about unanticipated harm. Frontiers in Global Women's Health 2023; Feb.

This case report describes the challenges faced by a woman who detranstions and who grieves over being unable to breastfeed her infant. Detransition is discussed and the importance of including in the informed consents before mastectomy the inability to breastfeed.

Brain:

Schneider MA, et. *al.* Brain maturation, cognition, voice pattern in a gender dysphoria case under pubertal suppression. Frontiers in Human Neuroscience Nov 2017; 11. *This patient showed an abnormal failure to increase brain white matter. In addition the patient experienced a reduction in IQ and memory during 22 months of puberty blockers.*

Post-surgical complications

Van der Sluis WB, *et. al.* Genital gender-affirming surgery for transgender women. Best Practice and Research Clinical Obstetrics and Gynecology Dec 2022.

The surgical procedures of vulvoplasty and vaginoplasty typically require 5 day hospital stay. The authors describe the risk of severe complications, the possibility of repeat surgeries and the fact that there is no accepted validated questionnaire to assess postoperative satisfaction.

Ortengren, C. et. al. Urethral outcomes in metoidioplasty and phalloplasty gender affirming surgery and vaginectomy: a systematic review. Translational Andrology and Urology 2022; 11: 1762-1770.

The authors review reports of surgical outcomes including the ability to urinate while standing after surgery. Of those reporting this result, 25% of patients were unable to urinate while standing. Up to 63% had complications including urethral strictures and infections. No description was provided of patient satisfaction after surgery.

Kamal K, *et.al.* Addressing the physical and mental impacts of postsurgical scarring among transgender and gender diverse people. LGBT Health 2023

The authors describe the "dearth of peer-reviewed research" on the "repercussions" of postsurgical scarring and the lack of coverage by insurance for "scar treatment".

Potter, E. et. al. Patient reported symptoms and adverse outcomes seen in Canada's first vaginoplasty postoperative care clinic Neurourol Urodyn 2023; 42: 523-529

Pain, bleeding, sexual dysfunction, and urinary symptoms were common (> 50%) in this series of 80 biologic males who had undergone surgery to create a vagina.

Wang, AMQ, et. al. Outcomes following gender affirming phalloplasty: a systematic review and meta-analysis. Sexual Medicine Reviews 2022; 10: 499-512.

The authors describe a 76% complication rate after attempts to create a penis in biologic females. Goals of surgery include being able to urinate with standing, having sensation, and aesthetics, i.e being similar in appearance to biologic male genitalia. The objective the authors considered did not include having a penis that can function for intromission. Only 6% of those centers reporting results aesthetic results.

Suicide risk

Wiepjes CM, *et. al.* Trends in suicide death risk in transgender people; results from the Amsterdam Cohort of Gender Dysphoria study (1972-2017). Act Psychiatr Scand 2020; 141: 486-491.

This long-term study of 8263 transgender adults, (mean age of 25 at first visit to gender dysphoria center) showed that suicide deaths occur during every stage of gender transitioning. There were 49 suicides out of 8263 persons with average follow-up of 7.5 years. This number is a rate of 40/100,000 which may be compared to 11/100,000 in the general population. Two thirds of those who died by suicide were still receiving treatment at the gender dysphoria center. The average age at the time of suicide was 41. This study provided no additional psychiatric information.

Biggs, M. Suicide by clinic-referred transgender adolescents in the United Kingdom. Arch Sexual Behavior 2021; 51: 685-90.

In this study, of the Gender identity Development Service in the UK, 4 patients committed suicide out of 15,000. This rate was 5.5 times higher than the overall adolescent population without psychiatric diagnoses. The study reached no conclusion as to the best approach to prevent these suicides.

Chen, D. *et. al.* Psychosocial functioning in transgender youth after 2 years of hormones. N Engl J Med 2023; 388: 240-250.

There was no control group in this study of children, aged 12-20 (mean age 16) treated with opposite sex hormones over 2 years in 4 US transgender clinics. Psychiatric care was not described. The biologic males showed no improvement in depression, anxiety, or life satisfaction. There were no reports of adverse physical events but 2 children, on treatment, committed suicide during this short-term study.

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