

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

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1 DANIEL WEISS, M.D.
 2 the witness herein, having been first duly sworn to
 3 tell the truth, the whole truth, and nothing but the
 4 truth, was examined and testified as follows:
 5 EXAMINATION,
 6 QUESTIONS BY MR. SELDIN:
 7 Q Dr. Weiss, good morning.
 8 A Good morning.
 9 Q My name is Harper Seldin. I'm an attorney for the
 10 plaintiffs. You and I will be doing this
 11 deposition today.
 12 Just a couple table setting things, have you
 13 ever been deposed before?
 14 A I have.
 15 Q How many times?
 16 A Two times.
 17 Q When was that?
 18 A That is mentioned in my C.V. The last time was
 19 2021. The time before that I believe was 1993,
 20 but the C.V. will indicate with certainty.
 21 Q Great. So when you are referring to your C.V.,
 22 you are referring to the two prior times you
 23 served as an expert witness in other matters?
 24 A Yes.
 25 Q Great. Okay. So some of this will be familiar to

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1 you, but we will go over it anyway just so we are
 2 on the same page.
 3 Today I will be asking you questions. You
 4 will provide answers. Those answers must be
 5 verbal. Head shakes will not come through.
 6 Uh-huh, huh-uh will not come through.
 7 If you answer a question, I will assume that
 8 means that you understood my question. If you
 9 don't understand my question, let me know and we
 10 will try again.
 11 Does that sound good to you?
 12 A It does. I understand.
 13 Q Now, is there any reason today, medication or
 14 otherwise, that you would not be able to
 15 understand me, understand my questions, and
 16 provide truthful responses?
 17 A No.
 18 Q Okay. The only other thing I will say is let's
 19 just try not to talk over each other. Even if you
 20 anticipate where I'm going, let me finish my
 21 question. I will try to let you finish your
 22 answer. That way Wendy will not yell at us, which
 23 is always my goal.
 24 The other thing is if you need to take a
 25 break at any time, let me know. I just ask if

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1 there is a question pending that you answer the
2 question and then we can take a break.
3 A I understand.
4 Q Great. Do you have anyone in the room with you
5 today?
6 A No.
7 Q Do you have any notes with you today?
8 A No.
9 Q Do you have a copy of your declaration in this
10 matter with you?
11 A I do.
12 Q Great. That will make it easy.
13 MR. SELDIN: Just for purposes of making
14 sure we have the exhibits right, Erica, would you
15 pull up what is marked as Weiss Exhibit 1. Great.
16 Q Does this appear to be the expert declaration that
17 you submitted in this case, or the first page of
18 it?
19 A It does.
20 Q You can see this PDF has about 113 pages on it.
21 Does that sound about right?
22 A It does.
23 Q Is this the same document as the one you have in
24 front of you?
25 A Yes.

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1 Q Does this declaration contain all of the opinions
2 that you intend to offer in this case?
3 A No.
4 Q What other opinions do you intend to offer in this
5 case?
6 A Other opinions might arise during the deposition.
7 Q Okay. So as of right now, these are all of the
8 opinions that you intend to offer in this case?
9 A They are.
10 Q Okay. So there are no additional opinions in your
11 mind or elsewhere that you intend to offer. As we
12 talk you may have further opinions?
13 A That is correct.
14 Q Okay.
15 MR. SELDIN: Could you pull up Exhibit 2.
16 Q Dr. Weiss, I'm showing you Exhibit 2. You will
17 see it has the case caption and notice of
18 deposition and request for production of
19 documents.
20 Have you seen this document before?
21 A I don't recall receiving this document, seeing
22 this document, no.
23 Q I will represent to you that it's the notice of
24 deposition and request for production of documents
25 that we gave to the State Attorney General's

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1 office in connection with this deposition.
2 If you look midway down the page it says
3 Request for Production of Documents. This is a
4 request from the plaintiff that you produce in
5 connection with this deposition your current C.V.
6 first.
7 Starting there, do you see that request?
8 A I do.
9 Q You included a C.V. with your declaration. Is
10 that your current C.V.?
11 A Yes.
12 Q Okay. I believe if you scroll all of the way to
13 the back of your C.V., Page 75 it's dated May 10,
14 2023.
15 A That is correct.
16 Q I take it there have been no changes to this in
17 the last sixteen days?
18 A Correct.
19 Q Great. Then, in addition, you will see back to
20 Exhibit 2 at the bottom of the page it asks that
21 you provide, "The declaration report, and rebuttal
22 report the deponent has most recently submitted as
23 an expert witness in any litigation related to the
24 provision of gender-affirming care to minors, if
25 such a declaration, report or rebuttal report has

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

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

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1 To prepare for today's deposition did you
2 speak to Ms. Youngs or any of the other attorneys
3 at the Attorney General's office?
4 A Yes.
5 Q Okay. When did you talk to them?
6 A Yesterday.
7 Q And for about how long?
8 A Oh, about two hours.
9 Q And do you recall which attorneys were present?
10 A Ms. Youngs and Mr. Fisher.
11 Q Was there anyone else present during your
12 preparation?
13 A No, there was not.
14 Q Other than that two hour conversation yesterday
15 with Mr. Fisher and Ms. Youngs, did you speak to
16 anyone else to prepare for today's deposition?
17 A No.
18 Q Okay. Did you speak with any of the other defense
19 experts in this case to prepare for today's
20 deposition?
21 A No.
22 Q Okay. Did you review the, to prepare for today's
23 deposition did you review any of the expert
24 declarations from the plaintiff experts.
25 Dr. Shumer, Dr. Karasic, Dr. Turban?

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1 A Yes, all three of them.
2 Q And have you reviewed the transcripts of their
3 depositions in this case?
4 A Only Dr. Turban's.
5 Q Do you recall when you reviewed Dr. Turban's
6 deposition?
7 A About a week ago.
8 Q Any other materials you can think of that you read
9 to prepare for today's deposition?
10 A No.
11 Q Have you spoken with any of the defense experts in
12 this case in any context at all?
13 A No.
14 Q Okay. So we know we are talking about the same
15 folks, have you ever had a conversation with
16 Dianna Kenny?
17 A No.
18 Q Kristopher Kaliebe?
19 A No.
20 Q Paul Hruz?
21 A No.
22 Q James Cantor?
23 A No.
24 Q I want to talk a little bit about your
25 professional background.

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

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

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

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

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

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

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

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

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

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

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1 A Yeah.
2 Q It seems that these seem to be mostly about
3 diabetes and metabolic disorders.
4 Is that about right?
5 A The broad area of diabetes endocrinology, yes.
6 There are other internal medicine related topics.
7 Correct.
8 Q Is any of this continuing medical education
9 pertaining to assessing gender dysphoria?
10 A No.
11 Q Does any of it pertain to diagnosing gender
12 dysphoria?
13 A No.
14 Q Does any of this pertain to treating gender
15 dysphoria?
16 A No.
17 Q Does any of it pertain to providing
18 gender-affirming care?
19 A I don't use that term. But treating gender
20 dysphoria does not relate to that.
21 Q And why don't you use the term gender-affirming
22 care?
23 A Perhaps we can defer that to later on in the
24 discussion because it's not -- I think it's gender
25 harming care. It's person harming care. It is a

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1 euphemistic term that is not appropriate to the
2 interventions that are, that some practitioners
3 apply to these minors. I think it's harmful. So
4 I don't call it gender-affirming.
5 Q So as part of your explanation you said it's
6 harmful to minors.
7 Do you also believe it's harmful to adults?
8 A Yes.
9 Q So you would not use the term gender-affirming
10 care for a person of any age?
11 A Correct.
12 Q So when I use the term gender-affirming care I'm
13 referring to in some part the medical procedures
14 that are listed in Senate Enrolled Act 480 in this
15 case.
16 If I refer to that broadly as treating gender
17 dysphoria, would we understand each other?
18 A I think it is a better term to use the term
19 treating gender dysphoria with hormones, puberty
20 blockers, surgery.
21 I would not call it gender-affirming care. I
22 think it is euphemistic and misleading language.
23 Q So just to make sure that we continue to
24 understand each other in this deposition, I will
25 likely use the terms gender-affirming care and

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

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1 A It is a designation that the AMA comes up with.
2 If you are studying a publication, analyzing it
3 carefully and reading it, that is considered
4 category two.
5 But if you are attending a meeting and they
6 have certified it as category one, then you get
7 category one credit. You can click on some sites
8 and get category one credit pretty easily.
9 But category two credit is still very
10 meaningful. Reading journal articles. Reading
11 the scientific literature. I have done extensive
12 reading on gender dysphoria that would be, that
13 would achieve many, many credits in category two.
14 Q And in terms of maintaining your medical license,
15 do category two credits count towards that?
16 A They do, but they are not as important. You have
17 to have a minimum of category one for maintaining
18 your license.
19 Q Is there a minimum number for category two?
20 A No.
21 Q So is it fair to say then that you could not
22 maintain your medical license merely by using
23 category two credits?
24 A That is correct.
25 Q Okay. I take it then when you have category one

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1 credits you receive some kind of a certificate or
2 acknowledgment so when the licensing board asks if
3 you are current you can demonstrate you have
4 attended the requisite number. Is that fair?
5 A That is correct.
6 Q Lawyers have something similar so I'm assuming
7 there are so many ways to track continuing
8 education of any kind.
9 Do you receive similar acknowledgments for
10 category two credits?
11 A No.
12 Q So pardon my ignorance. Is there such a thing as
13 category three?
14 A I have never heard of it.
15 Q Is it fair to say then that you have independently
16 researched and read about the treatment of gender
17 dysphoria which you characterize as category two
18 credits, but you don't have a running list of
19 that?
20 A Correct.
21 Q Do you recall the first time that you pursued any
22 continuing medical education about the treatment
23 of gender dysphoria?
24 A I was doing some reading during a period of time
25 when I was treating adults, which was

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1 approximately 2003 to 2013. So I read the
2 literature during that period of time.
3 Q So you have been in practice since about 1985, is
4 that right?
5 A Practice outside of Iowa since 1986.
6 Q Right. So from 1986 to 2002, let's say, you did
7 not have any continuing, any medical education
8 about the treatment of gender dysphoria. That all
9 began in 2003?
10 A I don't think that is accurate to state that
11 because there was some treatment of gender
12 dysphoria during my training in Iowa at the
13 University of Iowa.
14 There was a physician who was probably the
15 only doctor in the state treating adults with
16 gender dysphoria. I learned aspects of treatment
17 from him. That would have been during my
18 fellowship at the University of Iowa in the 1980s.
19 Q Who was that doctor?
20 A Dr. John MacIndoe.
21 Q I'll claim this is for the court report, but it's
22 for me, can you spell that?
23 A M-A-C-I-N-D-O-E.
24 Q Tell me a little bit about this training that you
25 received at the University of Iowa with

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1 Dr. MacIndoe?
2 A So he would see an occasional adult patient with
3 gender dysphoria. I would go into the exam room
4 and assess the patient along with Dr. MacIndoe and
5 talk about hormonal interventions.
6 Q About how many of those patients do you think you
7 encountered with Dr. MacIndoe?
8 A Maybe twelve.
9 Q Over what period of time?
10 A Years.
11 Q Two years? Four years?
12 A Two years.
13 Q Two years. Was that the length of your fellowship
14 at the University of Iowa?
15 A Yes.
16 Q Was your fellowship in a particular specialty?
17 A Yes. So the training, you know, there's four
18 years of medical school after college. And then
19 there is residency, which is three years. And
20 then two years of fellowship.
21 So the fellowship, my expertise, my
22 fellowship is in that subspecialty of internal
23 medicine called endocrinology metabolism.
24 Q So over the course of your two year endocrinology
25 fellowship with Dr. MacIndoe you believe you

Page 30

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

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1 Q So you would not have been diagnosing them with --
2 A No, I was not.
3 Q And do you recall what treatments these
4 approximately twelve adults were provided as a
5 result of Dr. MacIndoe's care?
6 A It was opposite sex hormone treatment.
7 Q When you say opposite sex hormone treatment, what
8 do you mean?
9 A So biologic males were given estrogen or androgen
10 blockers. Biologic females were given
11 testosterone.
12 Q And for these twelve patients do you recall how
13 many times you would have seen them?
14 A Maybe three times for each of the twelve patients.
15 Q Did Dr. MacIndoe in your presence speak to these
16 patients about how their treatments were working?
17 A Yes.
18 Q And what did they tell you and Dr. MacIndoe?
19 A That was a long time ago so I can't recall
20 specifics on that.
21 Q Do you recall generally how these twelve adults
22 fared on this treatment?
23 A My recollection from forty years ago is that they
24 valued the physical changes that they were
25 experiencing.

Page 32

1 Q Did you keep in touch with Dr. MacIndoe?
2 A No.
3 Q During your two year fellowship you would see
4 these patients as part of learning as a fellow
5 with Dr. MacIndoe.
6 Did you have any experience treating gender
7 dysphoria between the end of your fellowship and
8 2003?
9 A I don't recall treating when I was with University
10 Mednet, no. I think I only was treating when I
11 was an independent practice from 2003 on. There
12 were relatively few patients until the last decade
13 or so. Ten, fifteen years.
14 Q Between the end of your fellowship and 2003 did
15 you advertise any clinical expertise in treating
16 gender dysphoria?
17 A I did not advertise at all. I didn't need to.
18 Patients would come to me with their endocrine
19 disorders. I was not promoting myself. I didn't
20 need to. I was a sole endocrinologist in this
21 group of 110 doctors. I didn't speak up or talk
22 about my expertise in that area because there was
23 no need to. There were patients sent to me for
24 that.
25 Q So you didn't treat any patients' gender dysphoria

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1 from the end of your fellowship until 2003?
2 A Correct. They were not sent to me. I was not
3 asked to treat them.
4 Q Did you have any patients who were transgender
5 between the end of your fellowship and 2003?
6 A I don't recall.
7 Q Looking at your C.V. if you look at Page 16, Roman
8 Numeral XII, do you see your bibliography?
9 A Yes.
10 Q You will see that this runs through Page 18.
11 There is a Number 26 for the last publication.
12 Do you see that as well?
13 A I do.
14 Q Do any of these publications in your bibliography
15 pertain to the treatment of gender dysphoria?
16 A None.
17 Q Do any of them pertain to the assessment or
18 diagnosis of gender dysphoria?
19 A No.
20 Q Have you ever conducted any original research
21 about gender dysphoria?
22 A No.
23 Q Have you ever conducted any original research
24 about gender identity or transgender people?
25 A No.

Page 34

1 Q Have you published any peer reviewed articles
2 about the treatment of gender dysphoria?
3 A No.
4 Q Have you published any not peer reviewed articles
5 about gender dysphoria?
6 A No.
7 Q Thank you, Dr. Weiss. I'm now going to turn to
8 Page 20 of your C.V. This is Roman Numeral XIII,
9 Presentations to Medical Professionals.
10 A Yes.
11 Q You will see that first presentation is dated
12 March 31, 1981, correct?
13 A Correct.
14 Q Then if we go to Page 62 of your C.V., you will
15 see that the last entry is 564 and is dated
16 November 9, 2022.
17 Do you see that?
18 A Say that again.
19 Q I'm saying do you see the last entry in this
20 section?
21 A 564?
22 Q Yes.
23 A Yes, I see it.
24 Q Is it fair to say then this is a complete list of
25 your presentations from 1981 to 2022?

Page 35

1 A That is correct. This is to medical
2 professionals, yes.
3 Q Are any of these presentations regarding gender
4 dysphoria or its treatment?
5 A No.
6 Q On Page 63 of your C.V. it says, "Note, Dr. Weiss
7 continues to be a speaker presenting at programs
8 across the United States. However, as of June
9 2007 only programs that were non-promotional in
10 nature are listed above."
11 Did I read that correctly?
12 A You did.
13 Q What does that mean?
14 A So I have been a speaker for pharmaceutical
15 companies and those presentations relate to their
16 medications and teaching doctors about these new
17 medications.
18 So I listed some of those. Many of those
19 were listed early on among those presentations to
20 medical professionals.
21 As of June 2007 only the programs that were
22 not promotional, that were not pharmaceutical
23 related were listed. So those were just didactic
24 in nature without a sponsor by a pharmaceutical
25 company.

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

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

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1 morning programs so they don't interfere with
2 patient care.
3 Q And you listed Mounjaro as one of the medications
4 that you do promotional presentations for.
5 Are there other medications that you have
6 done presentations for? That was a bad question.
7 I'm trying to ask you of the medications that
8 you have made promotional presentations about,
9 have they all related to the treatment of
10 diabetes?
11 A No. So there have been medications for treating
12 cholesterol. There have been medications for
13 treating osteoporosis. There have been
14 medications for treating diabetes. Medications
15 related to obesity.
16 There are so many over the years because I
17 have been in practice for over thirty-five years.
18 I have been doing promotional programs since the
19 1980s.
20 Q Of the medications that you have done these
21 promotional presentations for, have any of them
22 been for the treatment of gender dysphoria?
23 A No.
24 Q Okay.
25 A Let me also spell Mounjaro for the court reporter.

Page 39

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

Page 40

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

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1 Q Why was that?
2 A Most endocrinologists that I have interacted with
3 are not on board with, are not convinced that the
4 evidence is good or they are uncomfortable
5 treating with opposite sex hormones for those
6 people with gender dysphoria so they don't see
7 those people.
8 Q When you say uncomfortable, do you mean because of
9 their perception of the evidence base or some
10 other reason?
11 A I think it's their perception of the evidence
12 base, yes.
13 Q What would you say in response to that?
14 A Now I would support them. I can understand their
15 feeling that the evidence is very weak because it
16 is both for adults and for children.
17 Back then when I was treating, obviously, I
18 was not aware of how weak the evidence was.
19 I was offering treatment. I was the
20 principal person in northern Ohio treating people
21 with gender dysphoria during that ten years of
22 time I was treating.
23 Q But at the time you were providing treatment to
24 adults?
25 A Correct.

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1 Q And was your perception that the treatment was
2 effective for them?

3 A I was not sure. There was an evolutionary process
4 there with me. I felt, I evolved to the point
5 where I saw that people were really not improving.
6 They had lots of other, lots of other
7 problems. Lots of psychiatric problems. Discord
8 in the family. There were other unresolved
9 issues, anxiety, depression. And I thought they
10 were inadequately evaluated when they were sent to
11 me because they were sent to me having seen a
12 therapist, but often those visits were one or two
13 visits and then they were told that they were good
14 to go. They met the criteria for hormonal
15 interventions.

16 But I didn't -- so, yes, they had physical
17 changes. But I don't think from a psychological
18 standpoint they really improved. Eventually I,
19 then I started to see more and more and my other
20 patients were not getting care. I could not see
21 new people because my practice is very busy. I
22 declined seeing new patients.

23 I continued to provide care for those
24 established patients. But as I stated in my
25 declaration, probably seventy percent discontinued

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1 their care. Or I should say more specifically,
2 they didn't follow up with me so I suspect they
3 discontinued their care because there was no one
4 else who could offer that care in the area.

5 Q When you say that you stopped seeing new patients,
6 what year did you stop seeing new patients for the
7 treatment of gender dysphoria?

8 A 2013.

9 Q Have you seen any patient for the treatment of
10 gender dysphoria since 2013?

11 A For the treatment of gender dysphoria, no.

12 Q Okay. So I want to make sure I have the timeline
13 correct. From 2003 to 2013 you saw patients for
14 the treatment of gender dysphoria.

15 In 2013 you stopped seeing new patients for
16 the treatment of gender dysphoria.

17 A Correct.

18 Q So for the existing patients that you had with
19 gender dysphoria, the last one of those people
20 that you saw would have also been in 2013?

21 A No. No. I continued seeing them until I left
22 Ohio.

23 Q What year was that?

24 A I left Ohio in December of last year, 2022.

25 Q So when was the last time you saw a patient that

Page 44

1 you were treating for gender dysphoria?

2 A Around that time. December of 2022.

3 Q Okay. So in your declaration I think you said
4 that you treated approximately one hundred
5 patients for gender dysphoria, is that correct?

6 A Yes.

7 Q Does that hundred patients include the twelve you
8 saw during your fellowship?

9 A No.

10 Q Okay. Of the hundred patients that you saw, that
11 was from 2003 to really 2020, right?

12 A 2022.

13 Q 2022. I apologize. Well, from when you left
14 Ohio?

15 A Yes.

16 Q Okay. So how many of those patients do you think
17 you treated continually over that period of time?

18 A Well, if seventy percent left that would leave
19 thirty.

20 Q So when you left Ohio in 2022 you still had thirty
21 patients you were treating for gender dysphoria?

22 A Correct.

23 Q Okay. And what did you tell them about why you
24 would be discontinuing care with them?

25 A Moving to Utah.

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1 Q Did you transfer their care to another
2 practitioner?

3 A I discussed options with them because I felt bad
4 about leaving. That was not just the patients
5 with gender dysphoria, but all my patients because
6 they had seen me for many years. Some of them
7 thirty years.

8 So I offered options and asked the
9 endocrinologist whom I hired years ago if he would
10 continue to manage them. They were on stable
11 hormonal treatment.

12 Even though he would not see people, new
13 patients, he was willing to continue their care in
14 most cases. I should say in all cases he was
15 willing to continue to manage those people.

16 Q Okay. You believe those thirty people were
17 appropriately continuing to receive care for
18 gender dysphoria at the time that you transferred
19 them to another endocrinologist?

20 A If I were to see them again I would not offer them
21 opposite sex hormones and all of that treatment
22 that I did then because I learned a lot more than
23 I knew back then.

24 They are on stable regimens. They are doing
25 as best as they can. They are getting

Page 46

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

Page 47

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

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

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

Page 50

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

Page 51

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

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

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1 A Yes.
2 Q Did either of these cases involve the treatment of
3 gender dysphoria?
4 A No.
5 Q Did either case involve anyone who was transgender
6 to the best of your knowledge?
7 A No.
8 Q Are there any other cases that you were a
9 testifying expert that you didn't include here?
10 A No.
11 Q Are there any cases where you were a consulting
12 expert that you didn't include here?
13 A No.
14 Q Are there any other cases where you have been
15 retained as an expert, but have not yet testified?
16 A Not that I recall.
17 Q There are several other states that have passed
18 laws similar to Senate Enrolled Act 480.
19 You are not an expert in any of those, are
20 you.
21 A No. I have submitted written testimony in
22 multiple states for legislation similar to the
23 Indiana bill, but I've not provided any expert
24 declarations in any other states.
25 Q And you have not been retained as part of

Page 54

1 litigation?
2 A No.
3 Q Is that something that you are interested in
4 doing?
5 A I think it's important to provide the science and
6 the facts and provide balance in this because I
7 think a lot of harm is being done to minors.
8 Q On Page 64 of your C.V. it has Participation in
9 Clinical Trials and then it goes to the next page.
10 For these trials what has your role been?
11 Are you the principal investigator for all of
12 these?
13 A Yes.
14 Q Okay. So in your declaration you talk about
15 having been the principal investigator in about a
16 hundred clinical trials.
17 Those are the ones listed here, is that
18 correct?
19 A Yes.
20 Q Do any of these pertain to the treatment of gender
21 dysphoria?
22 A No. It would be great if one did because there
23 are no randomized clinical trials with comparator
24 control groups for the treatment of gender
25 dysphoria in adults or minors.

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1 Q And were all these trials sponsored by
2 pharmaceutical companies?
3 A No.
4 Q Which ones were not sponsored by pharmaceutical
5 companies?
6 A The second one, the efficacy of fluoxetine. That
7 was an investigator initiated trial. I did that
8 one without funding. There was the ACCORD trial
9 in which I was a principal investigator. That was
10 analogous to a health sponsored trial. That
11 should be listed here. That is listed on Page 65.
12 That is Action to Control Cardiovascular Risk in
13 Diabetes. That was a National Institute of Health
14 sponsored trial. So that was also not a
15 pharmaceutical trial.
16 All of the others were pharmaceutical
17 sponsored trials except for Page 72, 2011 to 2012
18 Trial-Net was an NIH sponsored trial.
19 Q So with the exception of those, the rest of those
20 indicate at the end there has been a sponsor. So
21 I take it the rest of them were sponsored by
22 pharmaceutical companies?
23 A Correct.
24 Q Have you supervised any clinical research about
25 the treatment of gender dysphoria?

Page 56

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

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1 in support of legislation related to gender
2 ideology.
3 Q When did you first become a senior fellow in Do No
4 Harm?
5 A It was something like March or so of this year.
6 Early this year.
7 Q March of 2023?
8 A Correct.
9 Q And how did you learn about them?
10 A It's a long -- how did I learn about them? That
11 is a short story. I just saw the, I think I saw
12 something online with regard to what their efforts
13 were.
14 The head of the organization is the former
15 dean of the University of Pennsylvania School of
16 Medicine. He is a nephrologist. He is just
17 brilliant and articulate. I think his goals are
18 wonderful. They are well -- just the motivation
19 and the goals are really noble.
20 Q And do you remember where online you learned about
21 them or what you were doing online when they
22 popped up?
23 A I do not remember.
24 Q And so that is how you learned about them. What
25 happened next?

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

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

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1 Do No Harm?
2 A I don't think so.
3 Q Okay.
4 A I don't think so.
5 Q So --
6 A Wait. Excuse me.
7 Q Yeah.
8 A Yes, I must have known about Do No Harm because,
9 as I said earlier, Do No Harm said to please send
10 comments to Florida if you support this
11 legislation.
12 That is when I sent this email to Florida.
13 And it was only because of the Do No Harm email
14 sent to their members, most of them who are
15 physicians I think.
16 Q And when did you become a member of Do No Harm
17 separate from being a senior fellow if those are
18 different things?
19 A They are different things. I think I became a
20 member sometime last year. I do not recall when.
21 It may be mentioned on my C.V. I don't think so
22 though.
23 Q Just so I understand the timeline, sometime in
24 2022 you are online. You learn about Do No Harm.
25 Is that when you became a member?

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1 A Yes, when I saw the work they were doing. Yes.
2 Q And then you start getting Do No Harm's emails.
3 One of them was sometime before October 24, 2022
4 that solicits folks to send comments into Florida.
5 And that is what prompted this email from you
6 with the attached comments. Is that an accurate
7 sort of summary of what we have been talking
8 about?
9 A Yes.
10 Q Okay. And then did you send a copy of this to Do
11 No Harm?
12 A Only when asked after.
13 Q Okay. So Do No Harm said to send comments. They
14 say then thank you for sending comments. Please
15 send us a copy of what you sent?
16 A Correct.
17 Q Then you heard back?
18 A Yes.
19 Q Do you remember about when between October 24,
20 2022 and becoming a senior fellow that you heard
21 back?
22 A I don't remember.
23 Q Okay. And when you did hear back who reached out
24 to you?
25 A Kristina Rasmussen, who is their kind of chief

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

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

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

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1 yes. I think that is right.
2 Q Other than the legislative testimony that you
3 referred to, and you listed some states just now,
4 have you ever provided legislative testimony on
5 another topic other than the treatment of gender
6 dysphoria in minors?
7 A Another topic outside of gender dysphoria?
8 Q Correct.
9 A Yes. I have submitted video testimony in Ohio
10 about not requiring vaccine mandates to people
11 before -- it had to do with vaccine mandates. It
12 was that topic.
13 Let's see what else. That was about two
14 years ago I think. I can't recall any other
15 testimony.
16 Q Would that have been vaccine mandates in Ohio?
17 A Yes.
18 Q What was your position on vaccine mandates?
19 A They should not be required by the state.
20 Q Why was that your position?
21 MS. YOUNGS: Objection. What is the
22 relevance to the vaccines?
23 Q Dr. Weiss, what was your position on the vaccines?
24 Why was that your position?
25 A My position at that point was that there was, it

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

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1 the House, Families, Aging and Human Services
2 Committee to support the Save Adolescents From
3 Experimentation Act.
4 Q Would that have been -- do you recall was that
5 HV 454?
6 A That sounds familiar.
7 Q Was this testimony May 19, 2022, does that sound
8 about right?
9 A It does.
10 Q Okay.
11 MR. SELDIN: Erica, can you pull up
12 Exhibit 32.
13 Q While Erica finds that, Dr. Weiss, I have a link
14 to the recording of that testimony.
15 My question will be is that you, is that the
16 testimony?
17 A If it looks like me it probably is.
18 Q Famous last words in the court of law. We will
19 make sure it's you.
20 MR. SELDIN: Erica, if you could get us to
21 32.
22 Q While that comes up, Dr. Weiss, so in May of 2022
23 you were not a member of Do No Harm yet?
24 A No.
25 Q You were not a senior fellow yet?

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

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

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1 he contacted me. He said would I be interested in
2 just joining the organization. You know, it's
3 basically a non-political organization that tries
4 to provide the best science and the best evidence
5 for taking care of people with gender dysphoria.
6 So I joined.
7 There's, they have discussions online and so
8 on. They have several physician members that
9 are -- I'm just, I'm just connected to them. I'm
10 really not a member of the group in that sense.
11 They allow me to access their kind of interactive
12 site.
13 Q Do you have to be a member to access the -- are
14 you talking about -- you are on their website?
15 A Yes, that is all. I'm not even listed. You will
16 not find me, if you go to SEGM you won't see my
17 name there because I'm just -- I know about them.
18 They have their resources basically.
19 Q Who was the doctor from SEGM who reached out to
20 you about testifying in Ohio?
21 A Dr. William Malone. M-A-L-O-N-E. He is an
22 endocrinologist.
23 Sorry. What was that question? Now repeat
24 the question.
25 Q You said a doctor had reached out to connect to

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1 you from SEGM, the organization CCV, is that
2 right?
3 A I misspoke. Okay. Right. The doctor who asked
4 me about Ohio is Dr. Beck.
5 Q Who is Dr. Beck?
6 A He is actually one of the founding members of
7 SEGM.
8 Q You found SEGM because Dr. Malone. Once you were
9 part of SEGM Dr. Beck got in touch and asked you
10 about supporting this bill in Ohio?
11 A Correct.
12 Q Okay. And then the organization that was
13 supporting the bill in Ohio that you were involved
14 with related to your testimony was CCV, is that
15 right?
16 A I think that is what it's called. There are many
17 organizations supporting the bill. CCV was the
18 one that reached out to me and gave me a copy of
19 the bill. They communicated with me.
20 Q You will see actually we have up on the screen the
21 Exhibit 32-C which is from CCV.org.
22 A Okay.
23 Q I take it that was the organization you are
24 talking about there. I think they have a
25 recording of your testimony online.

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1 A Okay. Good.
2 Q Okay.
3 A So my recollection was accurate.
4 Q We love to hear that in a deposition. So during
5 that testimony you talked about how you estimated
6 that seventy-five percent of your patients failed
7 to persist in their treatment with you.
8 Does that sound about right?
9 A I think I modified that to seventy percent in my
10 statements to you earlier and in my declaration.
11 Q But the word "persist" is the word that you used.
12 A Okay.
13 Q I guess my question will be what does persistence
14 mean? Like we were speaking earlier about your
15 patients didn't return to treatment with you.
16 When you say didn't persist, is that what you
17 meant?
18 A Yes. So when they discontinued their care with me
19 I would equate that to lack of persistence in
20 their treatment. Although, accurately as you
21 stated, I can't be sure what happened to those
22 people.
23 Q We have talked about other reasons that people
24 might not have returned to you for care. It could
25 have been that they lost their insurance perhaps?

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1 A Correct. Many of those people were on Medicaid.
2 That is possible. Sure.
3 Q It could have been possible they were happy with
4 the results they got and didn't feel the need for
5 further treatment?
6 A That would be, that would be desistance if they
7 stopped. They would not have discontinued
8 hormonal, you know, to say -- well, then they
9 would basically desist. They would say I don't
10 really need this any more and they would stop
11 hormonal treatments.
12 Q Well, I think I'm asking a different question.
13 There are some treatments that, I mean, someone
14 might say I want to take testosterone because I
15 want my voice to be lower. Once their voice
16 achieved that pitch, they might say I have
17 achieved what I desired and I don't need more.
18 A That would not be the case in these people because
19 they are all adults who have their voices. Their
20 vocal cords will not change after the treatment.
21 They are all post puberty.
22 Q As part of your testimony you have talked about a
23 patient who had regretted the removal of their
24 testicles.
25 Does that sound familiar?

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

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

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

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

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

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

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

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

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1 to be compelling?

2 A I didn't see clear evidence that the children were

3 improving.

4 Q Do you have any firsthand knowledge of a minor

5 being provided with treatment for gender dysphoria

6 without parental consent?

7 A What do you mean by firsthand knowledge?

8 Q Well, we talked earlier about how there are

9 circumstances you believe where children can

10 assent to medical treatment and their parents can

11 consent and the provision of that treatment is

12 appropriate based on that informed consent

13 process.

14 Are you personally aware of a minor receiving

15 treatment for their gender dysphoria where that

16 didn't happen? Are you personally aware of that?

17 A I know of circumstances in which minors have

18 gotten hormones through Planned Parenthood without

19 parental consent.

20 Personally knowing them as someone I've taken

21 care of or in my, that lives in Ohio nearby, a

22 neighbor, no. I don't have that kind of personal

23 awareness.

24 Q You said during your testimony in Ohio that it was

25 immaterial that you had not visited any

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1 multi-disciplinary clinics in Ohio that were

2 treating pediatric patients.

3 Do you recall saying that?

4 A I think so.

5 Q Do you still believe that to be true that it's

6 immaterial?

7 A Yeah, I think it does not matter.

8 Q Okay. So you are comfortable relying on

9 secondhand reports to describe what you believe is

10 happening in that --

11 A They are very powerful statements by parents who

12 attend with their child at the clinic. So when

13 people say they have a very thorough evaluation,

14 they do not do any of that. They don't do this.

15 They will evaluate the child from a psychological

16 standpoint over months and really address all of

17 their other problems, that does not happen.

18 I don't believe it happens. I never hear

19 that it happens. With my experience with adults

20 it didn't happen. The parents don't say that it

21 happens. The comments from the extensive

22 evaluation, extensive interviews in Time to Think

23 that I've referenced in my bibliography at the

24 Gender Identity Development Center in the U.K.

25 that has decades more experience than we do in the

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1 United States, and the affidavit of Jamie Reed.

2 And I think there will be many coming out

3 along with many, many parental testimonies that

4 describe how minimal the evaluation is.

5 And we just see the plaintiffs. We don't see

6 extensive evaluation of these children. I mean,

7 look at these sad stories of these children who

8 felt terribly traumatized and they are treating

9 them with hormones.

10 There was one that was physically and

11 sexually abused by the father. Another one who

12 has two biologic male parents. One of whom is

13 transgender.

14 You wonder how much of this is pressure on

15 the child to have hormonal treatment. That all

16 needs to be explored. It's just not being done.

17 Q Dr. Weiss, I'm sorry to cut you off.

18 MR. SELDIN: Ms. Youngs, we will designate

19 parts of this testimony regarding the medical

20 records of the minor plaintiffs as confidential.

21 MS. YOUNGS: Certainly.

22 MR. SELDIN: Ms. Youngs, I believe in

23 Dr. Weiss' declaration he has several paragraphs

24 that we would like those designated as

25 confidential and redacted. I just wanted to flag

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1 those for the court reporter and for you that that

2 is how we would like to proceed. I assume that is

3 not going to be a problem?

4 MS. YOUNGS: No.

5 Q Sorry for that little bit of housekeeping.

6 Do you think that there are any minors who

7 are properly evaluated for gender dysphoria?

8 A I hope so.

9 Q For those minors who are properly evaluated, do

10 you still oppose the treatment for gender

11 dysphoria?

12 A The hormonal, or what you might call

13 gender-affirming care, yes, because I think it is

14 personally harmful and it does not help. There

15 are safer less harmful interventions like

16 supportive exploratory psychotherapy.

17 Q So it's not just the evaluations, because even if

18 a minor were appropriately evaluated, thoroughly

19 had a diagnosis of gender dysphoria and you agreed

20 with that, you would still oppose the provision of

21 the treatment of their gender dysphoria either

22 through puberty blockers or hormones, is that

23 correct?

24 A I would be more clear in stating that a thorough

25 proper evaluation would very, very likely reveal

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1 factors in the family dynamics, history, sexual
 2 abuse, physical trauma, bullying, social
 3 isolation, autism spectrum disorder or depression,
 4 anxiety.
 5 That all could be addressed and there would
 6 be no need for hormonal interventions that would
 7 be not helpful and likely harmful.
 8 Q Do you think it's possible that there are minors
 9 who do not have any history of trauma, do not have
 10 any co-morbid conditions, do not have any social
 11 or familial pressure and, nonetheless, had gender
 12 dysphoria that would benefit from treatment?
 13 A I think they may benefit from treatment. But the
 14 treatment is best hormonal or hormonal
 15 interventions.
 16 So even if such children did exist and, of
 17 course, in the Dutch study they found not very
 18 many of them. They had no other significant
 19 psychosocial issues, they treat them with these
 20 hormonal interventions and I don't think they
 21 helped them as we will discuss.
 22 Q So you don't believe that there are any minors who
 23 had gender dysphoria period, or who have gender
 24 dysphoria?
 25 Well, first question, do you believe there

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1 are any minors who have gender dysphoria?
 2 A Sure.
 3 Q And just gender dysphoria, no co-morbid
 4 conditions?
 5 A Well, I think there is an explanation. They may
 6 not have obvious co-morbidities. I think with
 7 supportive therapy, one would be able to identify
 8 reasons why they have rejected their natal sex.
 9 And those children, their dysphoria would
 10 likely resolve with that therapy. Because really
 11 what the goal is, the goal of treatment for gender
 12 dysphoria is not to make the person look like
 13 another sex. That is not the goal.
 14 The goal is to resolve the dysphoria, the
 15 distress. Right? So if you can resolve the
 16 distress with really safe reversible interventions
 17 to addressing the biopsychosocial issues, that is
 18 what should be done.
 19 Q So you believe there is no way to resolve gender
 20 dysphoria through physical changes, is that what
 21 I'm hearing you say?
 22 A I don't think physical changes are helpful. This
 23 would be the only disorder listed in the DSM for
 24 which there is an intervention to modify
 25 appearance to fix the mental disorder. It's the

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1 only one.
 2 Q Let's say I have a three year old child who has no
 3 history of trauma, no co-morbid conditions,
 4 nothing else going on except for gender dysphoria.
 5 Do you believe that that child is a candidate
 6 for medical treatment of their gender dysphoria as
 7 they get older?
 8 A So I think the diagnosis of gender dysphoria in a
 9 three year old is extraordinarily difficult. What
 10 is a three year old's understanding of gender?
 11 If you have had kids you know that boys like
 12 to put on mommy's shoes. Girls like to wear, you
 13 know, daddy's glasses. I mean, boys have, there
 14 is just exploration and children do these things.
 15 They might say they -- are they going to say
 16 they don't like their penis. They don't know what
 17 gender is at the age of three or four. I think
 18 that is frankly absurd, most of that.
 19 And we know, we talk about this later, those
 20 kids, that resolves over time in most of those
 21 children. If it does not, then they need
 22 supportive therapy to help them out.
 23 Q You can't imagine a circumstance in which a child
 24 could be accurately diagnosed with gender
 25 dysphoria?

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1 A In the absence of all other psychiatric or family
 2 dynamics, social causes, bullying, social
 3 isolation, influences of other children, no, I
 4 think there are other factors that explain it.
 5 It's a symptom of something else that is
 6 going on.
 7 Q You said they should receive supportive therapy.
 8 What do you think the goal of that therapy
 9 should be?
 10 A I think to resolve their dysphoria and to address
 11 their anxiety, depression. How they feel about
 12 themselves. Because it's not -- the child might
 13 come and say I really want to be a girl. Okay.
 14 Tell me more about that.
 15 This is not conversion therapy. We are
 16 talking about just helping them out to feel less
 17 distress, less anxiety. What is going on in your
 18 life? What's happening at home? Does your dad
 19 beat your mom up? Is there alcoholism?
 20 I mean, in the four plaintiffs we see a lot
 21 of that going on. None of these four children
 22 would have qualified for treatment based upon the
 23 only solid evidence that's claimed to be solid,
 24 it's really weak, which is the Dutch protocol.
 25 Because the Dutch excluded those people with

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1 any significant psychosocial issues. All four of
2 the plaintiffs have major psychosocial issues.
3 They would never have been treated per the
4 evidence that we have, which is the Dutch
5 protocol.
6 Q So earlier you said that, you know, the resolution
7 of the gender dysphoria was not going to come from
8 changing physical characteristics.
9 So the goal of that supportive exploratory
10 therapy would be to be at peace with one's
11 assigned sex, is that right?
12 A Correct. I think that being at peace would come
13 not with a focus on you have to accept your sex.
14 Not with something that might be called conversion
15 therapy. But really with exploring everything
16 that is going on in the child's life.
17 What has happened here? What happened? How
18 were they raised? What is going on? Have you
19 been abused? Have you been -- how safe are you at
20 home? What is going on at school? Do you feel
21 isolated? Do you have friends?
22 All of those issues. We know that social
23 media for all these girls has a powerful impact on
24 their reasons for all of a sudden now when they
25 are adolescents deciding they want to be boys.

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1 Q You believe that once all those issues have been
2 fully explored and addressed if they exist,
3 nonetheless, it's not appropriate to provide
4 gender-affirming, to provide treatment of gender
5 dysphoria to minors?
6 A To provide -- nonetheless, it would not be
7 appropriate to provide hormonal treatment, either
8 puberty blockers, opposite sex hormones, surgical
9 reassignment to minors, correct. That would not
10 be appropriate.
11 Q If you believe it or not, we started by talking
12 about your testimony in Ohio. I will now turn
13 back to that.
14 During that testimony in May of 2022 you were
15 still seeing patients, adult patients who you were
16 treating for gender dysphoria, is that right?
17 A Correct. Those would have been follow-up
18 patients, but not new ones.
19 Q Was your provision of treatment for gender
20 dysphoria to adults particularly lucrative?
21 A No.
22 Q During your testimony in Ohio you compared
23 gender-affirming care to providing weight
24 affirming care with an eating disorder.
25 Do you recall that part of your testimony in

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1 Ohio?
2 A Yes.
3 Q The term weight affirming care, does that come
4 from somewhere or did you make it up for your
5 testimony?
6 A I made it up.
7 Q Okay. You talked about how you provide
8 promotional presentations for Mounjaro. That's,
9 is that Tirzepatide?
10 A Yes, it is. Does Wendy know how to spell that?
11 It's T-I-R-Z-E-P-A-T-I-D-E.
12 Q So my understanding is that Mounjaro has some
13 profound weight loss side effects, is that
14 correct?
15 A Yes.
16 Q What about a patient who came to you in your
17 practice and said, I'm very overweight. I don't
18 want to go outside because I'm so overweight. I
19 don't want to see my friends because I'm so
20 overweight. I feel like this body is preventing
21 me from participating in society.
22 Do you think it would be appropriate to treat
23 that person with weight loss drugs?
24 A So I, as I said, I'm a diplomat of the American
25 Board of Obesity Medicine. I'm very knowledgeable

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1 about treating obesity.
2 Obesity has many adverse consequences. We
3 want to help people as best we can to help them
4 lose weight. There are medications approved for
5 the obesity. Yes, I treat those people.
6 Most of them are not dissatisfied with their,
7 well, their appearance, but they are really
8 struggling with knee pain, with sleep apnea and
9 other adverse consequences, medical consequences,
10 that derive from their weight. There is
11 medications approved for treating weight.
12 Mounjaro has been studied. It works really
13 well, but it's not yet approved for weight loss.
14 I would not give Mounjaro to those people. I
15 would offer them other medications which are
16 approved for weight loss by the FDA.
17 Q I'm not surprised. But you could imagine a
18 patient who said in addition to my knee pain and
19 my sleep apnea, I want to lose weight for that,
20 but I want to look thinner because I want to be
21 thinner in society.
22 Would that be an okay reason to provide
23 someone with a weight loss drug?
24 A It would depend on their body mass index.
25 Q Assuming it was not unsafe for them to lose

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

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

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

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

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

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

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1 in the health care field."
2 Do you see that?
3 A Yes.
4 Q So later on in your declaration in Paragraph 70,
5 you say that doctors, like all groups, are
6 susceptible to group think and social contagion.
7 Do you see that?
8 A I do.
9 Q Okay. So there is a list of organizations that
10 have endorsed or approved the treatment of gender
11 dysphoria for minors.
12 One of them is the American Medical
13 Association which, I assume, you are familiar
14 with?
15 A Sure. There are about thirty, twenty-five or
16 thirty percent of doctors who are members of that.
17 So the vast majority of doctors are not a member.
18 Q Do you think that the AMA, the American Medical
19 Association, do you think of that as a politically
20 motivated organization?
21 A Yes.
22 Q Do you think that that is an organization that has
23 been overtaken by group think and social
24 contagion?
25 A Yes.

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1 Q For the American Academy of Pediatrics, are you
2 familiar with them?
3 A Yes.
4 Q Is that an organization that you think is a
5 political advocacy organization?
6 A Not entirely. It has many political advocacy
7 positions. I think they have adopted viewpoints
8 that are not based upon good evidence in many
9 respects. And gender is one of them.
10 Q So you think that that, in that respect that is
11 subject, it has been overtaken by group think and
12 social contagion?
13 A Absolutely.
14 Q I am going to ask similar questions for another
15 couple organizations.
16 The American Psychiatric Association, do you
17 consider that a political advocacy organization?
18 A So I would not use -- I think that it's not a
19 political advocacy organization, but they failed
20 to carefully look at the evidence in the treatment
21 of gender dysphoria.
22 And so they have been swayed by the position
23 that the transgender activists take in that
24 regard. I think that is a clear way of stating
25 it. So it's not entirely a political advocacy

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1 group. They have been affected by these activists
2 and their positions fail to address the science
3 and the evidence.
4 Q Do you feel the same about the American
5 Psychological Association?
6 A Yes.
7 Q Do you feel the same way about the American
8 Academy of Family Physicians?
9 A Yes.
10 Q And in that same regard, do you consider them as
11 having been overtaken by group think and social
12 contagion?
13 A Yes.
14 Q So that I understand, the organization Do No Harm
15 that you belong to, you do not think of that as a
16 political advocacy organization?
17 A No. It is very difficult for people to be
18 outspoken and take positions that are not so
19 popular especially when there is -- I think one
20 can be labeled a transphobe. And, you know, you
21 can be accused and there is a tendency of threats
22 and violence from the other side.
23 So I think there are complex reasons why
24 people might take a stance in this regard. Many
25 of these people that are thinking the same are

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

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

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1 course of your almost twenty years in Ohio?
2 A I was in Ohio since --
3 Q I asked that poorly. From 2003 to 2022 during
4 your independent practice, you saw thousands of
5 patients?
6 A Okay. To clarify, my independent practice was
7 stopped when I was employed by Lake Health. That
8 was the end of 2019.
9 Q Okay.
10 A So 2003 to 2019 I was independent. Then I was
11 employed. You know, if you do multiply those
12 years times the 3,000 you will get that. That is
13 a lot of patients.
14 Q And so of that large number, about one hundred
15 during that whole time you treated for gender
16 dysphoria?
17 A Correct.
18 Q So a very small part of your overall practice?
19 A Correct.
20 Q And I believe in your declaration you describe
21 yourself as the principal physician in northern
22 Ohio offering hormonal treatment for adults with
23 gender dysphoria, is that correct?
24 A Correct.
25 Q And that was based on those patients during that

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

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

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1 A A letter from a therapist.
2 Q Did you require the therapist to have any
3 particular kind of background or licensure?
4 A Well, they had to be a licensed therapist.
5 Q Okay. You didn't require a psychiatrist, for
6 example?
7 A No.
8 Q A letter from a therapist. What would you look
9 for in that letter?
10 A I would look for a statement that that person met
11 criteria for gender identity disorder, which was a
12 DSM criterion or term at that point. And that
13 they were an appropriate candidate for hormonal
14 intervention.
15 Q You would require a letter from a therapist saying
16 that they had been diagnosed with gender identity
17 disorder in the DSM 4?
18 A Right.
19 Q And that they were an appropriate candidate for
20 treatment for their gender dysphoria using
21 hormones, correct?
22 A Yes.
23 Q Okay. And did you require anything else in the
24 letter?
25 A No.

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

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1 So there is movement towards changing the
2 terminology. But in gender dysphoria they have to
3 have significant distress associated with the
4 gender identity.
5 In either case, the people who would come to
6 me wanted hormonal treatment. Whatever you called
7 it, gender identity, gender dysphoria, they wanted
8 hormonal treatment to modify their appearance so
9 they would feel better.
10 Q Did the move from the DSM 4 to the DSM 5 have any
11 bearing on your decision to stop seeing new
12 patients?
13 A No, it did not.
14 Q Did you do any independent evaluation of the
15 diagnosis for, at the time, gender identity
16 disorder in your patients?
17 A Yes, I would question what their story was on
18 their feelings about their gender. When did it
19 start? What else was going on?
20 I was not treating depression, anxiety. I
21 did not address, you know, their childhood
22 upbringing and whether they were abused sexually
23 and those kinds of things, you know.
24 My hope was that the therapist would be
25 providing that.

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1 Q Did you have a particular evaluation or set of
2 questions or was this more general patient
3 history?
4 A There would be questions. I would ask about the
5 onset of their symptoms. I would go through the
6 whole history of when they started to reject their
7 natal sex.
8 It kind of went -- it was open with no, you
9 know, it was with open-ended questions so they can
10 talk to me about that like a therapist might but,
11 you know, in a forty-five minute session. I would
12 explore again on the next visit how they were
13 doing emotionally.
14 Q So someone comes to your office. They have a
15 letter. You have an initial appointment of
16 forty-five minutes.
17 At the end of that appointment would you
18 prescribe any medical treatment or would you
19 require them to come back?
20 A In most cases I would prescribe in these adults.
21 Occasionally I would ask them to come back. One
22 person who was eighteen who had a letter, but I
23 was really uncomfortable, there was a lot of stuff
24 going on with her. She was going off to college.
25 She wanted to have -- and I would not, I would not

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1 have been able to evaluate her for quite some time
2 after.
3 So I said I don't feel comfortable giving you
4 hormones at this time. I think you need to come
5 back. She was one I declined to prescribe. I
6 didn't really feel that she was adequately
7 evaluated.
8 Q Did that patient come back to you for treatment or
9 did you see that patient?
10 A I did not see her again. That was around probably
11 2012, 2013.
12 Q So right when you were going to stop seeing new
13 patients anyway?
14 A Yes.
15 Q And were there any other patients who you did
16 not treat in a similar way based on your
17 assessment?
18 A There were a few people that I wanted to have come
19 back and discuss further. But most people I would
20 initiate therapy on the first or second visit in
21 these adults.
22 Q Were there any patients -- what was the youngest
23 patient who you prescribed hormones or other
24 medication to?
25 A Probably twenty-one, twenty-two.

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1 Q So you saw one potential patient who was eighteen
2 and you ended up not providing treatment.
3 Then the next youngest patient you actually
4 prescribed to you believe was twenty-one or
5 twenty-two, is that accurate?
6 A Yes.
7 Q For the folks that came to you with a letter, were
8 most of them just starting hormones or had they
9 been getting hormones from someone else?
10 A Most of them had not been on any hormones at all.
11 Q So you would have been starting them on hormonal
12 treatment?
13 A Yes.
14 Q Of the hundred patients that you saw, what
15 percentage do you think you were starting new as
16 opposed to continuing someone else's
17 prescriptions?
18 A Probably ninety-five percent.
19 Q Typically what medications would you prescribe?
20 A So I would give testosterone to females. I would
21 give spironolactone, which blocks androgen action.
22 I would give estrogen along with that to those
23 males, biologic males. So biologic males would
24 get spironolactone and estrogen. It was Estradiol
25 usually.

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

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

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1 A Probably about maybe fifteen or so. Fifteen to
2 twenty. Something like that.
3 Q Had had surgery of any kind?
4 A Yes.
5 Q Of those fifteen to twenty do you recall which
6 surgeries they had?
7 A Most of them had mastectomies. Bilateral
8 mastectomies.
9 Q You said most of those fifteen to twenty. Do you
10 have an estimate of --
11 A So I would say -- yeah. So maybe five or so had
12 other surgeries besides mastectomies. So general
13 reconstruction or augmentation, mammoplasty. That
14 kind of thing. Breast implants.
15 Q Did you follow any guidelines or standards of care
16 in your practice regarding the treatment of gender
17 dysphoria?
18 A During that period of time I was following
19 Endocrine Society guidelines.
20 Q Do you recall which ones?
21 A Well, it would not have been 2017 because I
22 stopped in 2013. So it was 2009.
23 Q Okay. And then did you use the WPATH guidelines
24 at all?
25 A No.

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

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1 A Yes.

2 Q Okay. Did you independently advertise that you

3 provided these services? Or no?

4 A No.

5 Q What prompted you to stop seeing new patients in

6 2013 for the treatment of gender dysphoria?

7 A Well, I had a gradual realization that I was

8 really not helping people. Yes, they had these

9 physical changes, but they still had a lot of

10 psychiatric stuff going on.

11 Lots of them had anxiety and distress and

12 depression and sleep problems. They felt bad.

13 They were -- I was urging them to follow up more

14 regularly with a therapist. And there was an

15 increasing number coming out. I should not say --

16 I should say calling the office to be seen.

17 I would give priority over the years to get

18 those people in promptly to the practice even

19 though there was a delay, you know, my next

20 opening might be three months and I would try to

21 find a spot for the people with gender dysphoria.

22 I felt then that my other patients were suffering.

23 So the combination of that and what I was

24 doing was not helpful and my other patients were

25 losing out. I said that's okay. I'm not going to

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1 be seeing new people. I will take care of the

2 patients that I have. Those other patients can go

3 down to Metro.

4 Eventually other centers emerged. University

5 Hospitals started providing care.

6 Cleveland Clinic opened up a transgender clinic.

7 They promote theirs. Both of them are promoting

8 their practices.

9 Q So I think in your declaration you said you

10 realized the lack of benefits and the potential

11 harm these treatments caused, is that correct?

12 MS. YOUNGS: Can you point to where that

13 is?

14 Q Yes.

15 MR. SELDIN: Erica, can you bring up

16 Exhibit 1.

17 Q In Paragraph 8 you will see in the last two or

18 three lines, "I stopped seeing new patients with

19 gender incongruence when I realized the lack of

20 benefit and the potential harm these treatments

21 caused."

22 Did I read that correctly?

23 A Yes.

24 Q Okay. Great. And how were you measuring or

25 observing this lack of benefit?

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1 A It was really just from an open dialogue

2 discussion with the patients when they come back.

3 How are they doing? Asking what their emotional

4 state is. Mood. Are they feeling down or sad?

5 Have they lost pleasure in things? You know, are

6 they nervous or anxious a lot? How is their

7 sleep? So on.

8 Q Did you encourage those folks to seek other

9 additional medical treatment when you were here

10 about this?

11 A Yes. Therapists.

12 Q In the same paragraph you talk about the potential

13 harm.

14 What do you mean by potential harm?

15 A Well, I think I detail that in my declaration.

16 Q I mean, specifically with the adult patients that

17 you were treating from 2003 to 2013, what

18 potential harm were you talking about?

19 A Well, so given that the lack of long-term evidence

20 of benefit, even in adults, and the potential harm

21 with these opposite sex hormone treatments, I

22 didn't -- and I was not apparently achieving the

23 goal of relieving their distress, and potentially

24 these were -- giving estrogen to a man might be

25 harmful.

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1 There is thrombotic risk with it. You know,

2 clots in the veins and arteries. What harm am I

3 doing by giving testosterone to a female? So

4 there were a lot of unknowns and potential harms.

5 Q You said potential harms. Did anything bad happen

6 to one of your patients in that regard, or were

7 you concerned it might in the future?

8 A There were some concerns with some treatment.

9 There is some evidence that there is worsening in

10 a condition called sleep apnea.

11 There was a person I was giving -- a biologic

12 female I was giving testosterone to. That

13 person's sleep apnea got worse. That was a

14 potential harm. That is one that comes to mind.

15 The others might have been apparent with

16 longer follow-up. Not that I saw.

17 Q Did you treat any patients from 2003 to 2022? Did

18 you have any that you saw that whole time?

19 A With gender dysphoria?

20 Q Yes.

21 A From 2003 to 2013 was a period of ten years of

22 when I was treating the hundred patients.

23 Q I'm asking you a different question. Is there any

24 patient who you treated for gender dysphoria that

25 you saw in the first, you know, one or two years

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

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1 potential harms come to fruition in those
 2 patients?
 3 MS. YOUNGS: For clarity, that's gender
 4 dysphoria?
 5 Q Yes. Just for gender dysphoria treatment.
 6 A I would say no.
 7 Q You also said in Paragraph 8, the last sentence,
 8 "I also found that these persons had minimal
 9 psychological evaluation for their psychic
 10 distress."
 11 Did I read that correctly?
 12 A You did.
 13 Q So when you say that do you mean -- what do you
 14 mean?
 15 Do you mean prior to them initiating
 16 treatment with you?
 17 A Prior and even after.
 18 Q But at the time that you provided treatment you
 19 thought their evaluation had been sufficient for
 20 you to start them on hormones?
 21 A That is what I thought at the time. In retrospect
 22 I would say no, that it was inaccurate.
 23 Q Today what would you consider an appropriate
 24 psychological evaluation for an adult prior to
 25 providing treatment for gender dysphoria?

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

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

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

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1 endocrinologists in the area?
2 A Correct.
3 Q Okay. So rather than them having no care they see
4 you?
5 A Or they have to travel far.
6 Q Just to be clear, none of your patients are
7 treating for gender dysphoria?
8 A Correct.
9 Q Do you have any patients who are transgender?
10 A I have a couple of questioning patients. They are
11 non-binary or they are questioning.
12 Q And have they come to you for any kind of hormonal
13 treatment for gender dysphoria?
14 A No.
15 Q How many of those patients do you think you have?
16 A Two.
17 Q Okay. Out of how many total patients?
18 A I have to do the math again.
19 Q I know you have been seeing patients since
20 February.
21 A February. Yes.
22 Q Is it a couple hundred? Is it dozens? How many
23 people --
24 A A few hundred.
25 Q Do you prescribe puberty blockers in your current

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1 role?
2 A No.
3 Q Do you prescribe testosterone or estrogen in your
4 current role for anything?
5 A Testosterone, yes. Estrogen I leave to the OB/GYN
6 doctors.
7 Q What do you prescribe testosterone for in your
8 current role?
9 A People who have low testosterone. Men, biologic
10 males who are low on testosterone.
11 Q So I understand, you provide testosterone
12 prescriptions to patients who were assigned male
13 at birth?
14 A Yes. Biologic males and they have -- their
15 testosterone was found to be low at some point.
16 So I am replacing their deficiency in
17 testosterone.
18 Q The two non-binary or questioning patients that
19 you have, have you told them about your
20 perspective on the treatment of gender dysphoria?
21 A No. Because it was not appropriate for what I was
22 seeing them for.
23 Q What were you seeing them for?
24 A A thyroid problem.
25 Q Are those adults or are they under eighteen, those

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

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

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1 A Yes.
 2 Q Do you see a little bit down it links to WPATH?
 3 Do you see that?
 4 A Yes.
 5 Q It also links to the Endocrine Society guidelines?
 6 A Yes.
 7 Q As well as the Report for the U.S. Transgender
 8 Survey in 2015?
 9 A Yes.
 10 Q Have you spoken to your employer about their link
 11 to these resources?
 12 A No.
 13 Q Do you think it is a mistake they link to these
 14 resources?
 15 A Yes.
 16 Q Do you think it's ill advised?
 17 A Yes.
 18 Q If you scroll all of the way down you will see
 19 under Referrals it says, "Please direct any
 20 questions or comments to Associate Medical
 21 Director of LGBTQ Health, Matt Bryan." Then there
 22 is an email.
 23 Do you see that?
 24 A Yes.
 25 Q Have you ever reached out to Matt Bryan?

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

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

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

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

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

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1 increasing their number of children they are
2 harming.
3 Q Dr. Weiss, you have referred to other countries
4 and what they are doing.
5 MR. SELDIN: Erica, can you pull up
6 Exhibit 26, please.
7 A Florida is not another country.
8 Q We will get there.
9 A Okay.
10 Q Dr. Weiss, this is an Amicus brief that Do No
11 Harm, your organization, filed in a case called
12 Dekker v. Weida.
13 Do you see the document that I'm looking at?
14 A I do.
15 Q Have you seen this brief before?
16 A No.
17 Q Did you work on this brief?
18 A No.
19 Q Were you asked about this brief?
20 A No.
21 Q And were you aware that Do No Harm filed this
22 brief?
23 A No.
24 Q Okay.
25 MR. SELDIN: So Erica, if you can scroll

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

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1 MS. YOUNGS: Can we pull up the originals
2 as exhibits?
3 MR. SELDIN: We will do a little more on
4 this first. I think we will probably get there.
5 MS. YOUNGS: Okay.
6 A Sweden is 102.
7 Q Let's look at 102 in your declaration.
8 MR. SELDIN: Erica, can you pull up
9 Exhibit 1, Paragraph 102.
10 Q We will probably come back to this exhibit as
11 well.
12 A I have it.
13 Q Great. Are you looking at Paragraph 132?
14 MS. YOUNGS: 132?
15 Q Dr. Weiss, where are you?
16 A I am sorry. I pulled up the original hard copy of
17 the reference 102 in my declaration. I do have
18 that.
19 Q Dr. Weiss, do you have other documents in front of
20 you other than your declaration?
21 A I just have all my references. That's all. They
22 are all on my declaration.
23 Q You have the full text of all of the items that
24 are listed in your bibliography?
25 A Yes.

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

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1 MR. SELDIN: Maybe at a break we can sort
2 this out, Ms. Youngs. We might need copies of
3 those.
4 MS. YOUNGS: I presume it's just
5 everything that is in the bibliography.
6 A It is.
7 MR. SELDIN: I have no reason to doubt
8 that. I think we are entitled to see them.
9 MS. YOUNGS: Well, I don't know that we
10 can produce them at this moment.
11 MR. SELDIN: I don't need them today. I
12 will need them eventually.
13 MS. YOUNGS: Okay.
14 MR. SELDIN: I suspect with FedEx from
15 Utah to here we will get them next week or the
16 doctor can scan them.
17 Q Let's start from the beginning. Dr. Weiss, at the
18 beginning of your deposition I asked you what you
19 had in front of you. You confirmed you had your
20 declaration, which included your C.V., is that
21 right?
22 A Right.
23 Q Okay. And you also have hard copies of the
24 references in your bibliography on your desk, is
25 that right?

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

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

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1 A An hourly rate.
 2 Q What is that hourly rate?
 3 A I think \$325.
 4 Q What activities are you compensated for?
 5 A For my efforts to prepare expert testimony for
 6 those legislative bodies.
 7 Q You became a senior fellow in March 2023, this
 8 year?
 9 A Approximately early this year.
 10 Q So we will talk through the testimonies since
 11 then. But fair to say you believe Do No Harm
 12 would have compensated you for your time involved
 13 in some of that?
 14 A Yes.
 15 Q Do you receive compensation from Do No Harm for
 16 any other activities?
 17 A No.
 18 Q Do you know who provides the funding for Do No
 19 Harm?
 20 A No.
 21 Q Have you discussed this case with anyone at Do No
 22 Harm?
 23 A No.
 24 Q Have you discussed your declaration with anyone at
 25 Do No Harm?

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

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

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1 A If I was with Do No Harm, yes.
 2 Q And did you have to travel to testify at that
 3 hearing?
 4 A No.
 5 Q Who wrote your remarks for that hearing?
 6 A Daniel Weiss. Me.
 7 Q Did anyone review them other than your wife maybe
 8 for grammar?
 9 A No.
 10 Q And would anyone at Do No Harm ever have read
 11 them?
 12 A Only after they were submitted.
 13 Q I think you mentioned earlier that you testified
 14 in Montana, is that correct?
 15 A I believe that is correct.
 16 MR. SELDIN: Erica, could you pull up
 17 Exhibit 22.
 18 Q These are minutes from the Montana Senate. If you
 19 will scroll down to Page 3, the third from the
 20 bottom you will see your name, Dr. Daniel Weiss,
 21 Do No Harm.
 22 Do you see that?
 23 A Yes.
 24 Q Would this have been the January 27, 2023 hearing
 25 that you testified at in Montana?

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1 A Correct.
 2 Q Who asked you to testify at that hearing?
 3 A Likely Do No Harm.
 4 Q Were you compensated for your testimony at that
 5 hearing?
 6 A Yes.
 7 Q Did you have to travel?
 8 A No.
 9 Q Did you testify live or was it just written
 10 remarks?
 11 A I don't remember.
 12 Q Did you write your remarks?
 13 A I did.
 14 Q Did anyone other than your wife review them?
 15 A No.
 16 Q Would Do No Harm have read them before you gave
 17 them?
 18 A No.
 19 Q Would they have read them after?
 20 A I'm sure after they were submitted.
 21 Q Then we will pull up Exhibit 21.
 22 Dr. Weiss, in addition to your testimony in
 23 2022 did you testify again this year in support of
 24 a bill to ban care?
 25 A For minors with gender dysphoria?

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

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

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1 Q This was not a gotcha. I was really asking for
2 the answer on this one. It was not a trap.
3 You provided testimony in support of this
4 bill in North Dakota, right?
5 A Yes.
6 Q And were you compensated for providing this
7 testimony?
8 A I believe so, yes.
9 Q Would that have been by Do No Harm?
10 A Yes.
11 Q And then, again, did you write these remarks?
12 A I did.
13 Q Yourself?
14 A Yes.
15 Q Okay. I believe that we have talked about your
16 testimony in Ohio twice.
17 Dr. Weiss, when I say testimony, I mean live
18 or written remarks. You have provided testimony
19 in some form in support of bills that would ban
20 the treatment of gender dysphoria in minors in
21 Ohio, Utah, North Dakota, Montana, and earlier we
22 spoke about your letter to the Florida Board of
23 Medicine.
24 Does that all sound correct to you?
25 A That treatment we are talking about is -- sorry.

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

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1 testified in Indiana and Wyoming.
2 Did you testify in those places?
3 A I believe so.
4 Q Okay. Do you recall anything about your testimony
5 in Wyoming?
6 A Just it was similar written testimony. I think
7 that was live in Wyoming. I'm pretty sure it was
8 live. I'm pretty sure.
9 Q Do you recall when?
10 A Sometime this year. This spring.
11 Q Did Do No Harm compensate you for that testimony?
12 A I believe so.
13 Q Did you testify in support of Senate Enrolled Act
14 480 in Indiana?
15 A There was a bill in Indiana that I did support. I
16 submitted written testimony. It was not in
17 person. I don't remember the bill number. It had
18 to do with gender dysphoria care in minors.
19 Q Do you recall when that was?
20 A I think it was sometime this spring.
21 Q You don't think it was Senate Enrolled Act 480?
22 A I don't know. I don't recall.
23 Q Are there any other states where you provided
24 testimony on this or a similar topic that we have
25 not talked about?

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1 A Not that I recall.

2 Q Dr. Weiss, do you keep a running list anywhere of

3 the places in which you have provided this kind of

4 testimony?

5 A Yeah. I have a list of folders that have

6 testimony that I submitted. I have one for the

7 different states.

8 Q That would be the list that you would refer to

9 in trying to determine where all you have

10 testified?

11 A That would be the closest to a list, correct.

12 Q Roughly do you know how much in total Do No Harm

13 has compensated you for all of your legislative

14 testimony?

15 A Maybe about \$8,000.

16 Q Earlier we talked about why you don't include

17 Do No Harm on your C.V. as one of your

18 affiliations.

19 I'm curious why you don't include any of your

20 legislative testimony on there either?

21 MS. YOUNGS: Can you clarify? Don't

22 include what where?

23 A I don't understand.

24 Q The legislative testimony that we just spoke

25 about, that does not appear on your C.V., is that

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1 correct?

2 A Correct. I don't see any reason to mention that

3 on a C.V.

4 MR. SELDIN: Erica, could you pull up

5 Exhibit 26.

6 Q We will look at Page 2 of the document or Page 8

7 of the PDF. If you go to 8 of 25, that is where

8 it is.

9 Dr. Weiss, do you see that?

10 A Yes.

11 Q Do you see where I am at the top? I will just

12 read this.

13 "Amicus Do No Harm is a diverse group of

14 physicians, health care professionals, medical

15 students, patients, and policymakers whose goal is

16 to protect health care from a radical, divisive,

17 and discriminatory ideology."

18 A Yes.

19 Q Did I read it correctly?

20 A Yes.

21 Q And what is that ideology, do you know?

22 A Well, I would consult the Do No Harm website in

23 that regard. My focus is on gender dysphoria.

24 MR. SELDIN: Erica, could you please pull

25 up Exhibit 28.

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1 Q This is from the Do No Harm website. It says,

2 "Protecting Minors from Gender Ideology."

3 Is that the ideology that you believe is

4 being referenced there?

5 A Yes.

6 MR. SELDIN: Erica, can you please pull up

7 Exhibit 27.

8 Q Dr. Weiss, these are the FAQs from Do No Harm's

9 website. You will see that the first two are

10 "What is Critical Race Theory?" and "What is

11 anti-racism?"

12 Do you see those two?

13 A Yes.

14 Q Do you do any work for Do No Harm regarding

15 critical race theory and anti-racism?

16 A No.

17 Q So your sole focus in your work with Do No Harm is

18 gender ideology?

19 A Yes.

20 Q Are you on social media?

21 A No.

22 Q No Twitter? No Facebook?

23 A None at all. In fact, I eliminated a Facebook

24 account about a decade ago. Never used Twitter.

25 They are dangerous.

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1 Q Have you given any media interviews of any kind

2 regarding your work with Do No Harm?

3 A No.

4 Q Have you spoken at any conferences?

5 A No. On this topic?

6 Q On this topic?

7 A No.

8 MR. SELDIN: Erica, can you pull up

9 Exhibit 1.

10 Q I'm going to look at Paragraph 6 of your

11 declaration on Page 2.

12 Let me know if you can see that?

13 A Yes.

14 Q Do you see you say, "I have been a member of the

15 Endocrine Society since 1990 but I canceled my

16 membership in 2022 after the repeated failure to

17 respond to my concerns about its promotion of

18 hormonal interventions in children with possible

19 gender-related distress."

20 Did I read that correctly?

21 A Yes.

22 Q When you say "repeated failure to respond to my

23 concerns," how did you indicate your concerns to

24 the Endocrine Society?

25 A Emails.

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

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1 Practice Guidelines in your practice?
2 A On what particular disorder?
3 Q Any disorder?
4 A Some of them.
5 Q Okay.
6 MR. SELDIN: Erica, could you pull up
7 Exhibit 12.
8 Q Dr. Weiss, what I'm about to show you is from the
9 Endocrine Society website. It's a list of their
10 clinic guides by topic area. I'm going to ask you
11 for these topics that are listed, whether you
12 practice in this space and whether you use any
13 guidelines.
14 So going from the top, do you treat adrenal
15 conditions?
16 A Yes.
17 Q Do you use the Endocrine Society guidelines to
18 treat those?
19 A Some of them.
20 Q How about for hypoglycemia?
21 A Yes.
22 Q Do you treat that condition?
23 A Yes.
24 Q Do you use the Endocrine Society guidelines for
25 those conditions?

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1 A Yes.
2 Q Okay. Then just looking through the rest of this,
3 you will see there are several other conditions
4 listed.
5 How about for bone health and osteoporosis?
6 A I treat that.
7 Q Do you use these guidelines?
8 A Some of them.
9 Q And then for male reproductive endocrinology?
10 A Yes.
11 Q Are you a reproductive endocrinologist?
12 A No.
13 Q How about for diabetes, mellitus and glucose
14 metabolism, do you use the guidelines?
15 A I don't know what they are. I don't tend to refer
16 to them because I'm an expert. They are probably
17 outdated by the time they are written. I see so
18 much diabetes and I'm very current on the
19 literature on that.
20 I treat many people with diabetes. I don't
21 care about the Endocrine Society guidelines for
22 that.
23 MR. SELDIN: Erica, could you pull up
24 Exhibit 31?
25 Q Dr. Weiss, this is clinical guidelines from the

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

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

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1 monitoring (CGM) rather than self-monitoring of
2 blood (SMBG) glucose by fingerstick for patients
3 with type I diabetes receiving multiple daily
4 injections (MDIs)."
5 Do you see that?
6 A I do.
7 Q Do you agree with that recommendation?
8 A Yes.
9 Q Is that something that you use in your practice?
10 A Absolutely.
11 MR. SELDIN: Erica, can you take us to
12 Page 11.
13 Q You will see where it says Justification For The
14 Recommendation.
15 Do you see that?
16 A Yes.
17 Q It says there, "The panel justified a strong
18 recommendation despite the low quality of
19 evidence, based on recognition that iatrogenic
20 hypoglycemia is the limiting factor in the
21 glycemic management of diabetes and is a major
22 concern for individuals with diabetes and for
23 their family members."
24 Do you see that?
25 A I do.

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

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

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1 A I think it's, a lot of it is tradition. I think
 2 there are a number of reasons.
 3 Q Well, they are different specialities, though,
 4 right?
 5 A They are.
 6 Q So there are differences in how to treat pediatric
 7 patients versus adult patients?
 8 A True.
 9 Q And how do you know that most pediatricians stop
 10 care at eighteen?
 11 A Thirty-six years of practice.
 12 Q Then, Dr. Weiss, in Paragraph 10 of your
 13 declaration you say that you have training in
 14 diagnosis and treating patients with some mental
 15 health disorders including depression.
 16 Do you see that?
 17 A Yes.
 18 Q What training have you received in diagnosing and
 19 treating patients with some mental health
 20 disorders?
 21 A Some of it is from during residency in internal
 22 medicine. Some of it is from reading. Some of it
 23 is from online conferences. Some of it is from
 24 in-person conferences.
 25 Q And depression is a DSM 5 diagnosis, is that

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1 right?
 2 A Yes.
 3 Q Is that a diagnosis that you make in your
 4 practice?
 5 A Yes. Depression is common with diabetes, for
 6 example.
 7 Q Why is that?
 8 A It's not known.
 9 Q Do you have a theory?
 10 A No.
 11 Q So endocrinologists can sometimes be qualified to
 12 make a mental health diagnosis then?
 13 A Absolutely.
 14 Q So not just psychiatrists can make these kind of
 15 diagnoses, but other clinicians can?
 16 A Most people who treat depression are primary care
 17 people.
 18 Q Have you ever received any training in diagnosing
 19 gender dysphoria using the DSM 5?
 20 A The DSM 5 came out in 2013 and that's when I
 21 stopped treating.
 22 Q So you would not have received training in
 23 specifically how to use those criteria to
 24 diagnose?
 25 A It does not take a lot of training. That is why

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

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

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

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

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

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

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

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1 your career with folks about this topic that you
2 have accurately ascertained that most of them do
3 not agree, notwithstanding what the major medical
4 associations have said?
5 A Some of those organizations have made those
6 statements and many physicians are not members of
7 those organizations.
8 And it's not just my conversations with
9 physicians. It is also what is seen and what
10 other countries have concluded, as we will talk
11 about I'm sure.
12 Q Then, Dr. Weiss, in Paragraph 26 you say, "The
13 goal of treating children with gender dysphoria is
14 to resolve their gender related distress."
15 Do you see that, the first sentence of
16 Paragraph 26?
17 A Yes.
18 Q When you say that, do you mean pre-puberty
19 children?
20 A All children.
21 Q How are you defining children?
22 A Anyone under eighteen.
23 Q So you mean both children who have not hit puberty
24 and children who have hit puberty?
25 A Correct.

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

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

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1 Q Okay. Is detransition a term that you are
2 familiar with?
3 A Yes.
4 Q What does that term mean to you?
5 A That term relates to those who took therapies,
6 hormonal therapies, blockers, or opposite sex
7 hormonal therapies, to appear as the opposite sex
8 and after a period of time decide -- or maybe even
9 surgery, underwent surgery -- then changed their
10 mind and wanted to return to their natal sex.
11 Q What is the difference then between desistance and
12 detransition?
13 A Desistance is just discontinuing the efforts to
14 appear as the opposite sex. Detransition is
15 already, those children or adolescents or adults
16 who made the change to the opposite sex, the
17 change in the appearance, took those therapies or
18 interventions and now they want to return to their
19 natal sex.
20 Q So when you say desistance, do you mean the
21 resolution of gender dysphoria, or an
22 identification to the sex assigned at birth?
23 A It would be the identification with the sex
24 assigned at birth. What their psychic state is,
25 that does not speak to that other than they are

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1 returning to their, accepting their natal sex.
2 They might have depression, anxiety, who
3 knows.
4 Q So in your mind, desistance then is the resolution
5 of gender dysphoria by identification with the sex
6 assigned at birth, is that what you mean by
7 desistance?
8 A There is more work that needs to be done in this
9 area to study this. Unfortunately, little has
10 been done.
11 Desistance would be defined as no longer
12 having dysphoria related to your gender.
13 Q Okay. And is that different from identifying with
14 your sex assigned at birth?
15 A No, I would say it was the same. You are now
16 returning and identifying with your natal sex.
17 Q If a patient is receiving psychotherapy but
18 continues to have severe gender dysphoria, do you
19 think medical intervention is ever appropriate?
20 A No. By medical intervention you are talking about
21 to change the appearance of the child and giving
22 them opposite sex hormones? Is that what you are
23 referring to?
24 Q We have been talking about treatment with
25 hormones --

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

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

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

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

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

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

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

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

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1 A Yes.
 2 Q So you see where it says, "Moreover, this request
 3 is vague, overboard, and unduly burdensome to the
 4 extent it requests records for 'a related
 5 condition' because there are no conditions
 6 inherently related to gender dysphoria."
 7 Did I read that correctly?
 8 A Yes.
 9 Q Would it surprise you to learn that the medical
 10 records that have been produced in this case all
 11 pertain to the treatment of gender dysphoria?
 12 A I think that statement that there are no
 13 conditions inherently related to gender dysphoria
 14 is ridiculous. It's absurd.
 15 The whole patient psychiatric psychosocial
 16 status is related to gender dysphoria. Their
 17 family situation. Whether they were sexually
 18 abused. That is related to gender dysphoria.
 19 Whether they are physically abused. Were they
 20 bullied. All those.
 21 So there are no conditions related to gender
 22 dysphoria, that is a ridiculous remark. It's
 23 antithetical to any psychological care that that
 24 person might require.
 25 Q Earlier we were talking about diabetes. You said

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1 a lot of your patients with diabetes also have
 2 depression, correct?
 3 A Yes.
 4 Q Do you consider depression and diabetes to be
 5 related conditions?
 6 A There is more depression in people with diabetes
 7 and that is perhaps in part because of the burden
 8 of the diabetes care. But that is just an
 9 association.
 10 Q Other than that case, have you ever evaluated the
 11 medical records of a minor?
 12 A Yes.
 13 Q When?
 14 A Over my thirty-five years of practice I have. I
 15 took care of children down to the age of five.
 16 Q We talked about you thought that was less than one
 17 percent of your practice overall, correct?
 18 A Maybe a little more earlier then and then it
 19 became less later. Yes.
 20 Q You have interacted with the records of your minor
 21 patients, correct?
 22 A What is the question?
 23 Q I'm asking, we are talking about when you treated
 24 minor patients as a small part of your practice
 25 you interacted with their medical records as their

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1 physician?
2 A Yes. I also would have reviewed previous records
3 when I was assuming care for that child.
4 Q How long did your review of the medical records
5 take in this case?
6 A I don't remember. Hours.
7 Q Can you estimate approximately how many hours you
8 spent reviewing the medical records in this case?
9 A The medical records of the four plaintiffs, maybe
10 five hours.
11 Q Who did you discuss your review with, if anyone?
12 A I just reviewed them on my own.
13 Q Did you discuss, this is a yes or no question, did
14 you discuss your review with the attorneys for the
15 state of Indiana?
16 A Yes.
17 Q Did you discuss your review of the medical records
18 with any other physician?
19 A No.
20 Q Did you discuss them with your wife?
21 A No.
22 Q Then I assume I know the answer to this, have you
23 shared those medical records with anyone else?
24 A Absolutely not.
25 Q In Paragraph 29 you say one of the plaintiffs had

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

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

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

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1 from the -- I believe I'm not confusing. No. No.
2 That is A.M. I'm sorry.
3 With K.C. there is somewhere in the record
4 where that was apparent about a transgender
5 parent. I don't recall.
6 Q If it's not K.C.'s parents would you need to
7 revise your declaration?
8 A It's possible I am mistaken with regard to that.
9 That is what I saw, that there was a parent who
10 identified as transgender and was a biologic male.
11 Q And why was the sex of the parents notable to you?
12 A How they identify is notable because I would be
13 curious as to whether there was pressure on the
14 child from the age of four to socially transition.
15 That is unusual. So that ought to have been
16 explored by any biopsychosocial evaluation in this
17 child who has multiple medical problems.
18 Q In Paragraph 31 of your declaration you say, "The
19 mother of M.W. questioned the rapid onset of
20 gender dysphoria in her," you use the term
21 "daughter."
22 You said, "However, after a telephone call
23 with a health care provider, she no longer
24 expressed concern, though the file does not
25 explain."

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1 Do you see that?
2 A Yes.
3 Q Why was it notable to you that the clinicians
4 addressed the mother's concerns?
5 A That is not what was notable. What was notable
6 was the mother had those concerns. What happened
7 to those concerns? How were they addressed?
8 Q I mean, in general it's a good thing when
9 clinicians express concerns of parents in the care
10 of their children, right?
11 A Yes.
12 Q Doesn't that mean there was not immediate
13 affirmation here if, in fact, the mother had
14 questions that were strong enough that she
15 followed up with the clinician?
16 A They rate parents on their degree to which they
17 affirm. You know, so they are really evaluating
18 parents on an ongoing basis if they do any
19 questioning of them, of the gender issues that the
20 child has.
21 So I would wonder what happened here. We
22 don't know what the conversation was and whether
23 was the parent told if you don't affirm M.W. she
24 will kill herself. Was it that kind of a threat
25 which we often hear occurs in these kind of

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1 settings. I don't know. I wonder about that
2 because this later onset expression of gender
3 dysphoria in this sixteen year old suggests it has
4 not been an ongoing gender issue for years with
5 the child.
6 Q So it raises concerns in your mind when gender
7 dysphoria begins to appear in a later adolescent,
8 is that what I'm hearing you say?
9 A Yes.
10 Q You also don't believe that a three year old can
11 accurately express gender dysphoria, is that
12 right?
13 A Yes.
14 Q So there is no age between three and sixteen where
15 you think a child can accurately report gender
16 dysphoria?
17 A Well, they can mistakenly report it, but that does
18 not mean there are not co-morbidities or reasons
19 why they are feeling dysphoria that could be
20 addressed without hormonal interventions.
21 They can be dysphoric and attribute it to
22 their gender. But especially for a new, rapid
23 onset in this setting there is usually factors.
24 Like I think she had just broken, she had a
25 relationship that just broke up. She had a bad

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1 experience in school. Yes, that was M.W.
2 So there was a stabbing at the school. So
3 that needed to have been explored. This feeling
4 of gender incongruence, why did it come up all of
5 a sudden? But it is not clear to me from the
6 records that there was any exploration of that and
7 they moved right onto testosterone at the second
8 visit with the first visit being a video visit.
9 Q In your practice do you do telehealth visits?
10 A Yes. That is with established patients.
11 Q During the pandemic did you have any new patients
12 that started with telehealth?
13 A No.
14 Q Were there doctors in your practice who did?
15 A Not new patients, no. We only did televisits for
16 a short period of time. Then we were seeing them
17 in the office.
18 Q In Paragraph 32 of your declaration you are
19 discussing an informed consent sheet. In the last
20 two lines you said, "Among the potential
21 undisclosed harms are infertility, baldness, and
22 an increased risk of heart attacks and stroke."
23 Do you see that?
24 A I do.
25 Q This was for M.R.

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

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

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

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

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

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

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1 Q And what does institutional social transition
2 mean?
3 A It means that the child adopts a different name
4 and pronoun and lives as the opposite gender.
5 Q So you don't think that is an appropriate
6 intervention?
7 A Correct.
8 Q And in your view of gender-affirming therapy, is
9 the therapist pushing that or just merely not
10 opposing it?
11 A The therapist would push it.
12 Q What about a therapist that does not push it, but
13 says this is an option. How do you feel about it?
14 A I think that hypothetical situation is not one
15 that is realistic or meaningful.
16 Q So in your open exploratory supportive
17 psychotherapy would social transition be discussed
18 at all?
19 A It might come up.
20 Q What do you think the therapist's response should
21 be when it comes up?
22 A It really depends on the situation and the child.
23 It's so complex. It is an interplay of so many
24 factors.
25 Q Do you think there is ever a situation where the

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

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1 about?
2 A Yes. I referenced some papers.
3 Q Is there anything other than the papers that you
4 reference in your complaint -- I'm sorry -- in
5 your declaration?
6 A Yes. Yes. There are therapists who use it all of
7 the time and children and adolescents benefit from
8 it.
9 Q Which therapists do you know that are providing
10 the kind of open explorative supportive
11 psychotherapy that you are talking about?
12 A What do you mean by "know"?
13 Q You said you know there are therapists that
14 provide this kind of therapy. I am asking who is
15 it?
16 A Someone like Dr. Kenneth Zucker. Dr. Steven
17 Levine. Dr. Cantor. James Cantor. Dr. Marcus
18 Evans. There are others.
19 Q The same Dr. James Cantor who is a witness for
20 Indiana in this case?
21 A Yes.
22 Q Were you aware that both Dr. Zucker and Dr. Levine
23 have treated adolescent patients with
24 gender-affirming care?
25 A I'm not aware that they prescribed hormonal

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1 therapy for those people.
2 Q Are you aware of whether or not they recommended
3 hormone therapy for those people?
4 A No.
5 Q Would your view of their practice change if you
6 learned they had, in fact, prescribed
7 gender-affirming care in the form of hormones for
8 these patients?
9 A What was the question again?
10 Q Well, you told me that you think Dr. Cantor and
11 Dr. Zucker were providing the kind of open
12 exploratory supportive psychotherapy that you
13 think should be happening. Right?
14 A Right.
15 Q And I asked were you aware that they prescribe or
16 have recommended the prescription of hormones for
17 their patients with gender dysphoria. You said
18 you were not sure. Is that correct?
19 A I'm not aware that they, themselves, prescribed it
20 or that they recommended it.
21 If they did recommend it or prescribed it I
22 think they were doing, that recommendation was
23 inappropriate and not based upon good evidence.
24 Maybe they were not aware of the evidence at that
25 point when they prescribed it.

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1 Q So I will represent to you that Dr. Zucker's
2 clinic did treat adolescents with hormones.
3 Does that give you pause as to the
4 psychotherapy that he is providing?
5 A No.
6 Q So you think it's possible to provide the kind of
7 psychotherapy you think is appropriate while also
8 prescribing hormones to adolescents?
9 A I don't think it's appropriate to prescribe the
10 hormones.
11 Q In Paragraph 39 of your declaration, I believe
12 that takes us to Page 9, you say, "No other mental
13 disorders listed in the DSM are treated with
14 medication or surgery with the goal of altering
15 body appearance or function."
16 Do you see that?
17 A I do.
18 Q There is no citation for that, correct?
19 A Correct.
20 Q Would you agree the brain is part of the body?
21 A Yes.
22 Q So psychotropic meds do change bodily function to
23 the extent that they change brain function. Would
24 you agree with that?
25 A I agree that they do change brain function. Yes.

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

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

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

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

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

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1 Q Are there other medical treatments that you think
 2 are inappropriate for adolescents who are
 3 currently experiencing depression or anxiety?
 4 A Not that I can think of.
 5 Q Are there other medical treatments that you think
 6 should not be provided to adolescents because they
 7 have been bullied or have experienced trauma or
 8 abuse?
 9 A Medical treatments other than hormonal
 10 interventions for gender dysphoria?
 11 Q Other than that?
 12 A No.
 13 Q Would you agree that someone can have more than
 14 one condition that might require two different
 15 kinds of treatment?
 16 A Yes.
 17 Q But it is your position that even if an adolescent
 18 has no other diagnosis other than gender dysphoria
 19 they are still not a candidate for hormonal
 20 intervention or puberty blockers?
 21 A That is my view because there, because the
 22 evidence does not support benefit from those
 23 interventions.
 24 Q So in that case it would not be the existence of
 25 co-morbidities. It would be your view of the

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1 evidence base that would cause you to believe
 2 that?
 3 A Right. The evidence does not support benefit from
 4 hormonal interventions for gender dysphoria even
 5 in the absence of major co-morbidities.
 6 Q In Paragraph 60 of your declaration you say at the
 7 end, "When the GRADE score is 'low,' the true
 8 effect is likely to be markedly different from the
 9 estimated effect."
 10 Do you see that?
 11 A I do.
 12 Q Can you give me an example of that?
 13 A Can you be a little more specific in what you are
 14 asking?
 15 Q Sure. You say when the GRADE score is low that
 16 the true effect is likely to be markedly different
 17 from the estimated effect.
 18 And there is no citation there, right?
 19 A Well, the citation relates to GRADE. That is what
 20 GRADE, that is what -- the citation still relates
 21 to citation 42, which is on GRADE.
 22 Q Okay. So that is how you believe GRADE
 23 characterizes low in terms of quality?
 24 A Yes. That is right out of the GRADE criteria.
 25 Q All right. And can you give me an example of

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

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

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

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

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

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

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

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

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

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

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1 treating needs to know the interaction between
2 those two and treat both of them and maybe taper
3 off on one of those medications. Your depression
4 is much better. Maybe we can drop back on your
5 meds for your ADHD or vice versa.
6 You can't do that if you were doing hormonal
7 interventions and you have already transitioned
8 the person. That is not something that you can go
9 up and down on.
10 Q In Paragraph 80 of your declaration you are
11 talking about a quote and then you say at the end,
12 "Elsewhere this author writes that there are
13 'numerous gaps in knowledge' in transgender
14 medicine."
15 Do you see that?
16 A Yes.
17 Q Are there gaps in knowledge in other areas of
18 medicine?
19 A Not as much as in transgender medicine. And the
20 gaps are so large in transgender medicine that
21 practitioners are inclined to treat with these
22 interventions that I think are harmful.
23 Q So when there are gaps in knowledge in medicine do
24 you believe that we should withhold care?
25 A No. The care just continues to improve and change

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1 over time. But we always want to have the care be
2 the least harmful possible.
3 Q And so you would agree then that the way you close
4 those gaps to get to a place of care that is more
5 effective and less harmful is through research?
6 A Correct.
7 Q In Paragraph 86 of your declaration you say that
8 GnRH analogs are approved for use in children with
9 a relatively rare disorder called central
10 precocious puberty.
11 Do you see that?
12 A Yes.
13 Q So would you agree that for children experiencing
14 that condition GnRH analogs are safe to use?
15 A They appear to be. And there is no other
16 treatment for those children.
17 Q What about a child who has both precocious puberty
18 and gender dysphoria, would you consider GnRH
19 analogs to be an appropriate treatment?
20 A Yes, for the precocious puberty. Not for the
21 gender dysphoria.
22 Q But if they had both, you would still find it
23 appropriate to use the GnRH analog to treat them?
24 A For the precocious puberty. I've not seen a
25 single report of a child who has both though.

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1 Q In Paragraph 90 of your declaration you say,
2 "Seizures have been reported in children receiving
3 puberty blockers."
4 There is no citation to that sentence. Do
5 you see that?
6 A The citation comes in the next sentence.
7 Q Okay. So you believe that footnote 60 applies to
8 both those sentences?
9 A I think so. Let me check. Yes, it does apply to
10 both sentences.
11 Q So is that the Bangalore Krishna study?
12 A Yes.
13 Q Okay. Was that study in children who are being
14 treated for precocious puberty?
15 A Yes. There is very little data on children
16 treated with puberty blockers for gender
17 dysphoria. Very little published data.
18 Q So because central precocious puberty can only be
19 treated with GnRH agonists or puberty blockers,
20 even though there are some rare side effects it's
21 still an appropriate treatment in your mind?
22 A Yes.
23 Q So you would agree that medical interventions can
24 always have rare side effects?
25 A They can always have side effects. We don't know

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1 how rare these are in their use with children with
2 gender dysphoria because the data are not there.
3 These children -- there is no reporting. There is
4 no collection of data. They are just being
5 treated.
6 Q I'm asking you a broader question. Generally
7 speaking, medical interventions can have side
8 effects and some are more common, some are more
9 rare?
10 A Correct.
11 Q And even for medications or treatments where there
12 are those side effects, if the treatment on
13 balance benefits the majority of patients they
14 will continue to be prescribed, is that fair to
15 say?
16 A Yes, as long as the person knows the risk versus
17 benefit and gets full informed consent.
18 Q In Paragraph 96 of your declaration you say:
19 "Children who fail to progress through puberty are
20 infertile."
21 Do you see that?
22 A Yes.
23 Q Okay. So puberty blockers themselves don't cause
24 infertility though, right?
25 A They should not if we look at the data on

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1 precocious puberty. There is no good published
2 data in the treatment of children with gender
3 dysphoria.
4 Q Would you agree once the puberty blockers stop and
5 the child progresses through endogenous puberty we
6 have no reason to believe that blockers have a
7 negative effect on fertility?
8 A They should not. Although, there is not data
9 published for those with gender dysphoria.
10 Q You would agree with that statement when it is
11 used for precocious puberty?
12 A Yes, it appears that it does not impair fertility.
13 But the data that is published in the children
14 with precocious puberty is primarily biologic
15 females usually.
16 We have very, very little data on biologic
17 boys and their ability to conceive when puberty
18 blockers are stopped in them.
19 Q And that is something that you probably would want
20 more data on, right?
21 A Yes.
22 Q Can you think of other medical treatments that can
23 cause infertility in children that are minors?
24 A Chemotherapy.
25 Q You believe there are circumstances in which

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

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1 A Yes.
2 Q Is that statement generally true of all pediatric
3 interventions?
4 A Yes.
5 Q So it's not specific to the provision to treating
6 gender dysphoria in minors?
7 A Correct.
8 Q So you were talking earlier about the treatment of
9 Type I diabetes in minors and their transition to
10 adult endocrinologists.
11 A Yes.
12 Q Do you believe that, generally speaking, pediatric
13 endocrinologists do understand the long-term
14 effects of treating Type I diabetes in children?
15 A Yes.
16 Q Then in Paragraph 109 of your declaration you say,
17 "Short-term effects of testosterone given to natal
18 females include acne, baldness, facial hair,
19 clitoral enlargement and pelvic pain. There may
20 be deepening of the voice."
21 Do you see that?
22 A Yes.
23 Q And so for a person whose goal it is to reduce
24 their gender dysphoria, would you agree that some
25 of those side effects are actually intended

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

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

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

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1 Is it your understanding that the treatment
 2 of gender dysphoria using blockers and hormones is
 3 still being provided in the U.K. in some form?
 4 A That is still an option.
 5 Q Then in Paragraph 132 you discuss Sweden. In the
 6 second sentence you talk about, "Its new
 7 guidelines stated that the risks of hormonal
 8 interventions outweighed benefits and that
 9 hormonal interventions in minors can only be used
 10 as part of a research protocol."
 11 Did I read that correctly?
 12 A Yes.
 13 Q So in Sweden they are still providing care, but
 14 limited to research studies?
 15 A They are providing care, but it's hormonal
 16 interventions that are limited to research
 17 protocols.
 18 Q Yes. So you would agree then that hormonal care
 19 is still being provided to adolescents in Sweden
 20 in the context of research protocols?
 21 A Yes.
 22 Q Okay. Which in your view might be beneficial in
 23 the United States as well in the context of a
 24 randomized control trial?
 25 A Right. Carefully designed randomized control

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

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

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1 contagion in the same way as the AMA and other
 2 organizations?
 3 A Yes.
 4 Q Do you think that there are any large medical
 5 systems in the United States that have not been
 6 subjected to that kind of group think and social
 7 contagion?
 8 A No.
 9 Q We were talking about your prior experience as an
 10 expert in two cases. I believe that is in your
 11 declaration in Paragraph 13.
 12 Do you have that portion of your declaration
 13 up?
 14 MS. YOUNGS: Paragraph 13?
 15 MR. SELDIN: Yes.
 16 MS. YOUNGS: Okay.
 17 Q Okay.
 18 A Yes.
 19 Q For Suzanne Platz did you write a report?
 20 A Yes.
 21 Q Were you deposed?
 22 A Yes.
 23 Q Did you testify at trial?
 24 A No.
 25 Q Did the case go to trial?

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1 A No.
 2 Q Was your expert opinion in that case challenged in
 3 the form of a Daubert motion or a state
 4 equivalent?
 5 A No.
 6 Q For the second case, William Blair, did you do a
 7 report?
 8 A Yes.
 9 Q Were you deposed?
 10 A Yes.
 11 Q Did you testify at trial?
 12 A Yes.
 13 Q Did any party file a Daubert motion as to your
 14 testimony or try to limit it in some way?
 15 A Not that I'm aware of.
 16 Q In either case was your testimony limited or
 17 excluded by the court in any way?
 18 A No.
 19 Q Have you ever had to retract a research paper?
 20 A No.
 21 Q Have you ever had to issue a correction for a
 22 research paper?
 23 A No.
 24 Q Have you ever been sued for medical malpractice?
 25 A No.

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1 Q Have you ever been the subject of professional
 2 discipline?
 3 A No.
 4 Q Or sanctioned by the licensing board?
 5 A No.
 6 Q Have you ever had a professional complaint filed
 7 against you?
 8 A No, not that I'm aware of.
 9 Q Have you ever been arrested or charged with a
 10 crime?
 11 A No.
 12 Q Have you ever been the subject of a Title Nine
 13 complaint?
 14 A No. What is Title Nine?
 15 Q Have you ever worked at an academic research
 16 institution?
 17 A No. The answer is no, I've not been the subject
 18 to a Title Nine complaint.
 19 Q Have you ever been accused of any other form of
 20 discrimination or harassment?
 21 A No.
 22 Q Recalling earlier we were talking about your
 23 senior fellowship with Do No Harm. You also
 24 mentioned being a member of, I believe, SEGM,
 25 S-E-G-M, is that correct?

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1 A Yes.
 2 Q Are there any other organizations like that that
 3 you belong to?
 4 A Like what?
 5 Q Like Do No Harm or SEGM?
 6 A How are you characterizing them?
 7 Q Are you a member of any other organizations that
 8 take a position on the provision of treatment for
 9 gender dysphoria?
 10 A No.
 11 Q Are you a member of any other organization that
 12 takes the position on gender ideology as to how
 13 Do No Harm uses that term?
 14 A I will correct that statement. The answer is yes,
 15 there is one other organization. They take a
 16 position on treatment of gender dysphoria. That
 17 organization is AAPS, American Association of
 18 Physicians and Surgeons.
 19 They have been around since the 1950s. They
 20 also have a view that is similar to Do No Harm's
 21 view.
 22 Q And what was the extent of your involvement with
 23 AAPS?
 24 A I'm just a member.
 25 Q Do they have a newsletter that you read? Do you

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

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1 follow-up questions from any questions Ms. Youngs
 2 might ask, I have nothing further for you today.
 3 Thank you for your time.
 4 MS. YOUNGS: I have no rebuttal questions.
 5 (OFF RECORD AT 4:41 P.M.)
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 11 AND FURTHER THE DEPONENT SAITH NOT.
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(Signature waived.)

 DANIEL WEISS, M.D.

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1 STATE OF INDIANA)
) SS:
 2 COUNTY OF BOONE)
 3
 4
 5 I, Wendi Kramer Sulkoske, Notary Public in
 6 said county and state, do hereby certify that the
 7 deponent DANIEL WEISS, M.D. was sworn to tell the
 8 truth in the aforementioned matter:
 9 That the deposition was taken on behalf of
 10 the Plaintiffs at the time and place heretofore
 11 mentioned, with counsel present as noted;
 12 That said deposition was taken down in
 13 Stenograph notes, reduced to typewriting under my
 14 direction, is a true record of the testimony given
 15 by said deponent; and that the reading and signing
 16 by the deponent were waived, the witness being
 17 present and consenting thereto.
 18 I do further certify that I am a
 19 disinterested person in this cause of action; that
 20 I am not a relative or attorney of any of the
 21 parties or otherwise interested in the event of
 22 this action, and am not in the employ of the
 23 attorneys for the respective parties.
 24
 25

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

4 *Wendi K. Sulkoske*

5 _____
6 Wendi Kramer Sulkoske, Notary Public

7
8
9 Commission Number NP0661030

10 My commission expires December 1, 2030

11 My county of residence is Boone
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THE INDIVIDUAL MEMBERS OF THE MEDICAL LICENSING BOARD

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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 not 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

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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.

Daniel Weiss MD CDCES PNS CPI FAPCR

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

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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](#)



You don't often get email from drdanweiss@gmail.com. [Learn why this is important](#)

EXTERNAL EMAIL: DO NOT CLICK links or open attachments unless you recognize the sender and know the content is safe.

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 CDECES PNS CPI FAPCR

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 not 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

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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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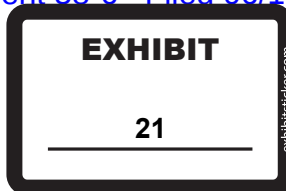
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Daniel Weiss MD CDECES PNS CPI FAPCR

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.

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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

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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

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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.

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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.

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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

Kozłowska, 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. Transsexualism, 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.

Daniel Weiss MD

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 Preventiolo* 2023;

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

Gurralla 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.

Daniel Weiss MD

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 detransitions 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.

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 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”.

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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. 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.

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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

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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.



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.

Kozłowska, 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: 11652.

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

Gurralla 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 detransitions 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.

The rate of suicide in this group translates into a 45-fold higher rate than the CDC reported suicide rates for those of comparable age in the general population.

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 response 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. Only 24% let their clinician know 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](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 an 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