REPORTER'S RECORD
VOLUME 1 OF 2 VOLUMES
TRIAL COURT CAUSE NO. D-1-GN-23-003616

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

HEARING ON APPLICATION FOR TEMPORARY INJUNCTION
AND PLEA TO THE JURISDICTION

On the 15th day of August, 2023, the following proceedings came on to be heard in the above-entitled and numbered cause before the Honorable Maria Cantú Hexsel, Judge presiding, held in Austin, Travis County, Texas;

Proceedings reported by machine shorthand.

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I N D E X

VOLUME 1 OF 2

HEARING ON APPLICATION FOR TEMPORARY INJUNCTION AND PLEA TO THE JURISDICTION

AUGUST 15, 2023

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PROCEEDINGS

THE COURT: All right. Then let's go on the record in Cause No. D-1-GN-23-3616. Today is August 15th, 2023, and we are here on both a temporary injunction and plea to the jurisdiction in the case referenced. I would ask those attorneys present to make their appearances for our record beginning with you, Ms. Wooten.

MS. WOOTEN: Thank you, Your Honor. Good morning. As stated, my name is Kennon Wooten. I'm a partner at Scott Douglass & McConnico representing plaintiffs pro bono in this matter. And if you'll permit, I'll announce the other people --

THE COURT: Sure.

MS. WOOTEN: -- appearing for plaintiffs. At counsel table for plaintiffs are Lori Leskin and Allissa Pollard from Arnold & Porter, which is also involved pro bono in this matter. In addition, we have from Lambda Legal Defense and Education Fund, Inc. Karen Loewy and Omar Gonzalez-Pagan. And last but certainly not least, we have Harper Seldin from ACLU Foundation.

THE COURT: Thank you. For the defense?

MR. STONE: Johnathan Stone for defendants.

MS. DYER: Heather Dyer for defendants.

MR. ELDRED: Charles Eldred for defendants.

THE COURT: All right. Thank you. Again, I will state for our record that there is no recording, broadcasting, or photographing admitted -- or permitted in this proceeding, and that would count both in this courtroom as well as the overflow courtroom in 8C. It is punishable by contempt if I find anyone has recorded or photographed or broadcast from our proceeding, but otherwise, you're all welcome in the gallery. Thank you.

All right. So would we like to admit some evidence? I know we discussed that.

MS. WOOTEN: Yes, Your Honor.

THE COURT: Okay. So I understand there may be some evidence we can admit if you'd like to go ahead with that offer, Ms. Wooten.

MS. WOOTEN: The parties conferred and identified 14 agreed exhibits. They are all loaded into Box. The exhibits consist of the eight exhibits defendants have identified for this hearing, and those are marked as D-1 through D-8. In addition, there are six of the exhibits that plaintiffs have identified for the hearing, and those are marked P-1, P-2, P-3, P-5, P-8, and P-11. At this time I'm offering the exhibits

marked as P-1, P-2, P-3, P-5, P-8, and P-11 into evidence.

THE COURT: Mr. Stone, as I understand it, those are agreed to.

MR. STONE: Yes, Your Honor, those are agreed to.

THE COURT: So I will admit P-1, 2, 3, 5, 8, and 11.

(Plaintiffs' Exhibits 1, 2, 3, 5, 8, and 11 admitted)

THE COURT: And Mr. Stone, do you at this time -- would you like to offer D-1 through D-8?

MR. STONE: Yes, Your Honor.

THE COURT: And I assume, Ms. Wooten, those are agreed to.

MS. WOOTEN: Yes, Your Honor.

THE COURT: Thank you. D-1 through D-8 are admitted.

(Defendants' Exhibits 1 through 8 admitted)

THE COURT: All right. So if we would like to begin with some opening statements.

MS. WOOTEN: Yes, Your Honor. We do have one more administrative matter that we believe may be helpful for the proceedings. Last night plaintiffs'

counsel provided defendants' counsel with a list of our witnesses and the order in which we anticipate presenting them, and I do have a copy for Your Honor and the court reporter if I may have permission to approach.

THE COURT: Yes. Go ahead. Thank you. Anything else, Ms. Wooten, before we begin with opening statements?

MS. WOOTEN: No, Your Honor.

THE COURT: All right. Give me one more second just to pull up a couple -- where would you like to do opening from? The lectern or the --

MS. LOEWY: Whichever Your Honor would prefer.

THE COURT: I'm kind of a fan of the lectern, so if you'd like to do that, that would be great. Just give me one other second to get my time calculator up. And, of course, you can run any exhibits -- well, how is that going to work?

(Discussion off the record)

THE COURT: Do you have a PowerPoint or something that you'd like to run?

MS. LOEWY: No, Your Honor.

THE COURT: Okay. Then I'm going to leave that alone for now so I don't mess anything up. Give me one other second just to do this. All right. Please go

ahead.

PLAINTIFFS' OPENING STATEMENTS

MS. LOEWY: Thank you, Your Honor. Good morning. My name is Karen Loewy. I'm here for the plaintiffs.

When a child develops a serious health condition, parents generally want nothing more than to make their child feel better and help them grow into happy, healthy people and so will work with their child's healthcare providers to figure out what is going on and determine what course of care will be medically necessary for that child.

Physicians and other healthcare providers will use their training and judgment to prescribe treatments in accordance with established standards of care to meet that child's treatment needs, help parents understand their options and their risks, and enable parents to make decisions about what their child's course of care will be.

For transgender young people in Texas and their parents and their healthcare providers, the ability to take these ordinary steps is at significant risk because of Senate Bill 14. Gender dysphoria is a serious health condition experienced only by transgender people characterized by the clinically significant

distress caused by the incongruence between their gender identity and the sex they were assigned at birth.

Evidence-based comprehensive clinical practice guidelines recommend certain medical treatments for gender dysphoria. And adolescents who experience gender dysphoria in Texas right now have access to those treatments. But SB 14 categorically bars the very medical treatments accepted as necessary, effective, and even lifesaving from being provided to minors for the purpose of treating gender dysphoria.

SB 14 at its core prohibits physicians and healthcare providers from prescribing, providing, or performing certain medical treatments to minors, namely puberty blockers, hormone therapy, and surgery, solely if those treatments are being provided to treat gender dysphoria. The rest of the bill incorporates that prohibition in a variety of ways; one, by requiring the Board of Medical Examiners to deny or revoke the medical license of any physician who provides the prohibited treatments and imposing other penalties; two, prohibiting any form of state funding being paid to any provider or entity that provides or facilitates the prohibited treatments; three, barring coverage and reimbursements for prohibited treatments under Medicaid and the child health plan; and four, empowering the

attorney general to bring enforcement actions against any person the attorney general has reason to believe is, has, or will violate the prohibition.

SB 14 threatens the health and well-being of transgender adolescents in Texas, their parents' autonomy to make decisions about their medical care, and the licenses and livelihoods of healthcare providers who have been and want to continue caring for them in accordance with the recognized course of treatment for gender dysphoria. In doing so, SB 14 violates plaintiffs' constitutional rights. It violates parents' fundamental rights to parental autonomy under Article 1 Section 19, which includes the right to seek medical care for their child and make judgments about what care that child should receive. Parents do not sacrifice these rights simply because their child is transgender.

SB 14 also deprives transgender youth of the Texas Constitution's promises of equality and equal rights by discriminating against them on the bases of sex and transgender status. By its plain terms, whether a minor can receive certain medical treatment turns on their sex assigned at birth or on whether they are transgender. SB 14 singles out transgender minors and excludes them only from accessing medically necessary care.

Finally, SB 14 deprives physicians of their vested property interests and their medical licenses and infringes the rights of all healthcare providers' occupational liberty without due course of law. SB 14 requires that physicians lose their licenses for treating their patients in accordance with established standards of care and undermines healthcare providers' ability to fulfill the obligations of their profession.

Today the Court will hear from families and healthcare providers who will be directly harmed if SB 14 goes into effect on September 1st as well as from experts who will establish that the treatments it prohibits are safe, effective, and part of the established course of care for gender dysphoria and will address the serious harms to transgender youth from cutting off and denying that care.

Plaintiffs seek temporary injunctive relief to ensure that the transgender youth of Texas can continue to receive medically necessary care in their own communities, that their parents can continue to make decisions about that care, and that their doctors and other health professionals can continue to provide that care without threatening their medical licenses or state funding.

These families and providers have stated viable claims that SB 14 is facially unconstitutional against the state defendants charged with its enforcement, claims on which they have a probable right to relief as every trial court considering similar wholesale bans on medically necessary healthcare for transgender minors has concluded. Enjoining SB 14 from going into effect while this Court assesses its constitutionality is necessary to maintain the status quo and shield transgender youth, their families, and their healthcare providers from harm. Thank you.

THE COURT: Thank you. For the defense?

DEFENDANTS' OPENING STATEMENTS

MS. DYER: May it please the Court. Good morning, Your Honor. I'm Heather Dyer for the defendants.

We are here today because plaintiffs claim that Senate Bill 14, which is the state's bipartisan prohibition on puberty blockers, cross-sex hormones, and surgeries for the treatment of gender dysphoria in minors, violates the Texas Constitution. To make it more concise for the Court, defendants will refer to prohibited medication and surgeries throughout this hearing as prohibited treatment.

As you know, defendants have filed a plea

to the jurisdiction requesting dismissal of plaintiffs' claims, and plaintiffs seek to enjoin the enforcement of Senate Bill 14 during the pendency of this suit. At the outset, defendants would note that since a question of jurisdiction has been raised, that issue should be decided before turning to the merits and subjecting defendants, who are entitled to sovereign immunity, to further litigation.

However, with regards to the jurisdictional question, Senate Bill 14 simply does not violate the Constitution, and plaintiffs have failed to allege sufficient facts that it does. Consequently, defendants retain their immunity to suit, and this Court lacks subject matter jurisdiction.

With respect to plaintiffs' first constitutional claims, the due course of law clause does not protect a parent's interests in providing medical treatment that is prohibited by the law, nor does it protect a physician's interests in providing medical treatment to a patient that is prohibited by the law. At best, it protects a citizen's interest in lawful common callings, but the prohibited treatment is not a common calling and will no longer be lawful on September 1st.

With respect to plaintiffs' second

constitutional claim, the statute does not deny or abridge equality under the law on the basis of sex. It classifies based on the medical purpose for which the treatment is being offered, not sex. It treats persons of both biological sex the exact same.

With respect to plaintiffs' third constitutional claim, the statute does not treat similarly situated people differently. It prohibits certain treatment for gender dysphoria, yes, but persons with gender dysphoria are not similarly situated to others. And Texas courts do not create suspect classes. Suspect classes are listed in the Constitution itself. While sex is listed, persons with gender dysphoria are not.

Even if plaintiffs could identify a plausible claim, Senate Bill 14 would still not violate the Texas Constitution because it not only passes rational basis, but it also passes strict scrutiny. It passes strict scrutiny for two primary reasons, the first being the State has a compelling interest in safeguarding the physical and psychological well-being of a minor. In *Prince v. Massachusetts* the Supreme Court of the United States stated a democratic society rests upon the health and well-rounded growth of young people into full maturity as citizens. That is

precisely what SB 14 was designed and enacted to protect.

The evidence will show in this hearing that sex is biological and immutable. However, gender identity is not. It can change over time. It can change going through puberty. And it can also change based on social circumstances and environments. Gender dysphoria is a psychological condition, not an endocrine condition where a person's biological sex does not match the perception of their gender. There are no physical medical tests for gender dysphoria.

Plaintiffs contend the scientific studies and medical association opinions on these prove that these prohibited treatments are safe and effective. However, that is simply not the case, or at least it is not an established fact. The evidence throughout this hearing will show the prohibited treatment will result in irreversible consequence for these minors. The consequences, to name a few, range from bone density problems, diminished cognitive ability, to sterilization. The risks associated with the prohibited treatment vastly outweighs any potential benefit, especially when you consider that gender identity by definition can change. Conversely, therapy has no risks. It is indisputably the only treatment that is

entirely safe, effective, and devoid of dangerous side effects.

Further, nothing in Senate Bill 14 prohibits individuals from receiving the care they seek to receive once they are of the age of 18. This law was enacted only to protect minors from scientifically unfounded treatment. The evidence will show that the State's restrictions on prohibited treatment is the least restrictive means of achieving that interest because the risks vastly outweigh any potential benefit, and a safe and effective alternative, being therapy, already exists.

The second reason Senate Bill 14 passes strict scrutiny and necessarily a rational basis review is because the State has a compelling interest in preventing medical procedures for which there is no informed consent. The evidence will show that a human brain is not even fully developed until you are in your mid twenties. Children under the age of 18 cannot understand or appreciate the impact that these prohibited treatments will have on their life in the long term.

Plaintiffs claim that prohibited treatment is reversible and that it does not cause infertility. However, the very standards they rely on in their

complaint note that a consequence of the treatment is partially irreversible, and a side effect of treatment includes potential loss of fertility. The evidence throughout this hearing will show that the prohibited treatment is in fact irreversible and does lead to infertility.

Just as an example, once a biological girl has a bilateral mastectomy, or a top surgery as it's often referred to, her breasts will never function the same again, and she will never be able to breastfeed her children one day should that be something she chooses to do. That is simply not something that a 13-, 14-, or 15-year-old can understand or appreciate at that stage in their life.

Children are albeit focused on what makes them happy in the moment, as they should be, but they do not have the brain development nor the maturity to make an informed decision to consent to these treatments that have lifelong altering impacts. Because they cannot give informed consent to the prohibited treatment, a ban on such treatment until they are of legal age passes strict scrutiny and a rational basis review.

Plaintiffs cannot meet their burden to show they are likely to succeed on the merits, nor will they be able to show that there's imminent irreparable

harm to meet the standard necessary for a temporary injunction. Accordingly, defendants respectfully request this Court deny plaintiffs' motion for a temporary injunction and grant defendants' plea to the jurisdiction. Thank you.

THE COURT: Thank you, Ms. Dyer.

All right. Ms. Wooten, who would you like to call as your first witness?

MS. LESKIN: Your Honor, we call Gina Goe.

THE COURT: Say the name one more time.

MS. LESKIN: Gina Goe.

THE COURT: Okay.

MS. LESKIN: Ms. Goe is proceeding under pseudo- -- is a plaintiff proceeding under pseudonym.

THE COURT: Yes. Yes. I just wanted to make sure I heard the right name. Just one second.

MS. LESKIN: And if Your Honor would indulge me, can I proceed from this location?

THE COURT: If that's more comfortable for you, that's fine.

MS. LESKIN: Thank you, Your Honor.

THE COURT: Hello, Ms. Goe. If you'll step forward here, I'll swear you in. If you will raise your right hand for me.

(Witness sworn)

THE COURT: All right. If you can make your way around and up to this witness stand, and just make sure -- the sweet spot is about six inches from the mic. Thank you.

MS. LESKIN: Thank you, Your Honor.

GINA GOE,

having been first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MS. LESKIN:

Q. Good morning.

A. Good morning.

Q. Will you tell us your name, please?

A. Gina Goe.

Q. And Ms. Goe, do you live in Texas?

A. Yes.

Q. Which county in Texas do you live in?

A. McLennan County.

THE COURT: And ma'am, you can be seated. If you're going to stay at counsel table, you can --

MS. LESKIN: Thank you, your Honor.

THE COURT: -- be seated to question the witness. Go ahead.

Q. (BY MS. LESKIN) Are you a member of PFLAG?

A. Yes.

Q. Tell me about your family, Ms. Goe.

A. We're just a family living life. We live in a small town. It's my husband and Grayson and myself and our two cats and a dog.

Q. And Grayson is your son?

A. Yes.

Q. Tell me about Grayson.

A. I think Grayson's pretty amazing. He's funny. He's smart. He's very curious, so he, like, engages in learning about things a lot on his own, like, taught himself to play the ukulele and wood whittle, and he likes video games.

Q. And how old is Grayson?

A. 15.

Q. What sex was Grayson assigned at birth?

A. Female.

Q. And what gender does Grayson identify today?

A. Male.

Q. How did Grayson -- when did Grayson tell you that he identified as male?

A. I think it was when he was about 11.

Q. Tell me about that conversation.

A. I don't remember exactly how the conversation went, but he told me that he felt like he was a boy.

Q. And prior to Grayson telling you that he felt like he was a boy, had you noticed anything about

Grayson's mental health?

A. I mean, yeah, we were dealing with some depression and anxiety, and he was having some trouble in school with grades and so forth, so we were, like, trying to address that as well.

Q. How were you addressing that?

A. So I took him to a psychologist, and then later on he saw a psychiatrist, and the psychiatrist prescribed medication for depression.

Q. Did you find that the medication that Grayson took was helping his depression?

A. Somewhat. It seems to take a while to find, like, just the right thing that works, but he was laying around less but still spending time in the room and still being somewhat moody.

Q. Did there come a time that you believed you needed to do more for Grayson?

A. I felt like that all the time, actually. One of the things that I noticed that I was concerned about was his lack of confidence in himself. And as a mom, I didn't really know what to do about it. I was trying to do everything I was supposed to with, you know, getting proper medical care.

Q. After Grayson told you that he felt like he was a boy, did you take any additional steps to treat him?

A. Yeah. So I tried to locate, like, a physician that was friendly to the LGBT community so that we could discuss this. And I didn't want it to be dismissed. I wanted it to be a conversation. And so we saw his primary and talked to her about it, and she, like, initiated referrals to endocrinology and adolescent medicine.

Q. And at some point was Grayson diagnosed with gender dysphoria?

A. Yeah. The adolescent medicine doctor did that.

Q. And what was the next step in Grayson's treatment that you discussed with the adolescent doctor -- the adolescent medicine doctor?

A. We talked about putting him on birth control to take and manage his menstrual cycle.

Q. And why was it -- why did you consider birth control for Grayson?

A. I have, like, personal experience with it and felt that it's relatively safe. And if -- if you take the right thing and you take it properly, then it does a pretty good job of managing the bleeding. So that was really important to us because for Grayson, a menstrual cycle is very distressing. Like, in the very beginning, like even with the first one, I was like -- it was odd for me to see him so upset about it. I didn't really

understand, but he was very distressed. And so managing that is a really important step in part of his care.

Q. Once you started Grayson on birth control, did you notice any changes in his mental health?

A. I could tell that he felt empowered because -- like, being in control of something that he didn't previously have control over. So it seemed like him taking the birth control and it doing a pretty good job managing the menstrual cycle was very helpful.

Q. Was there anything else you were doing during this time to affirm Grayson?

A. Yes. So we -- we tried with the pronouns. It's a -- it's an awkward change. Like, it's gotten better over time for us. But he was still in school, so I got him, like, a binder to help with that, and that did help him feel a little better. And then we just acknowledged how he felt, and we -- I asked questions a lot, and we talked about things. And I asked him about changing his name because I feel like that helps the pronoun change happen a little easier. And he really took his time picking a name and finally settled on it just a few months ago I think. I don't remember exactly, but it's fairly recent when the name was decided.

Q. And as you were deciding a name and using

proper pronouns, did you continue to notice a change in Grayson?

A. Yeah. I think just being a support and him knowing that I'm there for him and he doesn't have to hide who he is from me -- I mean, I might not a hundred percent understand all the time, but I'm there to support him, and I will do what I can to figure out the best way to do that.

Q. Did there come a time when you determined that Grayson needed more medical treatment?

A. Yeah. We had talked about -- kind of early on when we first saw the adolescent medicine doctor, we had talked about puberty blockers, and I had never heard of them before, but I guess at the stage of development he was at, those weren't an option. So once we got -- the goal was to get the periods under control and then later talk about testosterone treatment. The facility that we see those physicians at does not offer that care, so I had to do some digging to find a place that would give us that option.

Q. Did you understand that there were risks putting Grayson on testosterone?

A. Yes. So, I mean, I assumed that in the beginning, but I didn't know the extent to which the risk is until we talked to the doctor at the clinic

where he receives that care. That was our first visit with them. And she went into great deal about the ones that are reversible and the ones that aren't reversible. And I just -- I really felt that with any medication there's -- there's a risk. And as a parent, I have to weigh the risks with the benefits. And for this particular treatment, the benefits far outweigh the risks.

Q. How so?

A. So if he doesn't continue on the testosterone, I worry that, like, the mental aspect of -- the things that have changed for the better, like, he's more confident. He comes out of his room. He socializes. And that was -- when he first came out of his room, I was like, Are you okay? Like, you're out of your room. So I'm afraid that will just be completely reversed.

And, you know, with a history of suicidal ideation, you're talking about, for me as a parent of my son, I'm deciding between strong mental problems that may lead to suicide or a deep voice and some body hair and not being able to have children. Like, life, death; I'm going to choose life.

Q. What is your concern if the ban under Senate Bill 14 goes into effect?

A. I would say my biggest concern or issue is that

it completely hinders my ability as a parent to make medical decisions on a whole for my kid. That aspect of who he is is part of his medical care, and I won't be allowed to do anything about it, so now I have fractured medical care for my son. Am I going to be allowed to talk to the adolescent medicine doctor? I already know if it goes into effect that the clinic we were going to won't even see him for other gender-affirming care that doesn't involve medicine. So it's just insulting to take away a parent's right to do that. I don't -- I didn't do it by myself. We have a slew of doctors that are very good at what they do, and Grayson is part of the decision-making as well.

Q. Do you have a plan for what to do if SB 14 goes into effect?

A. No. I mean, I don't know what I would do. I mean, I would -- I would probably first go through, like, a grieving process, I would expect. I would be very upset. It's -- I -- I could go out of state or I could attempt to find care outside of Texas, and I have reached out to a Colorado facility, but there's, like, a waiting list. So in the meantime, prior to me being able to take him there, there's going to be a gap in his medical care. And I don't even know how much that might cost. I know it's going to take away time from my job,

and I don't know if my insurance would cover the cost of that. I don't know how much the medication would be. So it's -- it's probably cost prohibitive for me to be able to do that.

Q. If Grayson had to wait until he turned 18 to continue testosterone, what do you think would happen?

A. I mean, I think he would lose that confidence that he's built. He would feel -- I imagine he would feel defeated. Like, we went through so much to get here, and we've only been -- he's only been taking it for a short time, and I've already seen benefits. So all that work and all that effort and all the stress, like, okay, you get to have it again. Like, it's that rug that's ripped out from underneath you.

Q. Thank you.

THE COURT: Thank you, ma'am.

Mr. Stone or Ms. Dyer?

MR. ELDRED: No questions, Your Honor.

THE COURT: All right. Thank you.

Thank you, ma'am. You are done on the witness stand.

THE WITNESS: Thank you.

THE COURT: I think if you'll go back out this way. Thank you.

Next witness for the plaintiffs?

MR. GONZALEZ-PAGAN: Thank you, Your Honor. I'm Omar Gonzalez-Pagan for the plaintiffs. We would call Dr. Aron Janssen to the stand, please.

THE COURT: All right. Dr. Janssen. Good morning, sir. If you'll step forward and raise your right hand for me.

(Witness sworn)

THE COURT: You can make your way up to the witness stand.

ARON JANSSEN, M.D.

having been first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. GONZALEZ-PAGAN:

Q. Good morning, Dr. Janssen.

A. Good morning.

Q. Can you please state your name for the record and spell it out for the court reporter?

A. Aron Janssen, A-r-o-n, J-a-n-s-s-e-n.

THE COURT: One second, sir.

(Discussion off the record)

MR. GONZALEZ-PAGAN: Your Honor, if I may, I'm just authenticating one of the exhibits.

THE COURT: Okay.

MR. GONZALEZ-PAGAN: I don't believe we are going to spend much time with it. I can use the

Elmo.

THE COURT: Well, I want to make sure if there's any other presentation, that it's set up to do it, so if you'll bear with me.

(Discussion off the record)

Q. (BY MR. GONZALEZ-PAGAN) Dr. Janssen, what is your profession?

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

Q. Where are you currently employed?

A. I'm currently employed at the Ann and Robert H. Lurie Children's Hospital of Chicago. I'm also an associate professor of psychiatry at the Northwestern University Feinberg School of Medicine.

Q. Prior to your role at Lurie Children's Hospital, where did you work?

A. I was a psychiatrist at NYU Langone Medical Center, and I was also the founder and director of the Gender and Sexuality Service there.

Q. How would you describe your practice?

A. My role is mixed into a few different types. I do clinical care primarily with gender diverse and transgender youth as well as administrative and research work.

Q. You mentioned that you do clinical care with

gender diverse and transgender youth. What is the clinical care that you provide to those patients?

A. I provide primary mental health support and assessments for transgender and gender diverse youth.

Q. Are there any particular conditions that you treat them for?

A. I have done a fair amount of research and publishing in co-occurring mental health disorders among transgender youth, and so that is a particular niche of my clinical care.

Q. Do you treat them for gender dysphoria?

A. I treat them for gender dysphoria, yes.

Q. And what percentage of your current clinical practice is gender diverse and transgender adolescents?

A. Approximately 95 percent.

Q. Are there any clinical guidelines that you utilize?

A. I utilize the World Professional Association of Transgender Health Standards of Care, on its 8th version.

Q. And how long have you been working with patients with gender dysphoria?

A. I founded my gender clinic in 2011. I had worked with transgender and gender diverse youth and young adults prior to that, but that's when I started my

clinic.

Q. You said you also spend your time doing research. What are the areas of study that you research?

A. I study the overlap between co-occurring mental health disorders and gender dysphoria as well as suicide prevention and systems of care.

Q. Have you published any scholarly articles related to this -- to the treatment of gender dysphoria?

A. I have.

Q. Have those publications been in peer-reviewed journals?

A. They are.

Q. You also mentioned that you rely on the WPATH Standards of Care Version 8. Do you have any role in the publication or development of these standards of care?

A. I was one of the co-authors of that standard.

Q. If you can look at the screen, it's showing what's been already admitted as Exhibit 5. Do you recognize this document?

A. That is my curriculum vitae.

Q. Does this curriculum vitae accurately reflect your professional background and experience?

A. It does.

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

THE COURT: Is there any objection?

MS. DYER: No, Your Honor. No objection.

THE COURT: Thank you. So designated.

Q. (BY MR. GONZALEZ-PAGAN) Dr. Janssen, we mentioned gender dysphoria as a condition that you treat. What is gender dysphoria?

A. Gender dysphoria is a diagnosis within the DSM-V. There's actually two different diagnoses, gender dysphoria in children and gender dysphoria in adolescents and adults. And what it describes is the distress and impairment in functioning that's resultant from the discordance between one's sex assigned at birth and one's gender identity.

Q. I just want to clarify some terms for the record and the Court. You mentioned the term gender identity. What does gender identity mean?

A. Gender identity is simply the innate and deeply-held sense of gender.

Q. And you also made reference to sex assigned at birth. What does that mean?

A. Sex assigned at birth is typically based on phenotypic appearance. So the genitalia primarily is what is used to determine sex assigned at birth.

Q. Are there multiple sex characteristics?

A. There are.

Q. Is gender identity one of those characteristics?

A. Gender identity is one of the characteristics of sex, yes.

Q. What does the term transgender mean?

A. Transgender is an umbrella term to describe individuals who have a discordance between their sex assigned at birth and their gender identity.

Q. And you mentioned that there were two particular diagnoses, one gender dysphoria in children and one gender dysphoria in adolescents and adults that are used in this country. Is there anyplace where those diagnoses are contained or documented?

A. They are documented within the *Diagnostic and Statistical Manual* or the DSM-V as we refer to it.

Q. And who publishes the *Diagnostic and Statistical Manual*?

A. It's published by the American Psychiatric Association. It's the primary guide by which we use to make diagnoses in the field of mental health.

Q. Can you summarize the diagnostic criteria for gender dysphoria under the DSM?

A. Well, it's important to note that the diagnostic criteria for gender dysphoria for children requires more diagnostic criteria to be positive in order to make that diagnosis, but the elements are shared between them, and that includes, one, a sense of identity -- a deeply-held sense of identity that is discordant from the sex assigned at birth, but there's a number of factors, including relationship to the body, social relationships, and sense of self as it comes to gender and that there is clinically significant distress or impairment and that these symptoms are lasting six months or more.

Q. Who makes the diagnosis of gender dysphoria?

A. Primarily it is going to be a qualified and licensed mental health professional or medical professional within the United States. The WPATH or World Professional Association of Transgender Health Standards of Care recommend that that person have licensure to practice, experience in working with gender diverse youth, and expertise in the field.

Q. How is gender dysphoria diagnosed in children and adolescents?

A. It's important to note that this is an

individualized process and that the standard assessment is going to depend upon when you've seen the patient, what the family circumstances are. But in general what we are establishing is what is the history of this child's gender identity, what is the history of this child's relationship to their body, what are the social contexts of this child's life, what are the family influences. We want to understand are there co-occurring mental health diagnoses, what they are, and how they might impact the ability to understand gender or the ability to understand potential interventions. And we are gathering information from multiple informants, including the child themselves, any parents or caregivers or legal decision-makers for that child, and ideally members from the child's school or other community.

Q. Does the fact that a child or an adolescent exhibits gender non-conforming behavior or expression mean that they have gender dysphoria?

A. It does not.

Q. Is being transgender a mental disorder?

A. It is not.

Q. Is gender identity something that somebody can voluntarily change to be congruent with their sex assigned at birth?

A. It is not.

Q. Have there been efforts in the field of psychiatry or psychology to try to change a transgender person's gender identity to be congruent with their sex assigned at birth?

A. Unfortunately, there have been a lot of unsuccessful and harmful efforts to endeavor to do that.

Q. You mentioned that there have been some efforts that have been harmful. Have there been any medical -- have any medical or mental health groups taken any positions on such efforts?

A. There have been a number of medical organizations that have made statements opposing the use of reparative or conversion therapy for sexual orientation and gender identity. These include but are not limited to the American Psychiatric Association, the American Academy of Child and Adolescent Psychiatry, the American Medical Association, the American Academy of Pediatrics, the American Psychological Association, just to name a few.

Q. Is there an understanding of what causes someone to have a particular gender identity?

A. We need more research to be able to give you a definitive answer to that question, but the preponderance of published data we have on this supposes

that it's likely a -- there's biological influence to gender identity.

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

A. It's a universal developmental task to understand one's identity when it comes to gender over time. All of us have gender identities that evolve over time. It doesn't mean that our core sense of who we are has changed, but our understanding, our contexts can evolve over time.

Q. Once an adolescent hits the onset of puberty, is it likely that they would desist from their gender identity?

A. I think we have to pause for a second and talk about what desistance and persistence means because it's very specific. The group of researchers that were initially doing work in understanding and treating with medicine transgender youth and youth with gender dysphoria and what was previously in the DSM-IV, gender identity disorder, defined the term desistance as a child who met criteria for what was then called gender identity disorder or gender identity disorder not otherwise specified in childhood.

And by the time they hit Tanner stage 2 of

puberty or adolescence, if they no longer met criteria for that diagnosis, those kids were referred to as desisters. Those that persisted, so those kids that did have the diagnosis of gender identity disorder in childhood, hit adolescence and continued to have that diagnosis of gender dysphoria or what was then gender identity disorder, those kids persist almost universally throughout adulthood.

Q. Dr. Janssen, you've worked at two major institutions in two large states in different parts of the country. Do you have an awareness of the practices of other child and adolescent psychiatrists and other mental health professionals outside those institutions?

A. Given my role within the American Academy of Child and Adolescent Psychiatry, I've had the privilege to attend conferences all over the country and all over the world as well as present at numerous academic institutions, and so I've had plenty of opportunities to get a sense of how this field is practiced in multiple settings.

Q. Are there any best practice guidelines recognized within the medical and mental health fields for the treatment of patients with gender dysphoria?

A. In my experience, most mainstream medical professionals look to the WPATH Standards of Care.

Q. And how long has WPATH been issuing standards of care?

A. Since approximately 1979.

Q. And you mentioned Version 8 of the WPATH Standards of Care. Is that the most recent version?

A. It is the most recent version.

Q. When was that published?

A. 2022.

Q. Are you familiar with the process that was used to develop the WPATH Standards of Care 8?

A. I am.

Q. What are the WPATH Standards of Care based on?

A. The standards of care are based upon a review of the scientific -- the scientific literature in the field as well as clinical consensus from experts within the field.

Q. Besides the WPATH Standards of Care, are there any other guidelines that medical professionals use to treat patients with gender dysphoria?

A. The most commonly other cited guidelines are the Endocrine Society Clinical Practice Guidelines.

Q. And are you familiar with those guidelines?

A. I am.

Q. Do those guidelines also make recommendations regarding the treatment of adolescents?

A. They do.

Q. How are the WPATH Standards of Care and the Endocrine Society guidelines viewed within the medical and mental health professional communities?

A. They're viewed as the guidelines that we should all be striving to achieve in our clinical care with these individuals.

Q. Are there any -- have any medical or mental health professional groups recognized these guidelines as best practices?

A. They have, and these include but are not limited to the American Medical Association, the American Academy of Child and Adolescent Psychiatry, the American Psychiatric Association, the American Academy of Pediatrics, the American Psychological Association, just to name a few.

Q. In your experience, are the WPATH Standards of Care and the Endocrine Society Guidelines practice -- recommended practices followed by other clinicians?

A. All the clinicians I've had an opportunity to meet with strive to follow those guidelines, yes.

Q. In these Clinical Practice Guidelines, are the recommendations for the treatment of gender dysphoria the same across age ranges?

A. There are different recommendations for

treatment based upon age.

Q. Do the recommendations for treatment also differ based on the stage of development of the patient?

A. The recommendations for prepubertal youth are going to be different for those for adolescents which will be different for those for adults.

Q. What treatments are recommended for prepubertal children with gender dysphoria?

A. There are no medical recommendations for prepubertal youth with gender dysphoria. The treatment is therapy and social support.

Q. And what are the treatments that are recommended for adolescents with gender dysphoria?

A. For individuals with -- for adolescents with gender dysphoria, we're still recommending therapy for some folks and social supports, and for those for whom it is medically indicated, one would consider puberty blockers or hormones.

Q. Do the standards of care that you named specify what should be included in an assessment of an adolescent patient?

A. It does.

Q. What is that?

A. As I had mentioned earlier, the assessment is a comprehensive approach that has not defined specific --

it doesn't have a cookbook of how you're supposed to do it, so it allows for individualized approaches based upon an individual's training, experience, time working with the families, et cetera. But in essence, all of the components are going to be similar. How you get to those components is going to change, but that means you're going to do a diagnostic assessment, that you're qualified to make a diagnosis of gender dysphoria and that the symptoms are present and persistent across time and to significant impairments in functioning, that you're doing a diagnostic assessment for any other co-occurring mental health conditions and understanding how those co-occurring mental health conditions impact either the gender dysphoria or the patient's functioning, that you're doing an assessment of the social context in which that child lives, the family context, and school context in which that child is experiencing, and understanding the potential risks, benefits, and alternatives of whatever the proposed intervention is, whether that's therapy alone, whether that is puberty blockers, whether that's hormones, or whether that's surgery.

And most importantly is to recognize that a family is an integral part of the assessment. We are engaging parents from the beginning to understand their

experiences and their observations of their child and making sure, given they are the medical decision-makers for their child, that they have an understanding of the potential interventions that may be recommended.

Q. Are there any psychiatric comorbidities that are common in gender dysphoric patients?

A. We would anticipate any minoritized group that faces stigma to experience higher rates of depression and anxiety. And that's something that we see in elevated rates with kids with gender dysphoria. We also see increased rates of suicidal ideation, eating disorders, suicidal ideation. But I also think it's important to know when we follow these kids longitudinally, those presenting for care, the most common co-occurring diagnosis among kids with gender dysphoria is no diagnosis at all.

Q. You mentioned minoritized youth. Do you have an understanding of why these co-occurring mental health issues are common among patients with gender dysphoria?

A. I think there's a number of reasons. Number one, stigma and bias itself. Having to live in an identity that is constantly invalidated or rejected or criticized can lead to increased stress, anxiety, depression. The experience of gender dysphoria itself, your experience with your body rejecting your sense of

identity, the discomfort you feel every day, the constant buzzing of anxiety and worry that can be incredibly distracting can be in and of itself quite harmful.

Q. Does having anxiety affect an individual's understanding of their gender identity?

A. It would be highly unusual for anxiety to impact anybody's capacity to understand their sense of self.

Q. What about depression?

A. It would be highly unusual for it to impact it in that way.

Q. Does the presence of anxiety, depression, or other psychiatric co-occurring conditions affect the capacity of an individual to provide informed consent or assent to medical care?

A. Well, first, again, it's the parents who are providing the informed consent. But for the child who's providing an informed assent, it would be highly unusual for any psychiatric diagnoses to impact the capacity to consent. Even among our most psychiatrically-ill patients with chronic psychotic disorders or bipolar disorder, most of the time they retain the capacity to consent to almost all of their medical care.

Q. And you mentioned both consent and assent. Can

you explain to the Court the difference between informed consent and assent?

A. Yeah. I think we want to make sure that the care that we're providing is patient and family centered; right? So even though legally it is the parents who are providing the consent for any treatment, we are not going to make a recommendation if that adolescent can't also understand the intervention that they are agreeing to. That is the difference between assent and consent.

We need to -- the process is the same; right? We are understanding the child's ability to understand the risks, benefits, and alternatives of an intervention as well as the risks, benefits, and alternatives of not intervening, that we're assessing the capacity to understand what the intervention is actually going to do and whether or not that's realistic as well as that of the parents.

Q. Dr. Janssen, are you familiar with SB 14?

A. I am.

Q. Are the medical treatments for adolescents with gender dysphoria that are recommended by the Clinical Practice Guidelines prohibited by SB 14?

A. They are.

Q. How do these medical interventions that we have

been discussing alleviate gender dysphoria in adolescents?

A. It alleviates it on a number of different levels. First we see relief from the gender dysphoria itself. We see kids who -- as an example, one of the kids that I saw who had an incredible amount of distress every time menstruation would occur, then being able to access puberty blockers and knowing that they had control over their body, that their period was no longer going to come, just created a sense of relief and hope and an ability to understand and think about what their future life might look like as opposed to having a foreshortened sense of self, a foreshortened sense of their future. I've had kids describe having access to this medical care as lifesaving and that it increases functioning in a significant and positive way.

Q. In your experience, what are some of the consequences of not providing treatment for gender dysphoria -- medical treatment for gender dysphoria when such treatment is medically indicated?

A. Well, first, gender dysphoria is a diagnosis. It's a serious diagnosis. And if we have a treatment for it and we're not able to access that treatment, we would anticipate the symptoms and the functioning resultant from that diagnosis would worsen and

intensify.

The second major part that's really important to note is that the unwanted puberty will continue to progress over time. And what that means for a transgender youth is that your body will be changing, and your body will be changing into a way that is unaligned with your gender identity, and that can have lifelong consequences. In the moment you see distress from these changes, but it also means that if patients are going to wait until adulthood to transition medically, it makes it much more difficult and much more unsafe in their communities.

Q. Dr. Janssen, one argument that some of the defendants' designated experts have made is that providing medical care for adolescents diagnosed with gender dysphoria essentially ensures that they will persist in their transgender identity. What is your response to that?

A. There's no evidence to support that assertion.

Q. Is there any evidence that psychotherapy alone is sufficient to resolve an adolescent's gender dysphoria if medical treatment is indicated?

A. There is no evidence to suggest that. Utilization of psychotherapy alone has been used for a long time without alleviation of distress. I think it's

also important to note that delaying care that is medically necessary leads to worse outcomes in the long term for these adolescents as well.

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

A. There's no evidence to suggest that. And similarly as to my last statement, if you delay treatment for gender dysphoria in order to treat the co-occurring mental health diagnoses, it tends to delay improved outcomes.

Q. We've talked a little bit about the assessment and diagnosis of gender dysphoria. Can you tell me a little bit about the role of the mental health professional in deciding whether to undergo gender-affirming medical care?

A. There's a number of different factors that are involved that a mental health provider participates in. One is in that assessment process that has all the elements that we've talked about, is the diagnosis present, does the child understand the intervention and understand the risks and benefits of the intervention as well as the risks and benefits of not engaging in the intervention, understanding that co-occurring mental health diagnoses and whether or not they're impacting

the capacity to consent, understanding the social context and the family context in which those individuals live, and making a recommendation based upon medical necessity for any further interventions.

Q. In order to conduct this informed consent/assent process to discuss the risks and benefits of treatment, do you have to be aware of the research in this area?

A. You do, yes.

Q. Are you familiar with the body of research regarding the efficacy of gender-affirming medical treatments to treat gender dysphoria?

A. I am.

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

A. We see improvement in gender dysphoria. We see improvement in distress. We see improvement in mental health symptoms.

Q. How does this accord with your clinical experience?

A. It's much drier than my clinical experience. In my clinical experience, I see all those things, yes, but you also see things that don't make it into peer-reviewed journals, like a sense of relief, an

ability to take ten minutes in the morning to go to school as opposed to two hours because it took that amount of time to find that one outfit that feels like I can leave the house and people are going to recognize me for who I am as opposed to making assumptions about how I look. It is being able to imagine a future that can be actualized and make decisions for themselves. It is about having the confidence to go to the restroom, to not worry about menstruation when that's a rejection of their sense of self. There's a number of really profound impacts of these interventions that don't make it into the dry medical journals as we read them.

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

A. When we see adolescents with gender dysphoria able to have increased body congruence, when their body starts to change in accordance to their gender identity, we see improvements in functioning. We see improvements in mental health outcomes. We see improvements in core gender dysphoria symptoms.

Q. And how does that accord with your clinical experience?

A. Again, in a much drier way. We see kids who are able to live full lives as a result of these

treatments, as we heard earlier, kids who are able to leave their rooms, kids who are able to engage in social relationships, kids who are able to function, which is really what we're aiming for, is how do we improve functioning for these kids.

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

A. For those for whom it is clinically indicated, it is a highly effective intervention and in some cases is actually curative of gender dysphoria. We see improvements in gender dysphoria. We see improvements in mental health outcomes. We see improvements in functioning.

Q. How common is surgery for gender dysphoric patients under 18?

A. It's highly rare.

Q. Are there any particular types of surgeries that are more common than others?

A. More commonly adolescents would be accessing top surgery or chest masculinization surgery.

Q. And how does the research that you've just discussed accord with your clinical experience?

A. It's aligned with the clinical experience. We see adolescents who are able to live their lives fully,

who have improved outcomes, who feel more confident. The number of conversations I've had with transgender boys and young adolescent boys who take hours every morning to get the binder just right, to find that way of tucking their shirt in that allows them to feel confident without their chest giving them away, to have them leave the house and talk about this just sense of relief, I can go to gym class and I can participate, I can go swimming, there's just an intense improvement that we see among these kids.

Q. Some of the State's designated experts have argued that the provision of puberty-delaying medications is a one-way road to further medical interventions. What is your response to that?

A. There's no evidence to suggest that's the case. And in my clinical experience, I've had a number of youth who will start puberty blockers who opt to discontinue it because they felt aligned with their gender identity.

Q. Is there any evidence that puberty-delaying medications access -- or act as some type of switch that children will go on to persist in their transgender identity?

A. There's no evidence to suggest that. In fact, the data we have from transgender youth who were

followed in the community, their identity persists independent of whether or not they had access to gender dysphoria treatment such as puberty blockers. The recommendations that we require -- the requirements that we have for individuals to access puberty-blocking medications is quite high. It's a very high bar in order to reach recommendations for proceeding with this treatment, and so it's not surprising that most of those youth will go on to have persistent gender identity -- persistent gender dysphoria that requires other medical care.

Q. Some of the State's designated experts argue that mental health professionals believe that a patient suffers gender dysphoria solely based on the patient's self-report and that they really don't scrutinize and take it at face value. What is your response to that?

A. I mean, it's a little diminishing of the field of psychiatry and mental health in general. Self-report is a part of all medical history taking. It's an important element to be able to hear what the patient's experience is, but it's one component of an assessment. It's not the entirety of the assessment. We're always looking at multiple layers, not just what the patient is saying but how we are saying it and how it accords to or discords to the experience that parents and teachers

have about those same incidents and experiences.

Q. Some of the State's designated experts discuss a theory that an increase in the number of transgender boys in late adolescence presenting to gender clinics for treatment of gen- -- for gender dysphoria is a result of peer pressure or social contagion. What is your response to that?

A. I think it's a little reductive, and it's certainly not in accordance with my clinical experience. I have patients who talk about their experiences for years and years and years of distress, a sense of differentness that they had a hard time articulating. And once they found a community of support where they had the language and the tools and the mirror to be able to see this makes sense, this explains my differentness, this is exactly it, there's an experience of coming out, of talking about it. And so to an outside observer it may look like I went on a website and now I'm transgender or to a parent this seems like it could come out of nowhere, but most of the time these are years of developmental tasks, years of distress, years of exploration that children find in order to get to a sense of self.

Q. You mentioned websites. Some of the State's designated experts have suggested that the fact that

some adolescents find communities online with other transgender adolescents suggest that it's proof that social contagion is a reason to explain the prevalence of gender dysphoria. What is your response to that?

A. They have the relationship backwards. Minoritized youth seek out affinity spaces, whether that's with race, ethnicity, interests, hobbies, gender identity, sexual orientation, and it's not uncommon for like to seek out like. And it's from these groups that often kids have the most amount of social support that they can get. It doesn't create a gender identity.

Q. Some of the State's designated experts argue that adolescents based on their brain development lack the mental capacity to assent to this medical care. What is your response to that?

A. I have two responses to that. One, it's not true. And we have lots of evidence. As an example, in Europe the age of consent is 16 in most of the countries. We recognize that children have the capacity to assent in all types of medical care here in the United States. This seems like it is a bit of a Heilmeier (phonetic). Yeah.

Q. Some of the State's designated experts opine that parents and caregivers of transgender adolescents are unable to provide informed consent because there's

no full accounting of all the potential risks associated with these medical interventions. What is your response to that?

A. If we expected parents to have a full accounting not only of the known risks but of the unknown risks, we would never have any medicine that we would be able to practice in the field of pediatrics. There's no single intervention. Not even Tylenol has a full accounting of the potential risks.

Q. I would like to get into it a little bit and ask you about the harms that people may experience for not having access to care. You talked a little bit about this earlier. But can you tell me about what effect the lack of access to gender-affirming medical interventions has for transgender people with gender dysphoria?

A. It's a highly individualized experience, but it has profound impact. To be told that we know that there's medically necessary and clear standard of care that would make your life better and improve care for your gender dysphoria and you can't have access to it, you're going to have intensification of the gender dysphoria. It would not be uncommon to see worsening depression and anxiety. Sometimes it would not be uncommon to see increased thoughts of suicidality or

self-harm as well as a foreshortened sense of a future.

I've had a number of patients -- you know, I practice in Illinois. We have the opportunity to make recommendations for this treatment there. And even the patients I see in Illinois feel targeted and stigmatized and wonder why -- why are people targeting me in this way? What have I done? And that can have a real profound impact. We see -- in communities where these kinds of laws are passed, you see increased searches for suicide attempts and methods of suicide attempts after these laws are passed.

Q. Dr. Janssen, in your opinion, is the provision of gender-affirming medical interventions to treat gender dysphoria in adolescents experimental?

A. It is not experimental.

Q. Is it safe?

A. It is safe.

Q. Is it effective?

A. It is effective.

Q. Thank you, Dr. Janssen.

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

THE COURT: Thank you, sir. Do you have cross for this witness?

MS. DYER: Yes.

THE COURT: About how long?

MS. DYER: I would estimate maybe 10, 15 minutes at most.

THE COURT: All right. Go ahead.

CROSS-EXAMINATION

BY MS. DYER:

Q. Good morning, Dr. Janssen. Thank you for coming.

A. Good morning.

Q. I have just a few questions. I shouldn't take too much longer. I'm not trying to beat the horse. So first -- let me see. You testified that you treat minors with gender dysphoria; correct?

A. That is correct.

Q. Okay. And have you ever prescribed puberty hormone blockers or is that something you refer different patients to?

A. I refer patients.

Q. Okay. And when -- have you ever referred a patient on their very first visit to see you?

A. I don't have my records in front of me, but that would be highly unusual.

Q. After about how many visits would you say on average? Again, nothing specific about any of your patients obviously, but just on average, how often --

how long does it take you?

A. It's going to be really individualized and dependent on context. Given my niche in the field of working with kids with co-occurring mental health diagnoses and gender dysphoria, generally my assessments are going to be a little bit longer. But I'm also providing opinions sometimes for folks who have been in care with established professionals for years, so I have a lot of information, so in those cases it will take less time than to do a full thorough assessment because there's so much information that's already been gathered.

Q. Okay. And you've mentioned a thorough assessment. About how long does it take you to conduct one of those for, let's say, a brand-new patient?

A. First of all, I don't have, like, a nice answer for you because it really is dependent upon the clinically presenting symptoms.

Q. Would you say something along the lines of 15 minutes, 30 minutes, to five hours? I'm just trying to get an idea, not necessarily something specific.

A. Sure. I mean, again, it depends upon the complexity of the situation, what are the details of the co-occurring mental health conditions. Typically I'm taking three to five hours as an initial assessment over

a period of a few visits before I make any recommendations.

Q. Okay. And you said that gender identity was innate; correct?

A. Yes.

Q. Okay. Are you familiar with the American Academy of Pediatrics policy statement regarding gender identity?

A. I am familiar that they have one. I'd have to see it in front of me to comment on it.

Q. If I told you that it says that gender identity develops over time and yet for some people gender identity can be fluid, how would you respond to that?

A. I think that it's aligned with what I discussed in terms of how people understand and express their gender identity can change and evolve over time. That core sense of gender identity isn't something that is changeable.

Q. Okay. And then let me see. You testified that social media -- or I can't remember the exact phrasing counsel used for that, but that social media and social contagion is not something that had a direct impact or it broke it down to be too big of an issue where, you know, it wasn't directly the cause of it. Is that your -- a correct assessment of your testimony?

A. I'm not sure I understood.
Q. I know. I'm sorry. I guess what I'm trying to say is from my understanding of your testimony, you said that social media was not necessarily the cause of the influx of individuals you've seen that are now transgender boys. Is that correct?
A. I would say that there's no evidence to suggest that social media is the cause of increased rates of gender dysphoria.
Q. Would you say it's a contributing factor?
A. I don't think there's evidence to support that.
Q. Okay. Have you seen social media impact or social contagion impact any other mental health diagnoses?
A. I have seen it, yes.
Q. In what other mental health diagnoses?
A. Tics in particular.
Q. Okay. And why do you think that in tics in particular social media can be an impact but in gender dysphoria it's not?
A. What I would clarify is to say that media impacts all mental health disorders as well as social contexts, social relationships, family relationships. Part of what we're doing in an assessment is to understand how those social impacts influence a child's

sense of self and the reasons they're coming to a sense of self and the reason they are making recommendations or wishing for particular interventions. There's a difference between having a social media experience or a social context influence one's sense of self versus having to create a diagnosis de novo. That's the part that is not present.

Q. So would you say that social media does impact potentially a gender identity and gender dysphoria diagnosis?

A. I would say that my clinical experience is that by and large kids having access to peers who share their experiences has a really profound positive influence on their experience of self.

Q. Okay. And let's see. You had testified that -- oh, you testified that you're very familiar with the research in this area of gender identity and in gender dysphoria diagnoses; correct?

A. Yes.

Q. Are you familiar with the Bränström study? I may be mispronouncing that, but it's got a few accents on it.

A. I would have to see it in front of me. I'm not the best with names.

Q. Okay. It was a peer-reviewed -- if I told you

it was a peer-reviewed study that was conducted and happened through the American Journal of Psychiatry, have you -- if I told you that they had to issue a correction about their study, does that ring any bells about the study itself?

A. I have a bell that is ringing, but part of what I'm going to do in terms of studies is review all of the study to make sure I'm understanding it before I can comment with any specificity on it.

Q. Absolutely. If I told you that they -- that they did in fact issue a correction this year and they said that their study did not support a finding of improved mental health in post-surgeries for patients that have gone through plastic surgery for these things, how would you respond to that?

A. I would say our job --

MR. GONZALEZ-PAGAN: Objection, Your Honor. At this point counsel is testifying. If she wants to ask him about the study, she can show him the study.

MS. DYER: Your Honor, I was asking a hypothetical.

THE COURT: I'm going to overrule the objection. If you can answer, Dr. Janssen.

A. Part of our job as physicians, particularly in

this field, is to recognize the full body of evidence and clinical experience and look to the guidelines, the gold standard within the field for support and guidance in terms of appropriate next step. If we look at the broad evidence, the scientific peer-reviewed literature, we would say that the impact of surgery on gender dysphoria is positive and leads to improvement.

Q. And would you consider peer-reviewed studies to be the gold standard?

A. I would consider peer-reviewed studies to be the gold standard, yes, but it's a component, not the only component.

Q. And lastly, I noted that you testified that it's a parent who provides the informed consent. Did I understand that correctly?

A. In most cases it is the parent providing the informed consent process. There are occasions in which it is the State or other actors within the child's family.

Q. Absolutely. Their guardian. I should have clarified that. And you mentioned that the adolescents assent to that. You didn't use the word informed consent; you used assent. Is that correct?

A. That's correct.

Q. And you also testified that you're familiar

with the WPATH standards -- correct? -- and that you actually assisted in their creation also?

A. That is correct.

Q. If I told you that the WPATH standard expressly states that informed consent must come from a minor, how would you respond to that based on your testimony?

A. The document is the World Professional Association of Transgender Health, and so it encompasses recommendations and adjusts for individuals in the United States but also throughout the world. Many different countries have different ages of majority for capacity to make medical decisions. As I mentioned, in Europe the age at which patients consent to their medical care is 16, which is still recognized as a minor.

Q. Okay. And -- oh, lastly, with regards to the -- I call -- I refer to it as WPATH, if that's okay. The WPATH standards claim that a qualified mental health diagnosis must be done. Is that correct? Or is that -- are you familiar?

A. It depends on the context.

Q. In order to receive puberty blockers, cross-sex hormones, you mentioned that a mental health assessment was done on children.

A. A diagnosis of gender dysphoria is required to

access care. It is not necessary for that person to be a mental health professional. It could be other medical professionals that can give that diagnosis.

Q. So would you say that an endocrinologist can make a gender dysphoria diagnosis?

A. I would.

Q. And what about a family care practitioner?

A. I would.

Q. Okay.

MS. DYER: I have nothing further, Your Honor.

THE COURT: All right. Do you have redirect?

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

THE COURT: All right. Thank you, Dr. Janssen.

THE WITNESS: Thank you.

THE COURT: You're done on the stand.

Ladies and gentlemen, we're going to go ahead and take a morning break. It is 10:25. I would like to get started again at 10:40, and we are on break and off the record until then.

(Recess taken)

THE COURT: For the plaintiff, who's the

next witness?

MS. WOOTEN: Your Honor, next on the list is Dr. Shumer. As a matter of housekeeping, although we discussed invoking the rule yesterday, we did not do that on the record.

THE COURT: Okay. Yes, we did. So as discussed yesterday, we will invoke the rule in this case, which means that any witness that is not an expert is precluded from being in the courtroom during the testimony. So I don't think we've had an issue to this point, but yes, officially for our record the rule has been invoked.

And so, Dr. Shumer, come on up. Good morning, sir.

THE WITNESS: Good morning.

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

(Witness sworn)

THE COURT: Go ahead and make your way up there.

If you'll make sure that green light is on.

MR. SELDIN: Yes, Your Honor. Good morning.

DANIEL SHUMER, M.D.,

having been first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. SELDIN:

Q. Good morning, Dr. Shumer.

A. Good morning.

Q. Could you please state your name for the record and spell it for the court reporter?

A. Daniel Shumer, D-a-n-i-e-l, S-h-u-m-e-r.

Q. And what is your profession?

A. I'm a pediatric endocrinologist.

Q. And could you please summarize for the Court your formal education and training?

A. I attended medical school at the Feinberg School of Medicine at Northwestern University. Afterwards I was a pediatrics resident at Vermont Children's Hospital at the University of Vermont and also a chief resident there. I was then a fellow in pediatric endocrinology at Boston Children's Hospital. Concurrent with that fellowship I received a master's of public health from the T.H. Chan School of Public Health at Harvard University.

Q. And what current positions do you hold?

A. I'm a pediatric endocrinologist at Mott Children's Hospital University of Michigan. I am an

associate professor at the medical school of University of Michigan. I'm the medical director of the Child and Adolescent Gender Clinic at Mott Children's Hospital and the medical director of the Comprehensive Gender Services Program at Michigan Medicine, which is how healthcare is organized for transgender adult and pediatric patients.

Q. And over the course of your career, about how many adolescents have you provided gender-affirming care to?

A. Approximately 400.

Q. Have you conducted research on the treatment of gender dysphoria in adolescents?

A. I have.

Q. Have you published peer-reviewed articles on the treatment of gender dysphoria in adolescents?

A. Yes.

Q. And we're displaying on the screen what's been pre-marked and pre-admitted as Plaintiffs' Exhibit 8. Do you recognize this document?

A. I do.

Q. What is it?

A. It's my CV.

Q. And does this exhibit accurately reflect your education, training, and experience?

A. It does.

MR. SELDIN: Your Honor, at this time, pursuant to Rule 702, I would move to qualify Dr. Shumer as an expert witness on the nature of gender dysphoria, the provision, protocols, and treatment of gender dysphoria in adolescents, and the field of pediatric endocrinology.

THE COURT: Any objection?

MR. STONE: No objection, Your Honor.

THE COURT: All right. Thank you. So designated.

Q. (BY MR. SELDIN) And Dr. Shumer, were you in the courtroom when Dr. Janssen was testifying earlier about gender dysphoria?

A. Yes, I was.

Q. And what is gender dysphoria?

A. Gender dysphoria is distress caused by a disconnect between one's gender identity and assigned sex at birth which is lasting for more than six months in duration and also causing significant impairment in one's life or functioning.

Q. And how is gender dysphoria diagnosed?

A. It's diagnosed by a mental health or medical provider.

Q. And is any medical treatment provided for

gender dysphoria prior to the onset of puberty?

A. Prior to the onset of puberty, there's no hormonal intervention or medical intervention that would be required or recommended. Prior to the onset of puberty, the treatment of gender dysphoria involves supportive care and potentially psychotherapy.

Q. And taking a step back, Dr. Shumer, what is puberty?

A. Puberty is the process -- a life process when a person transitions from childhood to adulthood.

Q. And is there a clinical term used to describe the onset of puberty?

A. Puberty can be described by the visual appearance of a person going through puberty, and that is oftentimes referred to in medicine as Tanner staging. So Tanner, who was a doctor that came up with this system of observation, described that by observation of breast buds or testicular enlargement or other factors, you can describe how far someone is in puberty.

So, for example, at Tanner stage 1 there would be no visible evidence that someone has started puberty. Tanner stage 2 would be the first stage that you could see visible evidence that a person has started puberty, such as development of breast buds or testicular enlargement. If someone's at Tanner stage 5,

that would mean that they've completed the process of puberty.

Q. And at what age do people typically reach Tanner stage 2?

A. There's a wide range of normal, but on average about age 11.

Q. And do you use any guidelines in your practice as a pediatric endocrinologist?

A. Specific to the treatment of gender dysphoria, yes. I use the World Professional Association for Transgender Health Version 8 and the Endocrine Society Clinical Practice Guidelines.

Q. And does the Endocrine Society issue guidelines other than the ones you just referenced for the treatment of gender dysphoria?

A. They do.

Q. And do you rely on those in your practice as well?

A. Yes.

Q. And the evidence in the Endocrine Society guideline for the treatment of gender dysphoria, is that comparable to the evidence and other guidelines used in pediatric medicine?

A. Yes. Any medical problem that requires guidelines inherently is a complex issue. Otherwise, it

wouldn't need a guidelines written to describe how management should go. So all of the Endocrine Society Guidelines, for example, are based on similar evidence.

Q. And Dr. Shumer, what are the types of treatment that you provide for adolescents that have been diagnosed with gender dysphoria?

A. Sorry. Can you repeat that?

Q. Sorry. What are the types of medical treatment that you provide for adolescents that have been diagnosed with gender dysphoria?

A. So an adolescent with gender dysphoria that has started puberty, so is at Tanner stage 2, may benefit from intervention with GnRH agonists, which are oftentimes referred to as puberty blockers or pubertal suppression. Older adolescents may benefit from hormonal intervention such as testosterone or estrogen.

Q. And what is the goal of treatment for gender dysphoria in adolescents?

A. The goal of treatment is similar to the goal of treatment for any medical problem, to improve health. Specific to the treatment of gender dysphoria, it's to reduce the dysphoria in order to help to allow a young person to have the happiest, healthiest life that they can have.

Q. And in your clinical practice, what is the

informed consent or assent process like?

A. Similar to other informed consent process throughout medicine, an informed consent process involves first explaining what the condition is that's being diagnosed, what the treatment options for that condition are, how those treatment options work, how the treatment options may be provided to the patient, how they're taken, what we're expecting will happen if a patient takes those medications, what are the potential benefits that might be achieved or what are our goals of treatment, what are some potential side effects of medication, what are alternatives to treatment. And also, in so doing, the provider is assessing understanding from the patient themself and from the parent answering questions and then ultimately making a decision about next steps in care.

Q. And is that process unique to the informed consent or process for the treatment of gender dysphoria?

A. No. It's the same for any medical intervention that I'd be providing.

Q. And first you mentioned GnRH agonists or pubertal suppression. When might puberty blockers be medically indicated for an adolescent with gender dysphoria?

A. It may be indicated if someone has started puberty and, as puberty has started, gender dysphoria has persisted or intensified. And in that case we might expect that as puberty continues, the child would develop more secondary sex characteristics, those differences that help to identify men versus women; so for men, deeper voice, more body hair, more facial hair, body shape changes; for women, breast shape changes, body shape changes, skin softening. Those secondary sex characteristics are different between males and females due to different hormones.

GnRH agonists arrest the progression of the production of those hormones. And so in doing that, the child -- if puberty is causing distress, that distress would be alleviated. But also, by never developing the secondary sex characteristics associated with the unwanted puberty, in the long term that person would not have to carry those secondary sex characteristics with them for the rest of their life, which would have the potential for long-term harm.

Q. And are those the goals of puberty suppression for the treatment of gender dysphoria in adolescents?

A. Ultimately the goal is to improve gender dysphoria and delay decision-making about hormonal interventions until middle adolescence, and the -- that

goal is accomplished by preventing progression of an unwanted puberty.

Q. And Dr. Shumer, how does puberty suppression work?

A. I think it's first important to understand how puberty works. So puberty starts in an area of the brain called the hypothalamus, which starts making a hormone called GnRH in pulses. Those pulses then inspire the pituitary gland to make two other hormones, luteinizing hormone and follicle stimulating hormone, LH and FSH. And it's those hormones that tell the gonads, testes or ovaries, to make testosterone or estrogen.

So GnRH agonists are actually the same hormone that is being made in pulses by the hypothalamus, but when given as a steady dose interferes with those pulses, with the outcome that there's no LH and FSH production, and hence, no production of testosterone or estrogen. So it sort of turns off puberty at the source.

Q. And is puberty suppression reversible?

A. Yes. So when GnRH agonists are used, they are arresting the progress of puberty. And then if they were withdrawn, then puberty picks up where it left off.

Q. Based on your knowledge, your research, and your clinical experience, would you say that the use of

puberty suppression to treat gender dysphoria in adolescents is safe?

A. Yes.

Q. And based on your knowledge of the research and your clinical experience, would you say that the use of puberty suppression is effective for the treatment of gender dysphoria?

A. I would.

Q. And what's the basis for your opinion that these treatments are safe and effective?

A. Those opinions are based on the extensive available evidence related to the use of GnRH agonists for the treatment of gender dysphoria and also my clinical experience working with young people with gender dysphoria.

Q. And in your practice as a pediatric endocrinologist, do you treat any other conditions with pubertal suppression?

A. Yes. The most common condition that we use GnRH agonists is for something called precocious puberty, which is puberty that occurs too young.

Q. Are there conditions other than precocious puberty where GnRH agonists may be indicated?

A. They're sometimes used in children with cancer prior to chemotherapy to preserve fertility, and they

may be used for adult indications related to the menstrual cycle or for men with prostate cancer.

Q. And what are the side effects of pubertal suppression?

A. The most common side effect of GnRH agonists would be pain at the injection site if we're using injectable Lupron, that sometimes people could have headaches after administration. I think that -- when I think about side effects of GnRH agonists, I think it's important to think about, well, what are the side effects or consequences of stopping puberty.

So in someone with precocious puberty, we would be using GnRH agonists up until the average time that puberty starts, but it's different when we're using it for gender dysphoria. In gender dysphoria, we're not stopping puberty that's too early; we're stopping a puberty that is the wrong puberty for the individual. And so because we're delaying puberty longer than what would be typically expected, the consequences of delaying puberty would include changes to perhaps the timing of the growth spurt and the timing of bone density accrual, which is why we use GnRH agonists for a limited time as we're considering next steps.

The other side effect that I would mention is about six people out of the many thousands of people

that have been prescribed GnRH agonists have had elevated endocranial pressure, which would be a reason to stop the medication.

Q. And you spoke -- you mentioned bone density as a potential issue when delaying puberty. Can you talk about how that's managed in your clinical practice?

A. Yes. So how I explain it to patients is that every year our bones get stronger. So from a five-year-old to a six-year-old to a seven-year-old, every year our bones get stronger. And then when we go through puberty, our bones get a lot stronger. So puberty is, therefore, important for this bone density spurt.

Now, if you're using medication like GnRH agonists to delay puberty, every year your bones will get stronger still; right? Say you use GnRH agonists at age 12. Your bones -- your bone density at age 13 will be stronger, but it won't be as strong as if we didn't use the GnRH agonists and you were going through puberty and achieving that bone density spurt. That bone density spurt will happen for you after the GnRH agonists are either withdrawn or we start providing hormones like testosterone or estrogen. Everyone must go through puberty at some point in some direction in order to have that bone density spurt that allows adults

to have stronger bones than children.

Q. And does pubertal suppression have an effect on fertility?

A. GnRH agonists themselves do not affect fertility. One must go through some of your endogenous puberty to achieve fertility, but suppressing puberty or delaying puberty does not impact one's fertility.

Q. Are the side effects and risks of pubertal suppression different when treating, for example, precocious puberty as opposed to gender dysphoria?

A. Only with respect to those differences that I mentioned with regards to delaying things like the growth spurt and bone density accrual. Otherwise, the medication works exactly the same regardless of the indication that's being used.

Q. And for your patients who use puberty suppression to treat central precocious puberty, about how long are they on puberty blockers?

A. It would be used from the diagnosis of precocious puberty up until an age of average puberty. So that could vary based on when precocious puberty -- what age precocious puberty is diagnosed, but most often two to three years.

Q. And how does that compare to the amount of time that your patients who are treated with pubertal

suppression for gender dysphoria are on puberty blockers?

A. For gender dysphoria, it may be comparable or it may be less time compared to people with precocious puberty.

Q. Do you consider the use of puberty suppression to treat gender dysphoria in adolescents to be experimental?

A. I do not.

Q. Earlier you mentioned hormone therapy as another potential treatment for gender dysphoria in adolescents. When might hormone therapy be medically indicated?

A. Hormones may be indicated for an older adolescent who is having gender -- who is diagnosed with gender dysphoria and an element of that dysphoria is related to not progressing through puberty in concordance with the gender identity, not developing the secondary sex characteristics in concordance with the gender identity, and allowing that development of secondary sex characteristics would improve that distress.

Q. And so what is the goal of providing hormone therapy to treat gender dysphoria in adolescents?

A. At its core, it's again to improve health and

functioning of the individual. But specifically we're using hormones like testosterone or estrogen to mimic the normal rise of testosterone or estrogen in other people of that gender. So if someone is being prescribed testosterone, we're dosing the testosterone in order to raise the testosterone level up into the normal range for a young person that age. In so doing, very predictably, the development of secondary sex characteristics would follow similar to other young men that age; and similarly with estrogen, using estrogen, dosing estrogen to mimic the normal rise of estrogen in other young women, young women that age, and then predictably expecting the development of secondary sex characteristics similar to other young women, women that age.

Q. And in your practice as a pediatric endocrinologist, do you treat other conditions with hormone therapy using estrogen or testosterone?

A. Yes. Those are two very common medications used by pediatric endocrinologists.

Q. What conditions might you use them for?

A. Testosterone would be used for a boy or young man that's not able to make his own testosterone or not able to make enough testosterone. Specific conditions could include someone that has had bilateral testicular

loss or testicular torsion. Klinefelter syndrome is a condition that commonly requires supplemental testosterone. We use estrogen for women -- or girls that don't make their own estrogen or don't make enough estrogen. Examples could include ovarian insufficiency. Turner syndrome is a condition where the ovaries are underdeveloped and don't make enough estrogen, but really any condition where puberty doesn't go as planned, as normal, due to a challenge or difficulty making testosterone or estrogen.

Q. And based on your knowledge of the research and your clinical experience, would you say that hormone therapy used to treat gender dysphoria in adolescents is safe?

A. Yes.

Q. And based on your knowledge, your research, and your clinical experience, would you say that the use of hormone therapy is effective for the treatment of gender dysphoria in adolescents?

A. I would.

Q. And what's the basis for your opinion that these treatments are safe and effective?

A. Those opinions are based on the extensive evidence outlining the use of these medications, the evidence based on the treatment of gender dysphoria and

other conditions used to treat these medications, but specifically efficacy data specific to outcomes improving after treatment with hormones to treat gender dysphoria.

Q. Are there side effects or risks associated with using hormone treatment in adolescents with gender dysphoria?

A. As with any medical intervention, there are potential side effects of both testosterone and estrogen. How I think about side effects of testosterone, for example, would be, well, what are the side effects or the consequences of having a normal male testosterone level? Men and women, by virtue of having different hormone levels, have different risks for different things.

An example that I find easy to wrap my head around is going bald. So if a trans boy or man never took testosterone, his chance of going bald would be very low. On testosterone his chance of going bald would be very similar, say, to other men in his family.

For estrogen, an example that is easy for me to wrap my head around is related to breast cancer. A person with breasts intrinsically has a higher risk for breast cancer than a person without breasts. Some men develop breast cancer, but it's very rare. If a

trans woman never took estrogen, her risk for breast cancer would be very low. But on estrogen and subsequent development of -- with subsequent development of breasts, she would be at higher risk for breast cancer than if she never took the estrogen, it turns out probably not as high as cisgender women but high enough that anyone with breasts, whether it's endogenous production of estrogen or taking estrogen, should follow the same mammogram screening as any other woman.

Q. Are there risks to fertility associated with hormone treatment for gender dysphoria in adolescents?

A. I was going to just back up and add one other comment to the last question. I think that in addition to what would be side effects of having a normal testosterone or estrogen level, we think, well, what would be consequences of having an excessively high testosterone or an excessively high estrogen level?

We know that our goal in using testosterone or estrogen is to bring that level up to what's normal. But if someone has an excessively high testosterone level, that wouldn't be healthy. So I think about a baseball player abusing testosterone to hit more home runs. That person would be at higher risk for high red blood cell count, high blood pressure. And so when I'm dosing testosterone, I'm avoiding bringing a

testosterone level to an excessively high level, similarly to how I would be monitoring for that in using testosterone in other conditions.

For estrogen, an excessively high estrogen level, I would be concerned about a higher risk for blood clotting, and so when using estrogen for gender dysphoria or any other condition, I would be dosing appropriately and monitoring.

Q. Thank you, Dr. Shumer. I apologize for cutting you off. My next question was going to be about are there risks to fertility associated with the use of hormone treatment in adolescents with gender dysphoria.

A. I think fertility is a really important topic to talk about with anyone we're considering prescribing testosterone or estrogen. The first thing that I always like to point out is that neither testosterone nor estrogen should be considered birth control, that I've had patients and there are many patients every day on testosterone that become pregnant. There are many patients on estrogen that have participated in causing a pregnancy. That being said, if you're on an appropriate dose of testosterone or estrogen, it is less likely that you would ovulate or have a normal sperm count.

If a patient on testosterone or on estrogen desired fertility, what I would advise them is

to withdraw from the medication, wait for the menses or the testosterone level in their body to return to normal, and then attempt to achieve fertility. If they were still having challenges with fertility, they would be recommended to see a fertility expert.

There is probably a subset of people that if they are taking testosterone or estrogen for a long enough period of time may have reduction in their fertility, but also there's a big -- there's variability in fertility in people in the first place. So I think that going into the decision regarding testosterone or estrogen, this type of discussion is important to have.

Q. And are there steps that patients can take if preserving fertility is a particular priority for them?

A. It's recommended to discuss fertility preservation prior to starting testosterone or estrogen for the reasons I outlined. However, also I -- I hope that you get the sense that I would also not consider testosterone or estrogen the end of the story for someone's fertility, that it's -- that because there may be some impact on fertility, fertility preservation conversations should be -- should be discussed.

Q. And do pediatricians provide or prescribe other medications that may bear on fertility?

A. Yes. We have to have conversations about

fertility when prescribing other medications. Specifically, some chemotherapeutic agents have more significant risk for fertility than testosterone or estrogen, and, you know, important conversations are had with patients and families prior to the initiation of those medications.

Q. So conversations about fertility are not unique to the provision of hormone treatment to treat adolescents with gender dysphoria?

A. That's correct.

Q. And do you consider hormone therapy to be an experimental treatment for gender dysphoria in adolescents?

A. I do not.

Q. In your clinical experience, what are the benefits of gender-affirming medical care like pubertal suppression and hormone treatment?

A. I think that as a pediatrician, you know, I became a pediatrician in order to promote health in children. The experience of meeting a family who is entering the clinic for the first time, maybe feeling scared, anxious, maybe even a bit ashamed, and leaving that visit feeling hopeful and prideful is just such a rewarding experience for me. But the true reward is watching patients who maybe initiated care feeling

hopeless and helpless graduating from care as someone who is maybe going off to college, going to law school, getting married, starting a family, with a life that they didn't dream possible and their parents didn't dream possible before initiating care.

Q. Are you familiar with SB 14?

A. I am.

Q. And does SB 14 prohibit the care that we've just been discussing for the treatment of gender dysphoria in adolescents?

A. It does.

Q. And are there risks of not providing treatment when it is deemed medically indicated for an adolescent with gender dysphoria?

A. There are.

Q. And what are those risks?

A. A person with gender dysphoria that is not treated, I would be concerned that the gender dysphoria would persist or potentially intensify, and that may lead to negative health and mental health outcomes.

Q. And what are the risks of terminating treatment for adolescents with gender dysphoria when such treatment has been medically indicated?

A. That's quite concerning to me. A patient that is on treatment that's working for something that has

been a significant challenge for them who is then told that they can no longer continue the treatment that has been helpful to them I would imagine could have a devastating setback in their gender dysphoria care and their overall health.

Q. And so in your expert opinion, what are the effects of stopping pubertal suppression in an adolescent with gender dysphoria who has a medical need for that treatment?

A. Stopping pubertal suppression would allow the dysphoria-inducing puberty to resume, which would have -- would carry a risk of deterioration in gender dysphoria and health.

Q. And in your expert opinion, what are the effects of stopping gender-affirming hormone treatment in an adolescent who has a medical need for that treatment?

A. If a patient is taking testosterone or estrogen and seeing positive impacts related to the development of those secondary sex characteristics, stopping that medication would mean no longer continuing to develop those secondary sex characteristics and allowing the body to make the hormones associated with the unwanted puberty, which I would imagine for many folks would have a negative impact on their health.

Q. And do you have to imagine that or have you seen that in your clinical experience?

A. I have seen that in my clinical experience.

Q. And can that harm be mitigated by withdrawing care more slowly?

A. There's no protocol or recommendation about withdrawing care that's working slowly, so that would be experimental.

Q. And in your clinical experience -- based on your clinical experience, can you tell us why this care is so important for the patients that you treat?

A. It really provides an opportunity to live the life that the patient deserves. I think that patients that come to care, patients with gender dysphoria, are some of the most courageous and resilient people that I know, but they're really suffering from a condition that has a highly effective treatment. And providing that treatment can be invaluable in order to allow that child to achieve their full potential in life.

MR. SELDIN: No more questions at this time.

THE COURT: Thank you. Any questions from the defense?

MR. STONE: Yes, Your Honor, just a few.

MS. WOOTEN: Your Honor, if there's no

objection, may I give the witness some water?

THE COURT: There should be some right there. I'm sorry.

MS. WOOTEN: Okay.

THE COURT: Yeah, he's got -- I'm not that mean.

MS. WOOTEN: Thank you, Your Honor.

THE WITNESS: Thank you.

THE COURT: Go ahead.

MR. STONE: Thank you, Your Honor.

CROSS-EXAMINATION

BY MR. STONE:

Q. Doctor, Senate Bill 14 doesn't ban psychotherapy or counseling for minors with gender dysphoria, does it?

A. It does not.

Q. Psychotherapy is a treatment for gender dysphoria in minors, isn't it?

A. It's one of the potential treatments for someone with gender dysphoria, yes.

Q. You said you treated about 400 kids for gender dysphoria; right?

A. Yes.

Q. Have you ever prescribed cross-sex hormones for the treatment of gender dysphoria to a child who was 11?

A. I have not.
Q. 12?
A. Yes.
Q. 13?
A. Yes.
Q. 14?
A. Yes.
Q. Of the 400 adolescents that you've treated for gender dysphoria, approximately how many of them had top surgery as a minor?
A. Approximately 5 percent.
Q. Of the 400 adolescent patients that you've treated for gender dysphoria, approximately how many had bottom surgery as a minor?
A. I believe zero.
Q. Why is it that only 5 percent of the 400 adolescents that you've treated for gender dysphoria -- minors that you've treated for gender dysphoria have had top surgery?
A. I think it's a complicated question to answer, but specific in Michigan, insurance companies cover top surgery to treat gender dysphoria over 18. So patients that may benefit from top surgery under 18 would be paying out of pocket, and that would be prohibitive for some families. Also, the -- not all trans boys desire

or require top surgery. So we have a small -- a group of people that may desire and require top surgery, but not all of those people are able to get it.

Q. If money wasn't a factor, would you recommend more of the adolescents that you treat for gender dysphoria for top surgery?

A. I think it would be --

MR. SELDIN: Objection, calls for speculation.

MR. STONE: It --

THE COURT: Well, hold on. If you can try and rephrase that.

Q. (BY MR. STONE) Doctor, of the 400 adolescents that you have treated for gender dysphoria, do you believe that more than 5 percent of them could benefit from top surgery as a -- while they were still a minor?

A. Remember that there's two groups of patients that we're considering here. One group has received GnRH agonists in early puberty, so that group of patients -- one of the beauties of using GnRH agonists in early puberty is that they wouldn't have developed breasts that would require surgery. So that group of patients, zero percent of them would need top surgery. Patients that came to care later who developed breasts prior to the initiation of a medical intervention, I

would say the majority of them do have chest dysphoria as part of their distress and may benefit from chest surgery, but that's not uniformly true.

Q. So of -- I'm asking about the 400 percent. Is your answer of the 400 -- I'm sorry -- patients. So is your answer yes, that there's more than 5 percent that you think could benefit from top surgery as a minor?

A. Yes.

Q. Do you think all of them could benefit from top surgery as a minor that fall within that second category you just discussed?

A. No.

Q. Why not?

A. Because for some people chest dysphoria is not -- not a significant source of distress. For other people in describing the potential risks, potential benefits, and alternatives for top surgery wouldn't choose to have it.

Q. Of the 400 adolescents that you've treated for gender dysphoria, how many of them subsequently desisted?

A. What do you mean by "desisted"?

Q. What do you mean when -- how do you understand the word "desist" in the context of gender dysphoria to mean?

A. To me it's a word that's most commonly used to describe a prepubertal person who has a difference in gender identity that at the time of puberty no longer identifies as that gender or no longer carries a diagnosis of gender dysphoria. So in my practice I don't typically see prepubertal youth, so I would have a hard time answering that question.

Q. Okay. So what term would you use for somebody who has taken puberty blockers and cross-sex hormones and then subsequently stops because they feel like their gender identity aligns with their biological sex?

A. Right. So the number of people in that scenario would be extremely low.

Q. I'm not asking the number. I'm asking what would you call them. Is there a term that you have?

A. I think your description is how I would describe that.

Q. Okay. Of the 400 adolescents that you've treated for gender dysphoria, approximately how many of them have subsequently stopped taking the treatment that you prescribed to them because they determined that their gender identity aligned with their biological sex?

A. So I would say that one of the goals of GnRH agonists is to allow that to happen before making a decision for initiation of a cross-sex hormone. I would

say the number of people that have started pubertal suppression and then stopped pubertal suppression I would put in the range of about 10. And people who have stopped hormones because they identify as a gender that's more aligned with their biologic sex, I would say about two.

Q. So a total of -- that was percentage or the number of patients?

A. Number.

Q. Number. So 12 out of the 400?

A. Stopped either GnRH agonists or hormones because of a change in their understanding of their gender identity more aligned with their sex assigned at birth.

Q. Doctor, is gender identity immutable and fixed?

A. Yes.

Q. How many genders are there?

A. Gender is not something that I think about in terms of how many there are. Gender is a concept of oneself as male, female, or maybe neither one of those categories fits one's -- fits one's experience.

Q. So it's male, female, or neither?

MR. SELDIN: Objection, Your Honor, misstates testimony.

THE COURT: Sustained. Next question.

Q. (BY MR. STONE) Doctor, I want you to assume for the purposes of this hypothetical that gender identity is not immutable and fixed. Would that change your assessment as to whether or not the potential -- the risks outweigh the potential benefits for the treatment of gender dysphoria in adolescents and specifically with respect to cross-sex hormones?

A. No. I think that our job would be to try to understand what characteristics of a person would be helpful in predicting their future gender identity, and in using those clinical skills, working with patients and families, understand what potential interventions may or may not be helpful.

Q. Following along with the same hypothetical that gender identity is not immutable and fixed, would it change your assessment as to whether or not the risks outweigh the benefits of performing surgeries on minors for the treatment of gender dysphoria?

A. If gender identity was not fixed and immutable, I would want to understand the probability that someone's gender identity would continue to align with the desire for the surgery and then use that in a risk-benefit analysis with the patient and family.

Q. Informed consent is necessary from an adolescent themselves prior to starting cross-sex

hormones; right?

A. Yes.

Q. And informed consent from the patient, that is the adolescent, is necessary prior to performing a surgical procedure --

A. I'm sorry. I think I misunderstood your last question. Can you repeat it?

Q. Yeah. I asked if informed consent is necessary from the adolescent patient prior to prescribing cross-sex hormones.

A. So in our country the only people that can provide an informed consent are adults. So when prescribing medical interventions with youth, the term that we use is informed assent.

MR. STONE: Your Honor, I would like to show a demonstrative, so I'm going to go back to the table if that's okay.

THE COURT: Sure.

Q. (BY MR. STONE) Doctor, you testified earlier about the Endocrine Society Guidelines; right?

THE COURT: Hold on, Mr. Stone.

(Discussion off the record)

THE COURT: All right. Go ahead, Mr. Stone.

MR. STONE: I apologize, Your Honor.

THE COURT: That's okay.

Q. (BY MR. STONE) Doctor, can you see the highlighted portion on your screen? 2.4. Can you see 2.4 on your screen?

A. I'm with ya.

Q. Okay. Would you agree with me that the Endocrine Society Guidelines state that for the prescribing of cross-sex hormones, prior to it, the provider has to confirm the persistence of gender incongruence and the patient must have sufficient mental capacity to give informed consent, which most adolescents have by the age of 16? Is that what 2.4 says?

A. It does.

Q. Okay. So same question. Do adolescents with gender dysphoria have to provide informed consent prior to having a surgical procedure performed for the treatment of their gender dysphoria?

A. Yes, so I think we're using this word "informed consent" -- there's a bit of semantics here. Legally informed consent in our country is something that someone over 18 legally is allowed to do. I think that in the Endocrine Society Guidelines, clearly what they're meaning is that the person is informed of the risks, benefits, and alternatives.

So regardless, yes, a person that is receiving any medical intervention should be aware of what the medication or intervention is, what the risks and potential benefits are, what the goals are of that intervention, what the alternatives are. If we want to legally call that informed consent or assent, the idea remains the same.

Q. So when you use -- earlier when you were testifying that informed consent is not necessary from a minor prior to prescribing cross-sex hormones, the minor patient, you meant legally; is that -- is that correct?

MR. SELDIN: Objection, misstates testimony.

THE COURT: If you'll rephrase the question, Mr. Stone. I don't --

Q. (BY MR. STONE) I guess I'm not understanding. Could you explain to me, what is the significance of the law with respect to whether or not informed consent is needed from a minor prior to beginning cross-sex hormones for gender dysphoria?

MR. SELDIN: Objection, Your Honor. He's not an expert on the law in this instance.

THE COURT: Sustained.

MR. STONE: Well --

THE COURT: Sustained. Next question.

MR. STONE: Pass the witness, Your Honor.
THE COURT: Okay. Any redirect?
MR. SELDIN: None, Your Honor. Thank you.
THE COURT: All right. Dr. Shumer, thank you.
THE WITNESS: Thank you.
THE COURT: You're done on the witness stand.
From the plaintiffs, the next witness?
MS. WOOTEN: Your Honor, the next witness is Dr. Olson-Kennedy.
THE COURT: Okay. Dr. Olsen-Kennedy, if you'll please step forward and raise your right for me.
(Witness sworn)
THE COURT: Please make your way.

JOHANNA OLSON-KENNEDY,

having been first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. GONZALEZ-PAGAN:

Q. Good morning, Dr. Olson-Kennedy.
A. Good morning.
Q. Can you please state your name for the record and spell it out for the court reporter?
A. Johanna Olson-Kennedy. J-o-h-a-n-n-a. Last name is hyphenated, O-l-s-o-n hyphen K-e-n-n-e-d-y.

Q. Doctor, what is your profession?
A. I am a medical doctor.
Q. What type of doctor?
A. I am double board certified in pediatrics and adolescent medicine.
Q. And where are you currently employed?
A. I am an associate professor at the University of Southern California in pediatrics and also the medical director of the Center for Transyouth Health and Development at Children's Hospital in Los Angeles.
Q. And how would you describe your practice?
A. My practice is basically split between clinical care of adolescents with gender dysphoria and young adults with gender dysphoria, and the other part of it would be research.
Q. About how many patients with gender dysphoria have you treated over your career?
A. Over the past 17 years, probably between 11 and 1200.
Q. You mentioned that you treat both adolescents and young adults, but do you also treat prepubertal patients?
A. I have prepubertal patients that I see within the context of my clinic, but medical interventions are not appropriate nor warranted for prepubertal children.

Q. What are the treatments that you provide to patients with gender dysphoria, adolescent patients with gender dysphoria?

A. So adolescents and young adults, again, as we heard from prior witnesses, puberty suppressive medications as well as gender-affirming hormones.

Q. Are there any clinical guidelines that you utilize in your practice?

A. Also similar to the previous folks that were up here, I utilize the World Professional Association of Transgender Health Standards of Care Version 8 and the endocrine guidelines.

Q. And you mentioned that you spend your time doing both clinical care and research. What are the areas of study that you research?

A. My research is about the impact of medical interventions on physiologic and mental health of youth with gender dysphoria.

Q. And have you published any of this research in scholarly articles?

A. I have.

Q. And have these been in peer-reviewed journals?

A. Yes, they have.

Q. About how many peer-reviewed articles have you published pertaining to the treatment of gender

dysphoria?

A. Over 20.

Q. Have you ever served as a principal investigator?

A. I have and I do currently.

Q. And in what study do you serve as a principal investigator?

A. So my current study that I am the principal investigator on is a foresight study that is funded by the National Institutes of Health. It has been going on since 2015. And we received an extension of that grant in 2020 to continue it for another five years.

Q. About how many manuscripts have you published as a result of this longitudinal study?

A. I'm not sure of the exact number. I think around 25, something like that.

Q. On the screen is what has been admitted as Plaintiffs' Exhibit 11. Do you recognize this document?

A. I do.

Q. What is it?

A. That's my CV.

Q. Does that CV accurately reflect your professional background and experience?

A. Yes, it does.

MR. GONZALEZ-PAGAN: Your Honor, at this

time I would ask that Dr. Olson-Kennedy as a pediatrician, adolescent medicine doctor, and clinical researcher be qualified as an expert on the study, research, and treatment of gender dysphoria.

THE COURT: Any objection?

MR. ELDRED: No, Your Honor.

THE COURT: Thank you. So designated.

Q. (BY MR. GONZALEZ-PAGAN) Doctor, I would like to back up a little bit and ask about some of the history pertaining to gender-affirming medical care. How long has the use of hormones to treat gender dysphoria been around?

A. So we synthesized hormones in the late 1920s and early 1930s. And around that same time they were starting to be utilized for changing bodies in people with what we now call gender dysphoria. It was not called gender dysphoria back then. But trans people were utilizing synthetic hormones during that time period shortly after they were synthesized.

Q. And how long has the use of surgery to treat gender dysphoria been around?

A. I think the first surgery that at least is documented was in about 1940. I'm not exactly sure the exact date.

Q. But it's been around for decades?

A. It has been around for decades.

Q. And how long has the use of puberty-delaying medications to treat gender dysphoria been around?

A. So the use of GnRH analogues specifically for blocking puberty in youth with gender dysphoria began in the Netherlands in the 1990s.

Q. And how long have puberty-delaying medications been around to treat any condition?

A. We're getting close to about 50 years now for using central puberty blockers for other indications that we heard of like central precocious puberty, endometriosis, prostate cancer, other medical indications.

Q. When it comes to minors, are there any surgeries that are more commonly provided?

A. I think that the most common surgery that would be provided for youth with gender dysphoria who are minors would be chest surgery, chest masculinization surgery, or top surgery as it's colloquially referred to.

Q. And is surgery common in adolescents with gender dysphoria?

A. No.

Q. Just for the edification of those of us here, can you tell us a little bit about how people begin to

understand their gender identity?

A. So this is a highly individualized process for people whose gender identity is not aligned with their assigned sex at birth. So there are some people that are able to understand, organize, and verbalize about their gender identity being different in early childhood, but a lot of people might not have language for it. They might not feel safe talking about it or a variety of other things.

I really look to -- I think one of the largest surveys that has asked these questions of the trans population was the U.S. Transgender Health Survey, and it came out in 2015. They asked this question. There were about 27,000 respondents. And they asked this question: When did you first know that your gender was different from what was on your birth certificate? And about 60 percent of the respondents said age 11 or younger, and the vast majority were at age 21 or younger. I think there was about 6 percent who really did not have those feelings until after age 21, but 60 percent at age 11 or younger.

Q. When someone presents to you for a puberty-delaying medication, for example, does that demonstrate that their gender dysphoria is likely to persist?

A. Yes. If they have started their puberty process, it is highly likely that their gender dysphoria is going to persist and their gender identity will be something other than their assigned sex at birth.

Q. We talked a little bit about how long these gender-affirming medical treatments have been provided. Has gender-affirming medical care been studied throughout these decades?

A. Yes, it has.

Q. Are you familiar with the body of research that exists pertaining to the treatment of gender dysphoria?

A. Yes, I am.

Q. What are the type of studies out there assessing the efficacy of treatment for gender dysphoria in adolescents?

A. So all kinds of studies ranging from case reports to cross-sectional studies, observational longitudinal studies, prospective longitudinal studies. All kinds of study designs have looked at the impact of treatment.

Q. In your answer, you did not mention randomized clinic -- randomized controlled trials. Can you tell us why?

A. So the study design for a randomized controlled trial requires that participants be randomly chosen to

either be in a treatment arm or an untreated arm. So in a study that's looking at the impact of medical care for gender dysphoria, it is highly unlikely that anyone would make a decision to participate in a study where they might be randomized to not getting treatment. It's gender dysphoria that's driving people to come for treatment, so it's unlikely that someone would be open to the idea of not receiving that treatment.

So from an ethical perspective there are problems. But I also think, you know, as a scientist, as a researcher, there are flawed things that can happen when a study is randomized blindly, which means that both the participant and the researcher don't know whether or not they're getting the intervention. And so clearly you're not going to be able to have blinding or masking of the intervention because if someone's not getting the intervention, they're going to know that they're not experiencing those changes that come with the intervention arm. And so you have a methodologically flawed study that is not going to give you the answers that you need.

Q. When looking at the entire body of research, assessing the efficacy of medical treatments for gender dysphoria in adolescents, what does this body of research look at?

A. The body of research that exists looks at mental health aspects, improvement of these mental health symptoms over time, specifically around depression, anxiety, quality of life, psychological well-being, functioning, body esteem, body image. A whole variety of different things have been looked at in the existing literature.

Q. And what do these measures or metrics tell us about the efficacy of treatment for gender dysphoria?

A. The body of literature demonstrates that treatment improves people's mental health.

Q. How so?

A. So across all of these domains, so what we've seen is from different studies across the world that there is improvement in psychological functioning. There's a decrease in depression symptoms. There's a decrease in anxiety symptoms. Some studies have demonstrated an improvement in gender dysphoria. Other studies have demonstrated an improvement in body esteem, a large variety that include all of those things I talked about, and I'm probably missing some of them as well.

Q. Are there any particular studies that you would point to that specifically assess the efficacy of puberty blockers as treatment for gender dysphoria in

adolescents?

A. Yeah, there are a lot of studies. I think that for me a couple of studies stand out from the Netherlands published in 2011. The Netherlands -- there is a team of researchers in the Netherlands who really introduced this idea of using puberty blockers for gender dysphoria so that young people did not have to go through the distressing experience of the wrong puberty. They published on their earliest cohort of young people who went on puberty blockers in 2011 and demonstrated indeed that those people had better psychological functioning than prior to starting.

There was another study that came out in 2015. It came out from the UK. The first author was Rosalia Costa. And in this study they looked at people who had the treatment arm of just mental health therapy versus the treatment arm of mental health therapy and puberty blockers. And what they demonstrated is that over time the group that had mental health therapy and puberty blockers increased -- continued to increase over the course of the study in mental health domains that we discussed earlier.

The last one that I would bring up because I think it's an important study is also from the Netherlands. The first author is Vandermaesen. I think

it was published in 2019. And that group tried to create an uncontrolled treatment arm like we're talking about in randomized controlled trials by -- they had to use two separate cohorts, but one was individuals who were just referred for care in their clinic, and the other one was people who had undergone treatment already. And they replicated their findings that the group who had received intervention had better mental health than the group who was showing up for care.

Q. How does the research that you just discussed regarding puberty blockers compare to your clinical experience?

A. This aligns with my clinical experience. I've been doing gender care for 17 years and using blockers within my practice for that amount of time. It is -- I just think it's important to recognize that the number of people who engage in care in and around or before the time their puberty starts is extraordinarily low. It's just a very small part of across the board people who show up for care.

But people who have this opportunity to only go through one puberty that is aligned with their gender, it is a trajectory changer for them. They do not have to overcome some of the things that no matter how much intervention you have, no matter how many

hormones or surgery, you're not going to be able to walk back some of those permanent changes of endogenous puberty. So for people who have access to puberty blockers, their life is just different because of that, and their mental health is intact. It's the same as their peers that are not trans.

Q. Turning to hormones, are there any particular studies that you would point to that specifically assess the efficacy of treatment of adolescents with hormone therapy for gender dysphoria?

A. Also yes. I would say I look to the original cohort that I talked about that the Dutch have been kind of reporting on over time. In 2014 they put out a manuscript that looked at that cohort that we were just talking about after puberty blockers, hormones, and surgery and demonstrated that that group of people had eradication of their gender dysphoria, that their psychological functioning was even better than it had been at prior time points, and also that for some of those young people, their mental health and psychological functioning was actually better than the Dutch population as a whole. So that was a report out on their cohort.

There was a study that was a different kind of a design that looked at -- it was an online

study, so it accessed trans people online and divided that group into people who wanted access to gender-affirming hormones and didn't have it versus people who did have access to gender-affirming hormones and demonstrated a higher rate of suicidality and anxiety in people who were not able to access that care.

And then the third study, I'll just point to my own team. We published an article in the *New England Journal of Medicine* earlier this year, and this was data that reported out after 24 months of gender-affirming hormones, also demonstrating a decrease in depression, anxiety, and an improvement in psychological well-being, which included positive affect and patient satisfaction.

And those are probably the three studies that I think have different study designs that are important.

Q. And how does the research that you just discussed regarding hormone therapy compare to your clinical experience?

A. I just really appreciate what my colleague said, that research has a definitive dryness to it that does not provide the depth and fabric of the experience of people within my clinical practice. And so, you know, the young people that I take care of are a

great -- a great source of joy for me, and they also -- I just had a person last week who said I just want you to know something, that if you had not allowed me and helped shepherd me through these interventions, I really don't think I would be here today. And that's really a meaningful thing and not the first time that I've heard that. I've heard that hundreds of times over the last 17 years that I've been doing this work. So we don't sometimes capture the depth and personal experiences of people in a research context, but it aligns around symptoms of mental health.

Q. I'm going to ask you a little bit about surgery. Is there research evaluating the efficacy of surgical treatments for gender dysphoria?

A. Yes.

Q. What does that research tell us?

A. That body of research demonstrates similar findings to what we were just talking about. Surgical interventions demonstrate very good outcomes across multiple mental health domains and very low levels of regret.

Q. Are there any particular studies looking at the efficacy of chest surgery in adolescents?

A. Yes.

Q. What do these studies show?

A. The studies looking at chest surgery, in particular for trans masculine individuals, demonstrate very improved mental health, across multiple domains of mental health, and very low regret rates, little to none.

Q. And have you published research pertaining to the efficacy of chest surgery in adolescents?

A. I have.

Q. Some of the State's designated experts point to the limitations that some of these studies have to say that they do not prove that gender-affirming medical interventions are efficacious. What is your response to that?

A. I disagree.

Q. Why?

A. I think that, you know, research is a body, very much like a human body, and we look at -- the congregation of all this data together over multiple decades has demonstrated that interventions are efficacious, desirable, and have good outcomes for people. And so I just disagree with that assessment. That aligns with our clinical experience as well.

Q. There's been some discussion throughout the day about desistance. Are you familiar with the term desistance?

A. Yes.

Q. Based on the literature, what does this term refer to?

A. I've often seen desistance utilized in children, in prepubertal children. The bulk of the data that talks about desistance really has to do with people who have not yet started puberty.

Q. Some of the defendants' designated experts suggest that as many as 98 percent of minors with gender dysphoria come to identify with their sex assigned at birth and that therefore medical interventions to treat gender dysphoria in adolescents are inappropriate. What is your response to that?

A. I think probably the first thing to do is separate out these cohorts because not only are the diagnostic criteria different in prepubertal children than they are for adolescents and adults, and that's important because the criteria that define gender dysphoria in prepubertal children are really related most specifically to the kinds of things that people like and do and want to wear and play with. But for -- once people move into postpubertal or peripubertal age, the criteria are different, and they have to do with people's bodies.

And so when we look at that early data,

which is what most people are referring to when they're talking about these high rates of desistance, has to do with children who may, for example, like different kinds of clothes and toys and things like that. Many of those participants in those studies did not meet -- go on to meet criteria that we utilize when we determine treatment. And so that is -- whether or not somebody has gender -- also these studies were done before we had the terminology gender dysphoria and the criteria were different. But as they're progressing in age and development, we have different sets of criteria for them.

Q. Are you familiar with the term detransition?

A. I am.

Q. What do the -- what do you understand this term to mean?

A. I understand detransition to mean somebody who discontinues medical treatment and may or may not go back to living as their assigned sex at birth.

Q. What are some of the reasons that may lead someone to detransition?

A. In the research that's looked at detransition, there's a variety of reasons that somebody might detransition. The majority of those reasons have to do with something outside of the individual's experience.

It doesn't have to do with their own sort of changing or understanding of their identity; it has to do with outside pressures.

So some people -- for example, in the small handful of people in my practice that have detransitioned, it's related to how people are perceiving them, inability to access services, losing health insurance. And people have moved in and out of detransition and transition. And so there are a very, very small number of people who detransition because they come to affiliate more with their designated sex at birth.

Q. About what percent of people who detransition do so because they come to identify as their sex assigned at birth?

A. In -- so probably the largest study that looked at this was -- was Jack Turban's study. And I think that the numbers of people that -- so I have to go backwards on the number, so forgive me for a minute. But I think it's about 2 percent of people who said it was related to their sense of self.

Q. Does the fact that some people -- around 2 percent of the people who detransitioned; is that right?

A. 2 percent of all people who transitioned.

Q. So does the fact that there may be up to 2 percent of people that may detransition mean that gender-affirming medical care is ineffective or experimental?

A. No.

Q. And does the fact that someone detransitioned mean that they were not receiving gender-affirming medical care?

A. No.

Q. What percentage of people who receive gender-affirming medical treatment experience regret over their medical treatment?

A. Very small. I think about 1 percent.

Q. And if someone regrets treatment, does that mean that they no longer identify as transgender?

A. Not necessarily.

Q. So we're talking about a Venn diagram of 2 percent and 1 percent of people who will detransition and regret their treatment; is that right?

A. That's very small.

Q. Shifting gears a little bit, some of the State's designated experts have pointed to reports from government entities in other countries, specifically in England, Finland, and Sweden, as demonstrating a lack of evidence of the effectiveness of gender-affirming

medical interventions for adolescents. Are you familiar with these arguments?

A. I am.

Q. Do any of the reports from any of these countries recommend banning the treatment or its coverage for adolescents?

A. They do not.

Q. And to your knowledge, are any of these reports peer-reviewed?

A. Not to my knowledge, no.

Q. We've talked about the efficacy -- the research regarding the efficacy of hormone treatments and surgical treatments for gender dysphoria. Is there any research demonstrating that the use of psychotherapy alone is sufficient to treat a person's gender dysphoria if medical interventions are indicated?

A. No.

Q. What is the effect of delaying treatment for gender dysphoria when it is medically indicated?

A. So I can tell you from my perspective, because I certainly have families that come in to talk about and understand and learn more about interventions. And what I have seen unfortunately more than one time is that when somebody needs intervention but they don't have access to it, their mental health deteriorates and not

insignificantly. So many times somebody will re- -- a family will reengage in services after someone has been hospitalized for, you know, a suicide attempt or just significantly deteriorating mental health. And it is -- it's always -- it's always sad to me that people have to engage in services through a distress perspective, but that does happen occasionally.

Q. Doctor, as a clinician operating in this space for over 17 years and a researcher, do you consider the use of puberty-delaying medications to treat gender dysphoria in adolescents to be experimental?

A. No.

Q. Is it safe?

A. Yes.

Q. Is it effective?

A. Yes.

Q. As a clinician and researcher, do you consider the use of hormone therapy to treat gender dysphoria in adolescents to be experimental?

A. No.

Q. Is it safe?

A. Yes.

Q. Is it effective?

A. Yes.

Q. As a clinician and researcher, do you consider

surgical treatment for gender dysphoria to be experimental?

A. No.

Q. Is it safe?

A. Yes.

Q. Is it effective?

A. Yes.

Q. You know, we've talked a lot today about research and statistics that surround the treatment for gender dysphoria, particularly in your testimony. As a healthcare provider, can you tell us a bit about why this care is so important for the patients that you treat?

A. When I reflect back to when I started this work 17 years ago, I think as a -- you know, the care had been provided at my institution since the early '90s. I remember that we used to really celebrate when our patients graduated high school. Now I feel like because of access to services being more available, people are finishing college. They're going to graduate school. They're becoming doctors. They're becoming lawyers. They're becoming filmmakers. People are really thriving in their life, and they're able to sort of -- I just -- I reflect on families that say I'm so glad that my kid just has normal teenage problems or normal young adult

problems. It is really profound. It is why I have continued my career in this work, because people who could not imagine a future are thriving, and they really just -- they just have sunshine in their lives, and that's really important, and people deserve that.

Q. Thank you, Dr. Olson-Kennedy.

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

THE COURT: All right. Thank you. Is there a cross-examination for this witness?

MR. ELDRED: Yes, Your Honor, but I do see the time.

THE COURT: Yes. Okay. I just wanted to double-check that. All right. It's 12:00 o'clock. We'll be on our lunch break until 1:30 at which time we'll resume with questions for you, Dr. Kennedy. All right. We're in recess until 1:30.

MR. ELDRED: Your Honor, can we get a time before we recess?

THE COURT: Yes. Give me one second. Everyone else is excused but the attorneys.

(Lunch recess taken)

THE COURT: And Dr. Olson-Kennedy, you can come back up to the stand. Thank you. All right. We'll resume then with cross-examination.

MR. ELDRED: Thank you, Judge.

CROSS-EXAMINATION

BY MR. ELDRED:

Q. Good afternoon, Dr. Olson-Kennedy. My name is Charlie Eldred. I'm with the Texas Attorney General's Office. How are you?

A. I'm good. Thank you.

Q. I first want to ask about a study I think you wrote called "Chest Reconstruction and Chest Dysphoria in Transmasculine Minors and Young Adults: Comparisons of Nonsurgical and Postsurgical Cohorts." Did you write that study?

A. I did.

Q. And I'm assuming that study was about mastectomy surgery or something called top surgery or chest reconstruction; is that correct?

A. That's correct.

Q. And did it study minors getting this surgery as young as 13 years old?

A. The youngest was 13.

Q. Did you conclude it was safe and effective for a 13-year-old to get the surgery?

A. That's not what the study was really about. The study was really about the impact of surgery on chest dysphoria, but chest surgery is safe, yes.

Q. For 13-year-olds?
A. Yes.
Q. Okay. Next topic. Did I hear you say you've treated approximately 2,000 patients?
MR. GONZALEZ-PAGAN: Objection.
A. Around 1100.
Q. (BY MR. ELDRED) I apologize. Thank you. What percentage of your patients have you treated for five years or more?
A. I don't know the exact number offhand because people graduate out of my care when they're 25. Probably about 50 percent, maybe 60 percent.
Q. Okay.
A. That's an estimate, though.
Q. And so you don't treat people who are over 25; is that -- is that correct?
A. That's correct.
Q. New topic. Do you agree with me that gender identity can change spontaneously?
A. I don't know what you mean by that.
Q. Well, I think you said 6 percent of people -- and correct me if I'm wrong -- 6 percent of people over 21 -- I'm sorry -- 6 percent of people who have a -- who have gender dysphoria or have a feeling that their gender identity is different than their biological sex,

I think you said 6 percent come to that feeling over the age of 21. Is that true?

MR. GONZALEZ-PAGAN: Objection, misstates testimony.

MR. ELDRED: Well, I'm asking if it's true.

THE COURT: Hold on. I'll overrule the objection if you can answer.

A. In that study, 6 percent of the respondents said that they realized their gender was different from their sex assigned at birth after the age of 21.

Q. (BY MR. ELDRED) Okay. So before the age of 21, they did not have that realization?

A. I don't know the specifics beyond that number.

Q. Okay. So are you denying that gender identity can change in people?

A. In trans and non-binary people, their gender unfolds. Their process of their identification of their gender is different than people whose gender identity matches their assigned sex at birth.

Q. So is that a yes?

A. Can you repeat the question again?

Q. I think I asked -- I'll try it again.

THE COURT: I can -- I can repeat it.

MR. ELDRED: Thank you, Judge.

THE COURT: So are you denying that gender identity can change in people?

A. I don't think that it changes. It unfolds for people.

Q. (BY MR. ELDRED) And you see unfolding as different from changing?

A. Yes.

Q. Can the unfolding process occur well into adulthood?

A. Yes.

Q. Okay. I've got two more topics. The next one is: Isn't it true there's no physical tests that you can run on somebody to see if they have gender dysphoria?

A. To date that is correct.

Q. And is it also true that gender identity does not have a physical manifestation that you can test?

A. As science stands right now, no.

Q. As opposed to, say, diabetes. If I have diabetes, you can figure that out with physical tests; is that true?

A. That's correct.

Q. It doesn't matter whether I think I have diabetes or not. Whether I have diabetes or not is going to be determined by a physical test; is that true?

A. That's correct.

Q. But gender dysphoria and gender identity is the opposite of that; isn't that true?

A. Gender dysphoria is defined by a set of criteria that one can go through and answer and then make that determination. A professional can make that determination for somebody. The experience of having an incongruent gender identity from your sex assigned at birth, right now there is not a physical test to prove or disprove that experience.

Q. And I think that leads to my last topic. I've heard -- I think -- I can't remember if you said it, but do you agree gender dysphoria is diagnosed by certical med- -- certified medical professionals? Let me try that again.

Gender dysphoria is diagnosed by certified mental professionals. Did I say that right?

A. Gender dysphoria is diagnosed by licensed mental or medical professionals.

Q. And are you one of those?

A. I am.

Q. And we've heard testimony that gender dysphoria is a condition of distress. We've heard details about the kind of distress. But it has to last for six months; isn't that true?

A. It has to have been ongoing for at least six months before a formal diagnosis can be made.

Q. So if I -- if one of your patients is only -- if they report to you they've had distress for four months, can you diagnose them as having gender dysphoria and start treating them?

A. Well, they don't -- they would not meet criteria for a diagnosis of gender dysphoria if they've only been experiencing those symptoms for four months.

Q. Would you start treating them anyway or would you wait two months?

A. It's very hard to say given their specifics and their life history. I think that there's -- there are so many questions that I would have for someone in that situation, but I have had situations like that and I have not started treatment.

Q. But you have started treatment before six months of a reported dysphoria?

A. No, it's extraordinarily rare. By the time that someone gets to a medical facility, we're very much the last stop for people. They've been experiencing symptoms for a year and oftentimes much longer than that. So I can't recall for sure if I've ever had one person with that, but I don't think so, because I don't provide that diagnosis if somebody has been experiencing

those kinds of symptoms and experiences less than six months.

Q. But you don't personally believe that drug treatment should wait for six months after a report of gender dysphoria; isn't that true?

A. I'm not sure what you mean. It's -- when people come to my door, that's a very different -- people have been experiencing gender dysphoria for usually much longer than six months.

Q. Have you ever said that people should not be required to prove their gender to a therapist before embarking on a phenotypic gender transition?

A. No person can prove their gender to anyone.

Q. My -- will you answer my question, though, please?

A. I don't remember.

Q. Would it refresh your recollection if I showed it to you on your Facebook page?

A. Absolutely.

MR. GONZALEZ-PAGAN: Objection, Your Honor. I think it should be shown to counsel.

MR. ELDRED: I'm sorry, Judge. I should have --

THE COURT: Yeah, you can show it to him then.

MR. ELDRED: I should have asked for permission as well.

THE COURT: Yes.

MR. ELDRED: Where would you like me to go?

THE COURT: Well, I would show it to him first.

MR. ELDRED: Okay.

MR. GONZALEZ-PAGAN: Your Honor, I see a cut-out here from an image. It's unclear to me if it's from Facebook or any other website. It's not -- I cannot even see where the provenance of that is.

THE COURT: I'll let you show it to her and let's just go from there.

MR. ELDRED: Yes, Your Honor.

A. Yes, this looks like something I wrote.

MR. ELDRED: Okay. Do you mind if I just ask her right here?

THE COURT: Sure. That's fine.

MR. ELDRED: Just so we can read it together.

Q. (BY MR. ELDRED) So you wrote: People should not be required to prove their gender -- I'm sorry.

People should not be required to prove their gender to a therapist before embarking on a

phenotypic gender transition.

A. That's right.

Q. Do you agree with that or --

A. Yes.

Q. Okay. So is it true to say you don't actually believe people need six months of non -- of therapy -- let me try that again.

You don't believe people should have six months of reported gender dysphoria before you'd start treating them with drugs?

A. I don't think people should have to prove their gender because no one can do that.

Q. So that's a yes; right?

MR. GONZALEZ-PAGAN: Objection, Your Honor, asked and answered.

THE COURT: Sustained. Next question.

MR. ELDRED: Okay. I'll pass the witness.

THE COURT: Thank you, sir. Any redirect?

MR. GONZALEZ-PAGAN: Very briefly, Your Honor.

THE COURT: Okay.

REDIRECT EXAMINATION

BY MR. GONZALEZ-PAGAN:

Q. Doctor, you were just asked some questions about a comment you had posted pertaining to having

somebody not needing to prove their gender. That is different from making a diagnosis of gender dysphoria; is that correct?

A. That's correct.

Q. Okay. You were not saying that somebody needed -- need not meet the criteria for gender dysphoria in order to access medical treatment?

A. Can you ask -- there are so many negatives in these questions.

Q. In that statement -- in that statement, you did not say that somebody did not need to meet the criteria for a gender dysphoria diagnosis in order to access medical treatment?

A. That's correct.

Q. Thank you.

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

THE COURT: Thank you, sir.

Thank you, Dr. Olsen-Kennedy. You are excused from the witness stand.

Counsel for plaintiff, who would you like to call next?

MS. WOOTEN: Thank you, Your Honor. Counsel for plaintiffs announces Lazaro Loe will be our next witness.

THE COURT: All right. Thank you. We'll go and retrieve him.

MS. LESKIN: And again, Your Honor, Mr. Loe is a plaintiff proceeding under a pseudonym pursuant to the protective order.

THE COURT: All right. Thank you.

Hello, Mr. Loe. If you'll step here, I'll swear you in, and then you can take the witness stand. If you'll raise your right hand for me.

(Witness sworn)

THE COURT: All right. You can make your way around up to this chair here. There should be some water there for you as well.

All right. Go ahead.

LAZARO LOE,

having been first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MS. LESKIN:

Q. Good afternoon. Can you tell us your name, please?

A. Hi. Can you hear me okay?

Q. Yes.

A. My name is Lazaro Loe.

Q. And Mr. Loe, do you live in Texas?

A. I do. I live in Bexar County.

Q. Are you a member of PFLAG?
A. I am.
Q. Tell us a little bit about your family.
A. Well, I have a daughter named Luna. She's 12 years old. She's transgender. Around age five, five or -- well, about five, she told us that she was a girl. And, you know, at first it was pretty difficult for me to accept that. But, you know, there was a lot of indication that -- as we researched it more, that it wasn't just a phase, and so we started to affirm her and her identity as a girl through clothing and hairstyles and things like this.
Q. So let's back up just a little bit.
A. Uh-huh.
Q. What sex was Luna assigned at birth?
A. She was born a boy.
Q. And you said that at age five she told you she felt like a girl.
A. Yes.
Q. How did she express that to you?
A. I think initially she told my wife first, but she was always -- I mean, I had tried to get her into soccer and things that I'm into and more boys things like building things or whatever, and she never really was interested in those things. I mean, she liked

Frozen and girls things and pink and those kinds of things. Her proclivities were towards more feminine things, I suppose.

Q. And just because she liked pink and Frozen, did that mean that she couldn't also be a boy?

A. No, but, I mean, it was deeper than that because, I mean, I think that seeing her -- there was, like, an awkward period I think from the time that, you know, she could first speak until she was probably in first grade that she -- she just -- like a lot of strange things that were happening in school with regard to, like, her feeling uncomfortable in certain types of clothing and just kind of -- it was hard to describe, but it was -- she was pretty emphatic about that expression of, you know, that she was a girl. I mean, when she opened up to me about it, you know, I was kind of initially hoping that it might just be a phase, but, I mean, she was very -- she never wavered in that -- in that aspect of herself.

Q. You've mentioned that at first you resisted when Luna told you she was a girl. What do you mean by that, that you resisted?

A. I don't think I wanted to fully accept that it was -- that it was true. I mean, I was kind of hoping that it was something that she would grow out of and

that -- I mean, I think that it was okay for her to like Frozen and all these other things. We allowed those things. We didn't not allow them. But, you know, it took -- it took me a while to realize that -- to really see her as she truly is.

Q. And how did that change affect Luna, your change in accepting her?

A. I think that change was -- was tremendous because, I mean, I think that once I -- I mean, I think a lot of it had to do with the fear as a parent when you realize that, you know, the life of a transgender person, especially a kid, would be -- the road would be pretty difficult. So I was hoping that it wasn't true because of that, because of the challenges that she would face in life. But as we started to allow her to be -- to express herself more as -- the way that she wanted in terms of clothing and hairstyles and alternative nicknames and things like that, she just was so much more joyful. I mean, it was like she was half a person before, but as we started to accept her more, she just changed. She did better in school and she was just happier.

Q. At some point did you choose to seek care, medical care for Luna?

A. We did. So her mother and I, we -- we sought

out a child psychologist, and we had several appointments with her around age six.

Q. Why so early?

A. Well, because, you know, as we -- we -- like I said, we had a few kind of difficult years where we were trying to -- struggled to figure out what exactly was going on. And as -- as we started to kind of put the pieces together, I think we wanted some kind of third party opinion on what we were doing to make sure we were doing the right thing.

Q. And what did -- did the professional make any diagnosis of Luna?

A. She did. I think that within the first few sessions that we had with her -- I mean, I know -- I remember distinctly after the very first one that after we had our sort of meet and greet with the doctor, that you know, we left the room and she spent, you know, the session with Luna and, you know, immediately afterwards the doctor said, well, you know, your daughter is a girl. I mean, she had expressed it very completely in the session and has always expressed it that way to us. But, I mean, I think the official, you know, diagnosis was gender dysphoria.

Q. So what was the next step in caring for Luna and supporting Luna at that point?

A. I mean, I think that -- you know, that those initial consultations with the child psychologist were very reassuring to us because we felt like we were kind of on the right path as parents, and we could see the very obvious results with regard to her academic performance and her just -- her joyfulness and happiness because, you know, the sort of years prior had been a lot more difficult. So all that we did really was, you know, let her grow her hair long, and I remember going to Target and I kind of had donated all of her boys clothes and uniforms and things like that and purchased, you know, like 300 bucks' worth of clothing at Target for her and, you know --

Q. How did she react to that?

A. She was super happy, you know. It was a very joyful experience.

Q. At some point in time, did you come to investigate medical treatment for Luna?

A. I mean, I think it's been an ongoing thing for us. I mean, I like to read a lot, so, you know, I think even prior to meeting with the child psychologist I started reading books and reading about this issue and what the proper course of care would be. So we started having discussions early on about, you know, medical interventions, which didn't happen until much later. I

mean, you know -- but yes, I mean, we did -- we did talk about that with her.

Q. When you say you talked about it with her, with Luna?

A. With Luna, yes.

Q. And did you involve any medical doctors in those conversations?

A. We did. Yeah, we did. Around age ten we sought out treatment at a clinic and got a referral to a pediatric endocrinologist where she had several appointments prior to any medications being administered. So after meeting and consulting with, you know, this team of doctors, we decided -- and with Luna, of course, that she would start puberty blockers at age 11?

Q. At age 11.

A. Uh-huh.

Q. So how long was it then from the first time Luna told you she identified as a girl until you started her on puberty blockers?

A. I mean, the first time that she expressed that to us, she was -- I mean, I would say she was probably around age five, so it was, you know, about six years.

Q. What was the purpose of starting Luna on puberty blockers, is your understanding of starting her

on puberty blockers?

A. I mean, I think it was -- it was very -- very obvious, and, you know, Luna has obviously expressed, you know, a desire to have a more feminine appearance and body and was -- had a lot of anxiety around, you know, going through puberty as her biological sex.

Q. When you say she had anxiety, what did she tell you?

A. I mean, I think it's just -- you know, it's -- she would just say that -- I mean, I can't remember exactly, you know, the things that she would have said, but, you know, it's just -- I think it was more of a positive expression of a desire to have -- you know, to affirm her, like her physical appearance and how she feels on the inside, like who she is.

Q. Have you ever discussed with Luna whether to stop puberty blockers?

A. We have. I mean, I think every time that, you know, we have a doctor's appointment we make it clear that, you know, if she ever felt any anxiety -- or any discomfort with continuing the care, that, you know, it wasn't anything that she was -- she's a willing -- she's the one who really is wanting this treatment for herself, you know, and as parents also, you know, because we realize that we want the best possible

outcomes for her, you know, as an adult, and, you know, we think that this is obviously a lifesaving kind of care for her, that this is the right treatment for -- you know, for who she is.

Q. How long has Luna been on puberty blockers at this point?

A. I would say a little -- not quite a year and a half, about a -- you know, a little bit over a year.

Q. Have you had any discussions with Luna and her doctors about if there's any other medical treatments that would -- that may come along?

A. Yes, we have. We -- you know, we've talked to her doctor several times about starting hormone therapy, but she's not a candidate until she's 13.

Q. When you say hormone therapy, you mean starting her on estrogen?

A. Yes.

Q. And have you started to investigate any of the risks associated with taking estrogen?

A. We have. I mean, we've had several -- I mean, Luna is always present as -- you know, as is her mother and I, like in, you know, all the appointments, or at least one of the -- one of us has been there, but Luna is always there for every one of her appointments. And we've had several discussions with the doctor about it,

and she's, you know, pretty thorough in explaining, you know, exactly what will happen and, you know, kind of what the risks are, but she -- she understands that and she wants to continue with the treatment.

Q. What do you think would be the -- well, strike that.

Luna has not yet started estrogen; correct?

A. She has not.

Q. And she is continuing to take puberty blockers?

A. She is.

Q. What do you see as the potential impact on Luna if she was not able to take puberty blockers?

A. I think it would be devastating because, I mean, one of the conversations that we've had with the doctor in light of everything that's been going on, you know, here in the state is obviously the mental distress that it would create and just the -- as a parent, I mean, I think it's incredibly distressing to, like -- to have to think about, you know, your child having to suffer, you know, these kinds of -- like a reversal of, like, something that clearly she wants and needs. I mean, I think that it would -- she would change from a really happy, joyful, kind person into -- you know, I think she would become withdrawn. And I

would be worried about her mental health actually, not to mention the physical changes that she would experience that she's -- that she doesn't want, so...

Q. Have you made any plans for what to do if SB 14 goes into effect?

A. I mean, we're already struggling with that now because, I mean, the law has already had a chilling effect on the medical community here that provides this kind of treatment. So I think as far as our family is concerned, we're still trying to come up with a plan for how we would continue the treatment, which obviously we're going to do somehow, but we don't really know exactly what that's going to look like yet.

Q. How has Luna reacted to what's going on?

A. She's very upset about it all. I mean, I think it's confusing for a 12-year-old to try to figure out why, you know, so many people would hate, you know, people like her. I mean, she doesn't understand. She thinks they're stupid, actually.

Q. Thank you very much.

MS. LESKIN: No further questions.

THE COURT: All right. Thank you. Any cross?

MR. ELDRED: No questions, Judge.

THE COURT: All right. Thank you.

Mr. Loe, you're excused from the witness stand. I would head back to that door.

THE WITNESS: All right. Thank you.

THE COURT: Thank you. All right. From the plaintiffs, which witness is next, just in case Ms. Gould needs to grab them?

MS. WOOTEN: Brian Bond, Your Honor.

THE COURT: Okay. Mr. Bond, if you'll step forward and raise your right hand.

(Witness sworn)

THE COURT: All right. Make your way up to the witness stand.

BRIAN BOND,

having been first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MS. POLLARD:

Q. Mr. Bond, would you please state your full name for the record?

A. Brian Bond. My pronouns are he/him/his.

Q. And how are you employed?

A. I am the executive director now transitioning title-wise to CEO for PFLAG National.

Q. And is PFLAG a party in this case?

A. Yes, it is.

Q. Is PFLAG bringing this lawsuit on behalf of its

members?

A. Yes, it is.

Q. And you mentioned that you're in the midst of transitioning titles. How long did you hold the role of executive director of PFLAG?

A. Four years. I started February of 2019.

Q. And are your responsibilities now under your new title as CEO essentially the same as they were as executive director?

A. Exactly the same.

Q. All right. And what are those responsibilities?

A. I have the fiduciary responsibility for the organization. I manage the team of the organization. And I set the strategy for the organization.

Q. Mr. Bond, what is PFLAG?

A. PFLAG is the first and largest organization for LGBTQ+ individuals and their families. We were started in 1973 by a mom, a schoolteacher, math. And it's made up of truly for me the most amazing individuals, parents that want nothing more than for their kids to be safe and to thrive.

Q. And what is PFLAG's mission?

A. Excuse me. I'm sorry.

Q. No. Go ahead.

A. PFLAG's mission is to create a caring, just, and affirming world for LGBTQ+ individuals and those who love them.

THE COURT: If you'll slow down just a little bit, Mr. Bond.

THE WITNESS: I'm sorry.

THE COURT: That's okay.

THE REPORTER: Repeat that to make sure I got it.

A. Our mission is to create a caring, just, and affirming world for LGBTQ+ individuals and those who love them.

Q. (BY MS. POLLARD) And what -- is it your job as CEO to make sure that PFLAG achieves that mission?

A. Absolutely.

Q. And what kind of work does PFLAG do in order to achieve the mission?

A. We have three basic pillars. By the way, this is our 50th -- this is our 50th anniversary. Slow down, I know. This is our 50th anniversary. Our pillars are support, education, and advocacy.

Q. And how is supporting access to gender-affirming medical care for minors consistent with PFLAG's mission?

A. It's important for our mission, for our

parents, for our families, for them to be able to come to chapter meetings to hear from other parents, to know that the journey they are on -- that they're not alone, that they're loved, and to affirm them.

Q. As the executive director and now CEO, do you make decisions about whether PFLAG participates in litigation?

A. Yes.

Q. And why did you decide to participate in this litigation?

A. Because this is really important for our families here in Texas.

Q. Does PFLAG have bylaws?

A. Yes, it does.

MS. POLLARD: Your Honor, I would like to show what has been pre-admitted as Plaintiffs' Exhibit 3 to the witness.

THE COURT: Go ahead.

Q. (BY MS. POLLARD) All right. Mr. Bond, do you recognize this document?

A. Yes.

Q. And what is it?

A. Those would be our bylaws.

Q. Does it appear to be a true and accurate copy of your bylaws?

A. Yes, it does.
Q. And does this appear to be the most recent version of your bylaws?
A. Yes, it does.
Q. Okay. Thank you very much. That is all of my questions that document.
Is PFLAG a membership organization?
A. Yes, it is.
Q. How do people become members of PFLAG?
A. So people can join PFLAG by either joining the national office -- through the national office or they can join through one of the chapters, one of the 350 plus chapters across the country. By the way, I would add you don't have to be a member of PFLAG to go to one of our support meetings. It's open to everyone.
Q. And so if someone becomes a member through the local chapter, that makes them also a member of the national organization?
A. That is correct.
Q. Is the role of members contained within PFLAG's bylaws?
A. Yes, it is.
Q. And as the executive director, now CEO, how do you stay informed of what PFLAG members are experiencing?

A. There's multiple platforms for that. First of all, I'm very accessible. They can get to me directly, and many do. We have an RDs council, regional directors council, one for this area. These are volunteers who are in contact constantly with our chapters. There's obviously the chapter meetings. There are various social media private Facebook places for people to convene. I have staff directly assigned to this region. All that information ends up back up with me at some level.

Q. And how does PFLAG track its membership?

A. Through our database.

Q. And how many members does PFLAG currently have?

A. About 350,000 supporting members across the country.

Q. And how many Texas chapters do you have?

A. We have 18 chapters here in Texas, from El Paso to Beaumont and everywhere in between.

Q. And how many members do you have in your Texas chapters?

A. We have over 1500 right now.

Q. And are families with transgender children who are receiving gender-affirming medical treatment among those 1500 members?

A. Yes, they are.

Q. How do you know that?
A. Because I hear from them. They're terrified right now.
Q. Are you familiar with the families who are plaintiffs in this lawsuit?
A. Yes.
Q. And do you know that they are -- whether they are PFLAG members?
A. I do, from their declarations, yes.
Q. What kind of support does PFLAG provide to Texas members with transgender children?
A. There's constant support going on at the local level through our chapters in our support group meetings, education. And then from the national office there's various newsletters that we would send out specifically in Texas. And then there's a large array of publications that would be germane to Texas as well as anywhere in the country.
Q. And is that support ongoing?
A. Yes.
Q. All right. Are you familiar with a law known as SB 14?
A. Yes.
Q. If SB 14 is allowed to go into effect, how would it impact PFLAG members in Texas with transgender

children?

A. It's already starting to impact my members, my families here in the state. I'm hearing from members of our organization who are trying to figure out if they need to move, if they can even afford to move, what this means from care -- for care for their kid. All these folks are wanting to do is try to make sure that their kids can thrive and be treated equally. And this is very disruptive right now, terrifying in fact for my members.

Q. Thank you, Mr. Bond.

MS. POLLARD: I'll pass the witness, Your Honor.

THE COURT: All right. Thank you. Any cross-examination?

MR. ELDRED: No, Your Honor.

THE COURT: Thank you. All right. Mr. Bond, you're done on the witness stand.

Your next witness?

MS. WOOTEN: Your Honor, the next witness is Dr. Richard Ogden Roberts, III.

THE COURT: Okay. Dr. Ogden Roberts, if you'll step forward and raise your right hand for me.

(Witness sworn)

THE COURT: Take your place on the witness

stand.

RICHARD OGDEN ROBERTS, III,

having been first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MS. POLLARD:

Q. Dr. Roberts, would you please state your full name for the record?

A. I am Richard Ogden Roberts, III.

Q. And what is your role in this case?

A. I am a plaintiff in this case.

Q. And what is your profession?

A. I'm a pediatric endocrinologist.

Q. And are you licensed to practice in Texas?

A. I am, yes.

Q. And where are you currently employed?

A. I work at a large children's hospital in Houston, Texas.

Q. And are you here today in your personal capacity?

A. Yes.

Q. Can you describe for us your educational background?

A. I received a bachelor's of science in commerce from the University of Virginia in 2007. I hold a master's of public health in epidemiology from Tulane in

2010. And then I graduated from medical school back at the University of Virginia with my MD degree in 2014.

Q. And with respect to training, where did you perform your residency?

A. I did a residency in categorical or general pediatrics at UCLA in Los Angeles.

Q. And did you also complete a fellowship?

A. I did. My fellowship was at the University of Colorado in the Barbara Davis Center in Aurora or Denver, Colorado.

Q. And are you board certified?

A. I am. I am double board certified in general pediatrics and pediatric endocrinology.

Q. Are you currently a member of any professional organizations?

A. Yes. I'm a member of the American Academy of Pediatrics, the Pediatric Endocrine Society, WPATH and by extension USPATH, and GLMA.

Q. Dr. Roberts, what led you to pursue a career in medicine?

A. I think like many people who go into the field, I went into it out of a desire to leave a mark on the world and to help people.

Q. And at a high level, for those of us who aren't doctors, can you describe your current practice?

A. Sure. I, like several of the other witnesses you have heard, spend time in a variety of different settings. The majority of my practice is clinical, so I spend time seeing patients, but I also have administrative duties within my section and educational duties as well.

Q. And what is the patient population that you see?

A. I see obviously pediatric patients, so from birth until young adulthood, with endocrine conditions generally, including gender dysphoria.

Q. How many patients with gender dysphoria have you treated?

A. Throughout training and my current clinical practice, I estimate I've seen over 200 patients with gender dysphoria.

Q. And in what settings do you treat patients with gender dysphoria?

A. In clinical settings, so a doctor's office. Patients come in to see me and I spend time with them.

Q. Are there other physicians that work as a part of your practice?

A. Yes. I am a pediatric endocrinologist, but this care encompasses several other subspecialties, so I work alongside mental health professionals,

psychologists, and psychiatrists, Dr. O'Malley of whom is also a plaintiff on this case. I have partners within the field of pediatric endocrinology, Dr. David Paul. There's an adolescent medicine physician who we work with. And we have a social worker to help some other needs.

Q. What portion of your practice is related to providing medical treatment to youth with gender dysphoria?

A. In terms of my clinical time, it breaks down to probably 10 to 20 percent of the time I have dedicated to see patients that is allotted to the treatment of gender dysphoria.

Q. What does the remainder of your practice relate to?

A. General pediatric endocrinology. So I see patients with Type 1 diabetes, growth disorders, puberty disorders, thyroid disease, cancer, amongst others.

Q. Do you consider providing gender-affirming medical care to youth an important part of your practice?

A. Absolutely.

Q. Why is that?

A. I didn't become a pediatric endocrinologist to be a gender specialist. I discovered pediatric

endocrinology through my third and fourth year of medical school and really enjoyed the breadth of practice that it offered. And I would say over the course of my training, both medical school and then as a resident and fellow, experiences with gender-diverse individuals, both children and adults, caused me or allowed me to see the need that existed and sometimes the dearth of providers that were there able to provide that care, and it grew out of that.

Q. What types of medical treatments do you provide for patients with gender dysphoria?

A. I'm a pediatric endocrinologist, so I provide puberty-blocking hormones that you've heard about already as well as hormone therapies for youth with gender dysphoria.

Q. And if I use the term gender-affirming medical care, will you understand that to refer to the puberty-delaying medications and the hormone therapies that you mentioned in the context of gender dysphoria?

A. Yes.

Q. Do you provide any medical treatment for gender dysphoria to patients before they reach puberty?

A. No. As you've heard before, there's no medical therapy necessary for gender diversity before the onset of puberty.

Q. Are any of your transgender patients on Medicaid?

A. I believe so, yes, although I don't specifically track which insurance programs my patients have when they see me.

Q. And are any of your patients on the Children's Health Insurance Program or CHIP?

A. The same answer. I believe so, yes.

Q. And regarding the use of puberty-delaying medications and hormone therapies, do you also provide those same treatments to cisgender patients?

A. Yes. Those therapies are common practice or common medications for a pediatric endocrinologist to provide under other indications for cisgender patients.

Q. Is there a specific diagnosis that has to be made before you begin providing gender-affirming medical care to a transgender patient?

A. Yes. Patients must meet criteria per the DSM-V of gender dysphoria.

Q. And how do you determine if a patient is developmentally and emotionally ready to undergo treatment?

A. Yeah. As you've heard, the practice of medicine is a complex practice in which physicians get to know the patients that are in front of them and the

families that come to them. The ability to assess capacity is an ability that every physician learns throughout their medical training --

MR. STONE: Your Honor, objection. This witness is now talking about what every physician learns. He's not designated as an expert. Under Rule 701, he can offer a lay opinion, but it has to be based on his personal perceptions. And in this case, because this is a witness who's not designated as an expert but is a fact witness, we object to this testimony about what other physicians would do.

THE COURT: Well, what I'm going to do is repeat the question, okay?

THE WITNESS: Sure.

THE COURT: And how do you determine if a patient is developmentally and emotionally ready to undergo treatment?

So I'm going to overrule the objection and let you answer that question.

A. I would say that I use the skills that have been developed through a rigorous medical training to assess patients and their ability to understand and consent to therapies proposed to them.

Q. (BY MS. POLLARD) And are their families involved or their guardians involved in that process?

A. Absolutely.
Q. In what situations do you provide gender-affirming medical care to a transgender patient under 18 without the consent of their parent or guardian?
A. I have never.
Q. And in what situations would you provide gender-affirming medical care to a transgender patient, again under 18, without the assent of that patient?
A. Again, I have never.
Q. Do you utilize any clinical guidelines in your treatment of patients with gender dysphoria?
A. Yes. I utilize the WPATH Standards of Care Version 8 and the Endocrine Society Clinical Practice Guidelines.
Q. Does every transgender patient you see receive some sort of medical treatment for gender dysphoria?
A. No, not necessarily.
Q. And can you give us an example of when it might be the case that they would not receive medical treatment?
A. Sure. This care is very individualized. And there are times when patients come to me having met a criteria for gender dysphoria, lasting over a period of six months, who may not be ready to start hormone

therapies for a number of reasons. I can think of a recent patient who was assigned female at birth and plays hockey and wants to continue to be able to play hockey and fears that if he -- his gender identity is male -- starts testosterone therapy, he may no longer be able to play the sport that he likes to play.

Q. And are you aware of a law known as SB 14?

A. Yes.

Q. Have you seen any evidence of the impact of SB 14 on your patients?

A. Yes.

Q. If SB 14 is allowed to go into effect, what impacts would it have on the health of your patients with gender dysphoria?

A. I anticipate that patients with gender dysphoria, if SB 14 were to go into effect in this state, would increase their dysphoria and may increase other mental health aspects such as their depression or anxiety.

Q. Have any of your transgender patients attempted suicide before coming to see you?

A. Unfortunately, yes.

Q. If SB 14 were to go into effect and you were to continue treating your transgender patients consistent with evidence-based medicine, what risks would that

carry?

A. I would lose my license.

Q. In your view, how does SB 14 comport with your ethical obligations as a doctor?

A. SB 14, if it were to go into effect, would make me abandon patients with whom I have established relationships.

Q. And how does that impact you personally as a physician?

A. Well, that's terrible. You know, I went into medicine to connect with people and to help people. I spent the last month telling people that I may in fact not be able to see them come September 1. It would be heart-wrenching to lose these patients and the relationships that we've established over years.

Q. Thank you very much, Doctor.

MS. POLLARD: I'll pass the witness.

THE COURT: Cross-examination?

MR. STONE: Yes, Your Honor, just a couple.

CROSS-EXAMINATION

BY MR. STONE:

Q. Doctor, do you obtain informed consent from adolescent patients for whom you're treating them for gender dysphoria prior to beginning cross-sex hormones?

A. Mr. Stone, I obtain informed assent from my adolescent patients and informed consent from their parent or guardian before starting cross-sex hormone therapy, yes.

Q. Have any of your patients attempted suicide after -- for whom you're treating for gender dysphoria -- let me start again.

Have any of your adolescent patients for whom you're treating them for their gender dysphoria condition -- have any of them attempted suicide after beginning a treatment course in puberty blockers or cross-sex hormones?

A. Not that I'm aware of.

Q. Do you understand SB 14 is requiring you to wean your current patient population off of puberty blockers and cross-sex hormones over a period of time?

A. I understand that SB 14 allows a provision for some patients to be weaned off of their medications.

Q. When you say some patients, what do you mean by that?

A. I believe the wording of SB 14 states that if a patient has had -- started therapy before -- and I can't remember the exact date, but there is a date in there -- and had more than 12 mental health sessions prior to starting hormone therapy of any kind, including puberty

blockers, at least six months before starting therapy, that they may qualify for a wean.

MR. STONE: I'll pass the witness, Your Honor.

THE COURT: Any redirect?

MS. POLLARD: No, Your Honor.

THE COURT: All right. Thank you, Dr. Ogden Roberts. You are done on the witness stand.

The next witness for plaintiffs?

MS. POLLARD: Your Honor, plaintiffs would like to call Dr. David Paul.

THE COURT: Okay. Dr. Paul, if you could step forward and raise your right hand for me.

DAVID L. PAUL, M.D.

having been first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MS. POLLARD:

Q. Dr. Paul, would you please state your name for the record?

A. David Leo Paul.

Q. And Dr. Paul, are you a party to this proceeding?

A. Yes, I am.

Q. What party is that?

A. I'm a plaintiff.

Q. And what is your occupation?
A. I'm a physician.
Q. And would you walk us through your educational background?
A. So I attended Trinity University from '77 to '80 for undergrad and then University of Texas Health Science Center San Antonio for medical school from 1980 to '84.
Q. And where did you complete your residency?
A. At Wilford Hall United States Air Force Medical Center in San Antonio at Lackland Air Force Base from '84 to '87.
Q. And did you complete a clinical fellowship?
A. I did pediatric endocrine training for three years from '90 to '93 at the University of California in San Francisco.
Q. How long did you serve in the Air Force, Dr. Paul?
A. Four years of reserve and then 28 years of active duty.
Q. And when did you retire from service?
A. In 2012.
Q. And what -- at what rank did you retire?
A. Lieutenant colonel.
Q. Are you currently licensed to practice medicine

in Texas?

A. Yes, I am.

Q. And are you currently board certified in any medical specialties?

A. In pediatric endocrinology.

Q. And are you a member of any professional organizations?

A. GLMA, Pediatric Endocrine Society, the Endocrine Society.

Q. And where are you currently employed?

A. At a large children's hospital in Texas.

Q. Are you here today in your personal capacity?

A. Yes, I am.

Q. Do you currently work in a clinical capacity?

A. Yes, I do, full time.

Q. And how would you describe your current practice?

A. Busy. Much enjoyed. I spend six months a year as a hospitalist endocrinologist, so I take care of children that are sick in the hospital caring for all sorts of endocrine conditions. And then six months a year I'm working in the clinic setting.

Q. And as an endocrinologist, what types of conditions do you treat?

A. So as Dr. Roberts said, it's a tremendous

variety, but any glandular disorder, pubertal disorders, diabetes. Diabetes is a large portion of pediatric endocrine care. And again, on the inpatient side, a whole host of endocrine disorders, including thyroid cancer.

Q. Do you treat patients with gender dysphoria?

A. I do.

Q. Are some of your patients with gender dysphoria under the age of 18?

A. Yes.

Q. How did you first come to treat adolescents with gender dysphoria?

A. So in 2007 I was at the military base in San Antonio as a pediatric endocrinologist in the Air Force, and I was referred a patient -- excuse me -- from the adolescent clinic in that facility who came to them as a gender-identified child -- an adolescent who was assigned male sex at birth. She was getting estrogen on her own from a pharmacy out of Europe and on tremendous doses of estrogen.

Adolescent medicine didn't really know what to do. That was a very new human experience for them to help care for. So they recognized the endocrinologists were involved around the world and the country, and so they referred her to me, and I took over

her care. I saw her, and we contracted for me to be part of her healthcare, to take over her gender-affirming hormone care.

Q. Today would you say that care -- providing medical care for patients with gender dysphoria makes up a relatively small portion of your practice?

A. Yes, it is a small portion, perhaps 5 percent.

Q. And given that, why is providing medical care to youth with gender dysphoria important to you?

A. So I had already understood back then that there was a considerable mental health morbidity associated with gender dysphoria and with patients who experience transgender identity. And then after I took care of the young lady I spoke to you about for a couple years, she was approaching adulthood, and then I lost track of her. She stopped coming back to see me. A couple years after that, her sister sent me an email -- found me and sent me an email stating that she had committed suicide.

So I recognize that if these youth do not receive standard of care science-based help as they undergo gender transition, that it can be life-threatening. It can be threatening to their entire life existence, affecting every single aspect of their life. And it dawned on me that I had the skills to

provide this care. I already had the training within the endocrine exposure that I had. And these children needed care. So I decided from that moment forward I was going to be caring for children who were gender -- had gender dysphoria and who identified as transgender.

Q. Dr. Paul, what kinds of medical care do you provide to adolescents with gender dysphoria?

A. So yes, adolescents, which would be children who have onset of puberty or thereafter, if they have -- if they identify as a gender opposite to the sex that -- to the gender that they were given at birth, which is based on their genitalia at birth, and then they go into puberty and their secondary sexual development traverses down the pathway that is diametrically opposite to the gender that they identify as, I will pro- -- I will offer and go through the counseling to help them understand puberty suppression therapy using GnRH agonists. Later in adolescence the concept of hormone replacement therapy will come into play, which I can provide under the proper circumstances.

Q. And if I use the term gender-affirming medical care today, will you understand it to refer to the puberty-delaying medications and hormone therapy provided to youth with gender dysphoria?

A. Yes.

Q. Do you provide gender-affirming medical care to patients who are on Medicaid?

A. I do know that, yes.

Q. And do you provide gender-affirming medical care to patients who are on CHIP?

A. Yes.

Q. Can you tell us how the gender-affirming medical care that you provide has affected your adolescent patients?

A. I am almost weekly amazed at the outcomes, the positive outcomes from the children and adolescents that I care for who have gender dysphoria and who identify as transgender. They are probably the most impressive positive outcomes of all the patients I see. They are the most highly motivated. They faithfully take their medicines like none of the other patients that I see.

They actually have a tremendous change in how they feel about themselves, their self-esteem, their ability to interact with other peers, their academic performance, their family life. Every single corner of their life is dramatically changed, and I have seen this and heard their stories, even before they have any physical body changes, just knowing that they have the care provided to them, that they don't see that care going away. This was before SB 14. They know that the

hormone -- or that the puberty suppression is engaged and their bodies are not going to continue to physically change down the pathway that is opposite to how they want their bodies to be. And then the hormone therapies, they're circulating. They know it's going to provide the secondary sexual development that goes along with how they identify. They are beaming at the thought of what is going to come in the future.

Q. Do you also provide puberty-delaying medication or -- let's start with just puberty-delaying medication. Do you also provide puberty-delaying medication to youth who are not transgender?

A. I do, yes.

Q. And do you also provide hormone therapy to youth who are not transgender?

A. I do, yes, and -- yes, I do.

Q. Can you give us an example of circumstances in which you would provide puberty-delaying medication to a cisgender patient?

A. The most common again that's been talked about before is precocious puberty. That therapy has been around since the mid 1980s. And I've been using puberty suppression, GnRH analogues, ever since it first came on the market for precocious puberty. But it's also used, as was stated before, to suppress puberty to help

preserve fertility in cancer patients who are getting gonadotoxic drugs, and then also patients who have a variety of rheumatological disorders or excessive bleeding disorders -- uterine bleeding disorders.

We actually use puberty suppression in children for short stature to help -- with growth hormone therapy to attempt as best as possible to help a youth to reach a normal adult height. And that's a pretty common practice. So there's a whole host of reasons in other children that are cisgender that we use puberty suppression therapy for.

Q. And can you give us an example of circumstances in which you would provide hormone therapy to a cisgender patient?

A. Yes. The most commonly are children that have what we call hypogonadism where they're not capable of making the hormone -- the sex hormone they need to undergo puberty, and we will re- -- we will provide hormone replacement therapy for them.

There's also treatments we may provide for cisgender children who have secondary sexual development against their gender identity. For example, we have cisgender males, again, assigned male at birth, raised a male, identify as a male, undergo male puberty and then start having breast development. We have cisgender

females who will develop sometimes pathological causes of virilization of the body, including facial hair, deepening of the voice, and enlargement of the clitoris that we will actually provide hormone therapy for sometimes as part of that treatment. And then, of course, many of them will get surgical therapy as well to remove, for example, breast tissue in cisgender males. So hormone therapies are used in cisgender patients as well under different circumstances.

Q. Do you provide any medications to your transgender patients that you don't also provide to cisgender patients?

A. I do not.

Q. Is there a particular diagnosis that you require before providing any gender-affirming medical care to a transgender patient?

A. I'm sorry. The first part of that was do I require a diagnosis?

Q. Is there a particular medical diagnosis that you require before providing gender-affirming medical care to a transgender patient?

A. Yes, that they have gender dysphoria according to the DSM-V criteria.

Q. And do you require the consent of a parent or guardian before initiating gender-affirming medical care

for your patients?

A. 100 percent of the time, yes.

Q. And what does the informed consent process involve in your practice?

A. Once a diagnosis is established, the patient and par- -- legal guardians will, of course, ask and be allowed to ask as many questions as they need to ask to have a full understanding. So I disclose all the pertinent things I need to tell them about how the -- how I made the diagnosis, for example, what the treatments are available for them under that diagnosis of gender dysphoria, the potential benefits, which outweigh, but still discuss the potential known and possibly unknown risks, short term and long term.

I make sure that they have complete voluntary ability to ask for this treatment. I inform them of any alternative therapies that might be available for them to consider. And then I leave the final decision for puberty suppression or hormone therapy to the legal guardian as the consenting individual and then, of course, make sure that the adolescent has full capacity and understands and is mentally capable of assenting to that care.

Q. And in what situations would you provide -- or do you provide gender-affirming medical care to a

patient under 18 without the informed consent of their parent or guardian?

A. Never.

Q. In what situations do you provide gender-affirming medical care to one of your patients under 18 without the assent of the patient?

A. Never.

Q. And you mentioned SB 14 already. How are -- how would SB 14 affect your ability to practice medicine if it were to go into effect?

A. To practice the medicine for transgender patients?

Q. Yes.

A. It would halt that care completely.

Q. In your view, how does SB 14 comport with medical standards of care for transgender youth?

MR. STONE: Your Honor, this is not an expert witness. They're asking him for his -- to provide a medical opinion to the Court that I think is more properly an expert witness opinion. Like I said earlier -- it's a similar objection that I had with the last witness. Under 701, he can talk about his personal perceptions, but he's not qualified and has not been proven up or proffered as an expert in this case.

MS. POLLARD: May I respond, Your Honor?

THE COURT: If you can rephrase, I think that would be fine.

MS. POLLARD: Great.

THE COURT: Okay.

Q. (BY MS. POLLARD) Dr. Bond, in your view, how does SB 14 comport with how you view the med- -- your medical obligations?

A. Well, I feel that both puberty suppression and hormone replacement therapy for this population of youth, this vulnerable population, is well established in standard of care. It has been reviewed extensively by --

MR. STONE: Objection, Your Honor. Now we're going into the standard of care and his belief about the standard of care. He has not been proven up as an expert to talk about the standard of care. I think this is beyond the scope of what he can testify to as a fact witness.

THE COURT: Do you have a response?

MS. POLLARD: He's talking about his own view of medicine that he practices regularly as he's already seen and how it impacts his practice and his view of his own professional obligations. It's very specific to the doctor himself.

THE COURT: Right. So I'm going to

overrule the objection. I realize -- I don't necessarily need the expert designation under 701. He's a doctor. So if he -- he can testify about his understanding.

But that's where we need to limit it, to what your understanding is and how it affects your patient care.

THE WITNESS: Yes.

THE COURT: Okay.

THE WITNESS: Yes, Your Honor.

A. Probably -- to be short, it's established care all over the country, around the world. There's data to support it. There's science to support it. There's outcomes to support it. That I have seen in my personal practice in particular, across the board my patients have done profoundly well and have had no adverse side effects.

This bill -- this law will strip me of providing this standard of care consensus-approved treatment from 20 U.S. medical organizations, remove my ability to provide that care. It's the only care in my practice that is being removed. It is not being removed -- I have colleagues around the country who provide the same care under the same training --

MR. STONE: Objection, Your Honor. Now

he's -- again, he's talking about colleagues around the country and what other people are doing. This just is not limited to him.

THE COURT: Okay. I'll sustain that. Let's go ahead and ask the next question, please.

MS. POLLARD: Your Honor, to clarify, are you sustaining the objection only with respect to the last portion of the answer where he said colleagues around the country?

THE COURT: Correct. And remember, there's not a jury here, so I know what to do.

MS. POLLARD: Thank you, Your Honor. I was hoping it might encourage others in their propensity for interrupting my questions and the witness' answers.

THE COURT: That's all right. Go ahead to the next question, please.

Q. (BY MS. POLLARD) Have any of your patients or their families expressed concerns to you about SB 14?

A. Yes, many.

Q. What are those concerns?

A. That after all this time of receiving the care and seeing the positive outcomes for their children, they're going to lose this care, and they just don't know what to do. They don't know where to go. They can't get this care in the state of Texas, so I feel

that I am having to abandon them. And under the ethics of abandonment, I have to make sure they can get care elsewhere, but they actually can't get care elsewhere because the whole state of Texas will be banned.

So they're fearful. The anxiety levels are profound. And they're having to figure out how they're going to change schooling and jobs and whatnot in order to get this care if they can get this care. Some of them are worried about the concept of having to cross the border, which, of course, Texas is close to Mexico, where that care can be available. It's a rather dangerous undertaking, but some people are feeling that's the only place they can go.

Q. And are you concerned about the effect on transgender adolescents if SB 14 goes into effect?

A. I'm very concerned about the deterioration of their mental and their physical health and their social interactions and their achievements, yes.

Q. Do you think that the SB 14 weaning provision will mitigate the harm of withdrawing that care?

A. It'll worsen it. There is no such thing as weaning in the healthcare provision for this population. There's no guideline. There's no studies. There's no science. You can't even wean GnRH agonists to suppress puberty. It's an on or off treatment. The only way

that the SB 14 says for me in my private practice -- in my practice to wean them is if it's safe and medically appropriate, and yet there's no science or publication or guideline to say how to do that. The only way I could do that would be to ask the parent: How's it going with this weaning? Is it working out for you? Is it showing positive outcomes towards your child's health to wean them off therapy? This is as I think through what's going to happen, and it has no rationale to it whatsoever.

Q. What are your under- -- what is your understanding --

A. In fact, can I say one more?

Q. Absolutely.

A. The reason that was put in there is because the State recognizes there's dangers to stopping this medication, and they recognize that there's a section of the population on this care --

MR. STONE: Objection, Your Honor. This witness does not have -- they have not established --

THE COURT: Okay. Just make the objection, Mr. Stone, and I'll rule.

MR. STONE: Lack of personal knowledge.

THE COURT: All right. Thank you. Objection sustained. If you can ask a different

question.

Q. (BY MS. POLLARD) As a pediatrician who's practiced for 40 years, how do you feel about the possibility that the law might prevent you from providing gender-affirming medical care for your transgender patients?

A. How do I personally feel?

Q. How do you personally feel?

A. Well, I personally feel about as angry as I've ever felt. Sad. Bewildered. Although I fully see this type of behavior towards the LGBTQ+ community around the world, so it's not like I don't realize what's happening, but I'm still bewildered. I don't understand why these vulnerable children can't be left to be themselves. Anxious. Worried. I've lost one child that I took care of who was transgender. I don't want any other child to even have a detriment in their life story going forward, much less to lose them from this planet.

Q. Thank you very much, Dr. Paul.

MS. POLLARD: I'll pass the witness.

THE COURT: Mr. Stone, any cross-examination?

MR. STONE: No questions, Your Honor. Thank you.

THE COURT: All right. Thank you. Dr. Paul, you're excused from the witness stand. Thank you.

All right. Where to next? Oh, wait. Let me see. Yeah, where to next?

MS. POLLARD: All right. Plaintiffs call Alex Sheldon.

THE COURT: All right. Please step forward and raise your hand.

(Witness sworn)

THE COURT: All right. Go ahead and make your way up to the witness stand.

ALEX SHELDON,

having been first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MS. POLLARD:

A. Can you hear me okay?

Q. I can.

A. Great.

Q. Mx. Sheldon, would you please state your name for the record?

A. Yes. It's Alex Sheldon, and I use they/them pronouns.

Q. Mx. Sheldon, where are you currently employed?

A. I work at GLMA.

Q. And is GLMA a plaintiff in this case?
A. Yes, we are.
Q. And is GLMA bringing this case on behalf of its members?
A. Yes, we are.
Q. What is your role at GLMA?
A. I am the executive director.
Q. And how long have you held that role?
A. Just about a year now.
Q. And what are your responsibilities as the executive director at GLMA?
A. I set the strategy for the organization in accordance with our mission. I oversee our day-to-day operations. I manage our staff. I am the key liaison to our board of directors. And I have general budgetary and fiscal oversight.
Q. What is GLMA?
A. We are the oldest and largest association of LGBTQ+ and allied health professionals in the country.
Q. And what is GLMA's mission?
A. Our mission is dual-fold. We both advocate to advance LGBTQ+ health equity, and we promote equality for LGBTQ+ and allied health professionals in their work and educational institutions.
Q. As executive director, is it part of your job

to ensure that GLMA achieves its mission?

A. It sure is.

Q. How does GLMA work to achieve its mission?

A. We work through research, advocacy, and education, but our main role is to bring to bear the vast expertise of our multidisciplinary health professional membership in each of those areas.

Q. As the executive director, do you make decisions about whether GLMA participates in litigation?

A. Yes.

Q. And did you make that decision for this case?

A. I did, yes.

Q. And why did you decide that GLMA would participate in this case?

A. Well, as an LGBTQ+ health equity organization, it's incumbent on us and me in particular to stay abreast of the political landscape that governs care, the provision of healthcare for the LGBTQ+ community. And when we heard that this harmful legislation was moving forward in Texas, and elsewhere but in Texas, we knew that, one, it would potentially restrict access to care for trans young people in the state; and not only that, that it would tie the hands of our health professional members. They would either be forced to comply with the law and therefore abandon care and

endanger the lives of their patients like our members have attested to so far, or they would -- if they chose to continue to act in accordance with their extensive training and with evidence-based care and continue that care for young people, they would potentially risk losing their medical licenses or risk other disciplinary actions. So we knew that it would drastically undermine their medical expertise, their professional ethical obligations as well as their occupational freedom, so we felt compelled to act.

Q. And why does GLMA support access to gender-affirming medical care for minors?

A. We support access to care because we know that it is evidence-based lifesaving care, and we act in accordance with the expertise of our medical membership.

Q. And I'm going to move to a different topic for a moment. Does GLMA have bylaws?

A. We do.

Q. All right. I'd like to show you what has been marked as Plaintiffs' Exhibit 2. As the executive director, are you familiar with GLMA's bylaws?

A. Sorry. Just one second. Yes, I am.

Q. And does this appear to be -- does Exhibit 2 appear to be a true and correct copy of GLMA's bylaws?

A. Yes, it does.

Q. And does this appear to be the most recent version of your bylaws?

A. Indeed it does.

Q. Those are all of the questions I have about that document.

Is GLMA a membership organization?

A. Yes, we are.

Q. How do people become members of GLMA?

A. Through a membership form that is online -- excuse me -- and by paying membership dues.

Q. Who can be a member of GLMA?

A. Anyone can be a member of GLMA, but we mostly have members who are health professionals, and we also have a designation for members who are LGBTQ+ health equity supporters.

Q. How many members does GLMA currently have?

A. Just about 1,000 members nationwide.

Q. And what is the role of members within GLMA's organization?

A. As I said, our members bring to bear their vast expertise in health profession -- health professions and our research, advocacy, and education initiatives, but their role primarily is to advance our mission through their own work and to -- they can cast an advisory vote to inform our strategy. And also they contribute to our

annual conference through submitting sessions for educational purposes.

Q. And is the role of members addressed within GLMA's bylaws?

A. It is, yes.

Q. Does GLMA have members who work in Texas?

A. Yes, we do.

Q. Do any of your Texas members currently provide gender-affirming medical care for minors?

A. Yes, they do.

Q. And does that include the three physician plaintiffs in this case?

A. Yes. Dr. Paul, Dr. Roberts, and Dr. O'Malley.

Q. As executive director, are there ways that you keep up with what the GLMA members are experiencing?

A. Yeah, absolutely. Well, first, we -- I'm very accessible to our members through our annual conference as well as other ways in which I interact with our members very, very often. And also, since some of this legislation has moved forward, we have started to convene gender-affirming care providers from throughout the country on a biweekly basis virtually, and that also includes members in Texas.

Q. If SB 14 is allowed to go into effect, how would it impact GLMA members providing gender-affirming

medical care to youth in Texas?

A. I think it would have a devastating effect. From what we've heard already from testimony today, it would put -- it would truly tie the hands of our health professional membership. They really would be putting their medical licenses on the line in order to save the lives of their patients. And as folks have attested to today, they got into these provisions to help people and to save lives. And if they can't do that, then they are no longer fulfilling their professional obligation. And many of them have said that they might be forced to leave the state and practice elsewhere.

Q. Thank you very much.

A. Thank you.

MS. POLLARD: Pass the witness.

THE COURT: Thank you. Any questions?

MS. DYER: No questions.

THE COURT: All right. Thank you. You may be excused from the witness stand.

Uh-oh. Did we break it?

MS. WOOTEN: Sorry, Your Honor.

THE COURT: That's okay.

MS. WOOTEN: Are you ready for the next witness or would you like to take a break?

THE COURT: Well, let me check in with

Ms. Crain.

THE REPORTER: We can go a little bit longer.

THE COURT: I try to make it at least till 3:10 or 3:15 so that our afternoon isn't too long. So I'd say let's get started.

MS. WOOTEN: Thank you, Your Honor. The next witness plaintiffs are going to call is Sarah Soe.

THE COURT: All right. Thank you.

MR. STONE: Your Honor, I believe this is their last witness for today. So I just wanted to let you know that we are trying to reach one of our witnesses to see if we can get them here in time to be able to keep going potentially this afternoon if that's okay.

MS. WOOTEN: Yes. And Your Honor, we're also trying to reach one of our witnesses to see if it's at all possible to get that witness here.

THE COURT: Okay.

MS. WOOTEN: So perhaps we'll confer during the break.

THE COURT: That should work out perfectly. Thank you.

MS. LESKIN: And Your Honor, Ms. Soe is also a plaintiff proceeding under pseudonym.

THE COURT: Understood. Thank you.

Hello. Come on up here and I'll swear you in before you take the witness stand. If you'll raise your right hand for me.

(Witness sworn)

THE COURT: You can make your way around and up to this witness chair.

SARAH SOE,

having been first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MS. LESKIN:

Q. Can you tell us your name, Ms. Soe?

A. Yes. Sarah Soe.

Q. And Ms. Soe, you live in Texas?

A. Yes.

Q. What county do you live in?

A. Hays County.

Q. Are you a member of PFLAG?

A. Yes, I am.

Q. Tell us a little bit about your family.

A. Well, there's me. There's my husband, Steven. And we've been married 18 years. There's my older daughter and a younger daughter, so Stephanie and Samantha.

Q. And we're here today to talk a little bit about

Samantha. So can you tell us a little bit about her?

A. Yeah. She's -- she's a really bright kid. She's played soccer for a number of years, loves soccer, learning how to play guitar, likes to read, a pretty good student, loves choir and really doing really well in choir.

Q. How old is Samantha?

A. 15.

Q. What sex was Samantha assigned at birth?

A. Male.

Q. And what gender does Samantha identify with today?

A. Female.

Q. How did you learn that Samantha identifies as female?

A. Well, so a number of years ago, probably like when Samantha was around like fifth, sixth grade, she had been crying herself to sleep every night pretty -- pretty much not -- we didn't really know why. She just wasn't really talking about it. And I usually would go in to tuck her into bed, and I would just sit on the bed and we'd talk, and -- and one night she said to me, "Mom, I think I'm transgender." And -- yeah. So I just -- you know, that's when.

Q. And what was your reaction when Samantha told

you she thought she was transgender?

A. I -- I said I love you. I -- I think I just -- just wanted her to know that I'm -- I'm there. I'm always going to be her mom. And so I just said, okay, well, you know, you're young, so you have lots of time to think about, you know, who you're going to be and things like that. So -- so I just kind of tried to reassure her that, you know, I'm there for her and that it's okay.

Q. Did you make any -- take any steps to talk to any of Samantha's medical providers?

A. Oh. Well, so after -- after Samantha first told me, then we -- Samantha, you know, told my husband, and I asked Samantha before her wellness check, her annual wellness check that she does on her birthday -- I asked would she feel comfortable talking to our family pediatrician about -- about how she's feeling about her gender. And the pediatrician -- Samantha said yes, she felt comfortable. So we talked to the pediatrician about that. And the pediatrician did ask like, you know, do you feel like you need a referral to a specialist or anything at this time? And Samantha said she did not feel like she needed to. And so -- and so we just -- you know, we let it -- we let that sit. And she -- over the next -- course of the next year, we --

she did say at that point, at the next year's wellness check, that she did feel like she would like to speak to someone else about how she was feeling.

Q. So I want to just talk a little bit about that one-year time period then. Samantha told you she didn't want to go see a specialist at that time. Did you do anything as a family to support her in her gender identity?

A. Yes. So she had told us that she wanted us to use a new name, a female name, and so we started to do that in our household. We told -- she wanted to tell her schoolteachers and, of course, we supported what she had to say. And she started using a new gender. She -- the female and non-binary kind of gender so that she -- she was kind of in a transition I think.

And we -- we actually -- because she had been crying, you know, before, we -- we took her to a therapist. She was starting to get counseling just to have someone to talk to. The school -- we also talked with the school counselor, and the school counselor talked to our -- meanwhile we had done a bunch of research -- right? -- on our own, just reading everything we could to try and educate ourselves about how to support our child. And that was helpful I think for us, but she was seeming more and more depressed.

She was becoming more withdrawn. And so she quit playing soccer, which had been with a boys team.

And so one day actually -- I'm very close to her, and I felt like something didn't feel right. She had been feeling sad and not really engaging very much. And I had a bad feeling, you know, like when you're -- you just have not a good feeling in your heart about what's -- how things feel. And she went to school. She was very quiet. And I was about to head off to work, but I asked my husband could he give the school a call, you know, just to have the school counselor just check in on her because we had already been in touch with the counselor a lot. So my husband did. And this was like still in the morning. And as he was on the phone with the school counselor, the school counselor got an alert, a red flag alert on her computer that said that my child Samantha's computer alerted them because she had been searching how to kill yourself.

So -- so I didn't go to work and I went to my child's school and I got her. And we -- you know, after we talked with the counselor and the counselor was like, okay, you -- like, do you have a -- do you have a plan? And like, is it okay for us to release you? My child and I went home together, and we just talked and we talked. And I think at that point I kind of knew

things probably needed to change, that we couldn't really keep going on like this. Things felt like they were getting worse for her.

Q. As her -- as her mom, were you scared for her?

A. Oh, yeah. Yeah, no, I mean, I could see in my child's eyes that things were not right. And yeah, I was scared for her.

Q. What was the next step that you took? You said things had to change, so what did you do?

A. Well, we actually -- we went back to our pediatrician, and she suggested we go have our daughter see a psychiatrist, so we found a psychiatrist, and our daughter started going to the psychiatrist. And then at the next -- and she started taking some antidepressants and doing talk therapy. And then at the next wellness check, which was, you know, a year later, I guess, I asked my child -- and the doctor asked the child, like, you know, would you like a referral, I guess following up, and we said yes. Yeah. And we talked about that as a family. We kind of had done our own research, so we kind of knew that that was possibly what might happen, but yes, we said yes, please do give us a referral.

Q. Before you got that referral, you mentioned that Samantha had started talk therapy and I think you said antidepressants.

A. Yes.
Q. Did that help?
A. I think it -- it might have helped a little bit, I think probably, but it I guess brought home to me just how serious things were.
Q. Did you meet with a specialist?
A. Yes. It took a while because there was -- I think it was like three or four months before we could get in. So, you know, we did meet with a specialist. The specialist was really, really nice. She spent more than an hour with us just getting to know our child and finding about their history and things like that. And she told us what some of the risks were, which we kind of knew, you know, that there could be some impacts like bone loss, bone density loss potentially for certain things. Yeah.
Q. Let me just stop you one second. When you say risks, risks of what?
A. Oh, okay. So -- yeah. So we talked about options for, like, how to treat gender dysphoria, which is -- which is what our child was diagnosed with. And -- and one of the options that the doctor laid out for us was that before we would do any kind of hormonal sort of treatment, which my child was sort of asking about, that really at this time we would put a pause.

And so she suggested puberty blockers as a temporary kind of let's kind of see how things go kind of measure and explained to us what a course of treatment may look like, you know, given how -- our daughter's own particular case. And because our child had had some mental health challenges, you know, she had said we really want to give you lots of time to meet with your therapist and try to make sure that you are healthy. And so -- so we -- we -- we did start the puberty blockers fairly soon. Our child had entered puberty, and so that was sort of time to sort of give her time to kind of think about things and us.

Q. And did you see an impact on Samantha after she started puberty blockers?

A. Yeah. I think she felt -- I think she felt better. I think she was doing a little better at school and doing better, like, with her friends and things. Things were -- were a little bit better. She wasn't crying at night anymore. But -- and her mental health was sort of stabilizing, and we didn't have some of the other scares that we had had.

Q. And you mentioned that the next step would be hormone therapy. Did you have conversations -- at what point did you have conversations with your doctor about hormone therapy?

A. I think in the initial consultation when we talked about gender dysphoria, she mentioned that that was one of the treatments that they do eventually offer. It wasn't something that we were necessarily going to do right away. We knew that. But -- yeah, I'm trying to think back here. I think she -- she mentioned it, but it was my child really who had mentioned it a few different times. And so my child had asked her doctor about it and the doctor responded.

Q. How long was it before -- from the time that Samantha first told you she identified as a girl until you started her on puberty blockers?

A. I think it had to have been probably two years I'm going to say.

Q. And then how -- at some point did you start her on hormone therapy?

A. Yes, we did. We started a little more than a year after starting the puberty blockers.

Q. Did you see any change in Samantha's mental health after she started the hormone therapy?

A. Yeah. So --

Q. What did you see?

A. Well, it was -- it was good. So she -- she started to -- she had been starting to make some new friends in choir, which was the treble choir, and she

just kind of felt really good about being in there, included. She, like, just started smiling more and seeming more open and outgoing. She found some friends who were accepting. And she had some teachers who were also accepting that I think made her feel safe and cared for. And yeah, she -- she stopped crying at night and I think just seemed a lot happier.

Q. You mentioned the conversations with your doctors about starting hormone therapy. Was the decision to start Samantha on hormone therapy an easy one for you?

A. So that's like -- so that's an easy and a hard question. So it was hard because the doctor did say, you know, there are some risks like -- like what I mentioned, the bone density loss, or potential infertility. There are some, like, potential negatives. But it was also not a hard decision because I felt like my child's life was in danger. And my job as a parent -- as a mom, but as a parent probably -- is to keep my child safe, and I would do anything to keep my child safe.

And our child was, you know, talking about threats of suicide, was cutting herself on her leg with razors. If -- if she was not moving in the right direction, if she was starting to move in the wrong

direction, I think I would be very afraid that she would be at risk for suicide. So seeing how positively she responded to having a body that was trying to look like she felt like she was, that meant a lot to me, and I -- what matters most to me is keeping my child safe.

Q. What concerns do you have if SB 14 goes into effect?

A. I -- well, I made a promise to my child that I would keep her safe no matter what. So I will -- I will do what I need to do as a mom to keep my child safe. I will take my child out of state if I need to. If I have to pay an exorbitant amount out of pocket for the medical care that she needs, which is -- which is the standard of care, I will do those things, and I will find a way, because that's my job, is to keep my child safe. I think if her medical care was taken from her, I would be afraid that she would kill herself.

Q. You mentioned that you would take your child out of state. Is your desire to stay in Texas?

A. Yes. So I own a home here with my -- with my husband, and we both have jobs here in Texas. And my job is the job I expect to retire with. So I have no intention of leaving. I have eight chickens at home and five cats and two dogs, and, you know, I have citrus trees in my backyard, and I don't want to leave any of

them. But, you know, I'll leave my chickens behind if it takes -- if it means helping my child.

MS. LESKIN: Pass the witness, Your Honor.

THE COURT: Any questions for this witness?

MS. DYER: No questions.

THE COURT: All right. Thank you.

Thank you. Your time on the stand is done, and you can head back out to that door.

We're going to take our afternoon break. And if we can be back by 3:35, we'll resume then at that time. And just in case -- I forgot to mention earlier, if there's anybody new in the gallery, there's no recording, broadcasting, or photography, so please keep that in mind. All right. We're on break.

(Recess taken)

THE COURT: And who do you officially call?

MS. WOOTEN: Your Honor, we call Mary Moe.

THE COURT: Okay.

MS. WOOTEN: And if the Court will allow, we would be grateful for a time check before her testimony begins.

THE COURT: Sure. Give me one second. Two hours and 28 minutes remaining for the plaintiff.

And I guess on the defense there's just been about 11 additional minutes used, so I'll have -- I can update that I think later today.

MS. WOOTEN: Thank you, Your Honor.

THE COURT: Okay. I take that back. I forgot to add the last 15 minutes from the past witness. Let's see. So about two hours and ten minutes.

MS. WOOTEN: Thank you, Your Honor.

MS. LESKIN: And, Your Honor, Ms. Moe is also a plaintiff proceeding under pseudonym.

THE COURT: Correct. Thank you.

If you can step forward here, I'll swear you in before you take the stand. If you will raise your right hand for me.

(Witness sworn)

THE COURT: You can make your way around there and up to this chair. There's water there. And it's good to be about five or six inches from the mic.

MS. LESKIN: May I proceed, Your Honor?

THE COURT: Yes. Please go ahead.

MS. LESKIN: Thank you.

MARY MOE,

having been first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MS. LESKIN:

Q. Can you introduce yourself to us, please?
A. Yes, ma'am. My name is Mary Moe.
Q. Ms. Moe, do you live in Texas?
A. I'm in transition right now. I have a house in Montgomery County that I would like to return to.
Q. And we'll talk a little bit more about that. Are you a member of PFLAG?
A. Yes, ma'am.
Q. Tell me about your family.
A. My husband, Matthew, and I have been married for 10 years. We have two beautiful children, one precious little trans girl and one cis boy.
Q. And we're here, as you know, to talk about your daughter.
A. Yes.
Q. And her name is Maeve?
A. Maeve.
Q. Tell us a little bit about Maeve.
A. Oh, Maeve is bright. Since the time she was born, she loved dancing. She loved twirling. She has a love for learning, extremely intelligent. By the time she was 18 months she was doing sight words already. So prior to kindergarten we had her tested to see where she was academically because she was just excelling in every aspect, and at that point she was reading at a third

grade level.

Q. And how old is Maeve now?

A. Maeve is nine, about to be ten. She would prefer that I tell people that she's ten because she's --

Q. Almost ten.

A. She's reached the mark. Yes.

Q. And what sex was Maeve assigned at birth?

A. Maeve was assigned male at birth.

Q. And what gender does Maeve identify as today?

A. Maeve identifies as a girl.

Q. When did Maeve tell you that she identified as a girl?

A. By the time she could talk, she showed a preference for feminine things. We tried to pump the brakes as much as we could. And whenever we were pumping the brake, she would make statements like, "Will I ever like girl things -- or "Will I ever like boy things?" So it wasn't that she necessarily said I'm a girl, but there were so many things that happened along that journey over time that pointed us in that direction.

Q. And did there come a time when Maeve actually told you she was a girl?

A. She said she would -- she -- she has reached

that point, absolutely. But she was really young whenever she started to transition, and so she would say I like girly things, I'm a girl, I'm a girl -- I don't know the exact words that she would use whenever she first -- whenever we first discovered that she was trans, because it was more like I like girly things, I like hanging out with my friends, because she always hung out with the girls. She would put shirts on her hair to make long hair.

Q. Did there come a time when you thought it was -- you saw it was more than just preferring girl things and more that she identified as a girl?

A. Yes.

Q. And how did that come to pass?

A. We went through a really rough -- rough period where she was starting to lose sleep at night. She was begging and pleading, Will I ever like boy things? Will I ever fit in with the boys? One day I'll like boy things. But she kept on getting disappointed whenever it didn't happen. She started avoiding eye contact with people. She started biting her nails till they bled. And her love of learning just plummeted. Her love of learning -- she would just say I don't care. And it seemed like we weren't listening to her, so why -- why the hell was she going to listen to us on some of these

things?

Q. Did there come a time when you accepted that she was a girl?

A. Yes.

Q. When that was?

A. It's been a process. It wasn't -- it wasn't overnight. I mean, it started out with getting pink socks, and it progressed into me and my husband debating for six months on the back porch if we were going to get her a pink bike because we were worried about bullies.

Q. When you -- did you buy Maeve that pink bike?

A. Yes.

Q. How did she react when you got that pink bike for her?

A. She lit up. She lit up. She just sparkled.

Q. How else did you continue to support her as she was working this through?

A. Whenever she started biting her nails and losing sleep and -- you know, this was going on for weeks at this point. I decided to talk to her pediatrician as well as I sought counseling for her.

Q. And what did the doctors tell you?

A. The doctors described a situation called gender dysphoria and encouraged me to look into it a little bit more.

Q. And how old was Maeve at that point?
A. She was about five.
Q. Did you look into gender dysphoria more?
A. Absolutely.
Q. How did you do that?
A. I started researching wherever I could, whatever I could get my hands on essentially. And I was very cautious on what sources I was getting my information from because there was a lot of misinformation out there. It was a very confusing situation, so talking to the professionals and reaching out to friends and family that have medical background to add some additional guidance was incredibly helpful.
Q. At some point was Maeve diagnosed with gender dysphoria?
A. Yes.
Q. And who made that diagnosis?
A. She has that diagnosis from a therapist as well as from a doctor.
Q. Have you ever attempted to investigate medical treatment for Maeve to treat her gender dysphoria?
A. We've looked into our options, but we're not there yet.
Q. So Maeve has not yet received medical treatment?

A. No.

Q. What have you done to support Maeve and her gender dysphoria?

A. To support Maeve, I have let her grow her hair out. I've let her wear what she's comfortable in. I let her present herself how she feels. We do touch base with a gender doctor because her dysphoria creeps up at times. She's starting to see her body change, and it makes her very uncomfortable, and we go back to those sleepness nights whenever she's seeing those changes. Did I answer the question?

Q. Yeah.

A. Okay.

Q. You said that her dysphoria creeps up. What is she seeing that's causing her dysphoria to creep up?

A. She has recently started getting some hair under her armpit, and it makes her uncomfortable the more -- the longer it grows.

Q. Have you talked with Maeve about the potential for medical treatment?

A. Yes.

Q. And tell me about those conversations with Maeve.

A. I have explained that there are -- there's medicine out there that can just pause puberty to buy us

some more time, because if -- if she goes through a testosterone journey in puberty, she will develop facial hair. She'll get that Adam's apple. She'll get chest hair. And at this point those ideas are absolutely terrifying to Maeve.

Q. How so?

A. She starts -- if she starts seeing her body change in these ways, that's all she can see. All she can see is gender. She forgets to look at her books and focus on her friends and her love of learning.

Q. When you and people around you treat Maeve as the little girl that she is, how does she react?

A. She flourishes. She eats it up. She soaks it in.

Q. You mentioned that you have not yet started medical care for Maeve, but you've talked to the doctors about it?

A. Briefly. Briefly.

Q. And is there a reason you haven't started medical treatment yet?

A. We're just not there. She has not reached Tanner 2 at this point.

Q. So as of right now, how does SB 14 affect you and your family?

A. Oh. SB 14 prevents Maeve from going to the

doctor whenever she needs to just to check how her body's changing, to have a conversation with the doctor to ease her anxiety.

Q. Have doctors told you that, that they wouldn't treat her and her gender dysphoria --

A. Yes.

Q. -- here in Texas?

A. Yes.

Q. What has your family done to prepare in case SB 14 goes into effect?

A. A week ago, two weeks ago, I relocated with my children out of state, and my husband is still down here.

Q. And what was the purpose of relocating out of state?

A. So that my child can go to the doctor and talk about whatever she feels the need to have a conversation with her doctor about.

Q. Is it your desire to return to Texas?

A. I would like to. I grew up here. I have family. We have family. We have friends, the kids, their neighborhood. I sat there and held my little boy last night as he was crying because we don't live in a big neighborhood where he can ride his bike anymore. Yeah, I would like to return to Texas, but Texas has

become very ugly towards me and my family.

Q. You said that you relocated with your children. Where is your husband?

A. My husband is still in our home in Montgomery.

Q. And how has that separation impacted your family?

A. It sucks. It absolutely sucks. We are a family that sits down to dinner four times a week. My husband is the Cub Scout leader of my little boy's Cub Scout group. Going to Cub Scouts with mom is not going to be the same. I have not been away from my husband this long since we got married. He's my best friend. I got married because I wanted to do this together with him, and now I feel divided because I've got to protect my children and put their emotional, physical, and mental health first and foremost.

Q. You said you left Texas at least temporarily to allow Maeve to be able to talk to her doctor.

A. Uh-huh.

Q. What is your concern if Maeve is not able to get medical treatment, to get puberty blockers at the appropriate time?

A. As I've said before, you know, whenever her body's changing and she is not able to talk to doctors about what's going on with her body, gender becomes the

forefront and everything else goes to the side. And I just want her to be a kid. My husband and I both want -- just want her to be a kid.

MS. LESKIN: Pass the witness, Your Honor.

THE COURT: Any questions for this witness?

MS. DYER: No questions.

THE COURT: All right. Thank you, Ms. Moe. Your time on the stand is done. And you may exit back through that door. Thank you.

All right. So is it my understanding that at this time we'll have a witness out of order?

MR. ELDRED: Yes.

THE COURT: All right. And who would that be, Mr. Eldred?

MR. ELDRED: Dr. Colin Wright.

THE COURT: Okay. Dr. Wright, if you will step forward, I will swear you in.

(Witness sworn)

THE COURT: All right. You can make your way around and up to the witness stand.

Go ahead.

MR. ELDRED: Thank you, Your Honor.

COLIN WRIGHT,

having been first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. ELDRED:

Q. Will you please state and spell your name?

A. My name is Colin Wright, C-o-l-i-n, W-r-i-g-h-t.

Q. What is your profession?

A. I'm an evolutionary biologist, and I'm a fellow at the Manhattan Institute.

Q. What is an evolutionary biologist?

A. It's somebody who studies how life evolved over the planet from simple beginnings to the diversity of life we have today.

Q. And what is your academic background?

A. So I'm specialized as an evolutionary behavioral ecologist. I study the evolutionary significance of behavior. I have over 30 papers published on this topic. One component of education that's involved in that is having a firm grounding in biological sex because this is the sort of underpinning for some of the largest sex differences we see in nature in terms of behavior. And I've also been publishing articles in medical journals on the biology of sex and in peer-reviewed academic books.

Q. What degrees do you hold?

A. I have a Ph.D. in evolutionary biology from

UC Santa Barbara and then a bachelor's of science in evolution, ecology, and biodiversity from UC Davis.

Q. Do you have any postdoctorate work?

A. I do. I spent two years as an Eberly research fellow at Penn State.

Q. What did you study there?

A. I studied evolutionary behavioral ecology of social insects.

Q. And where do you work now?

A. I'm currently at the Manhattan Institute.

Q. Have you ever testified as an expert before?

A. No.

Q. Are you familiar from your -- pardon me. From your knowledge, experience, training, and education, are you familiar with the concept of biology of the male and female sex?

A. Very familiar.

Q. And we may have gone over this a little bit already, but just explain your education and training that makes you familiar with that concept.

A. Yes. So it's a foundational concept in my field of evolutionary behavioral ecology. If you're studying the evolutionary significance of behavior, one of the main things you're going to want to look at is what males and females are and have a knowledge about

what that is across a broad spectrum of species because that's going to help you design experiments, to execute them, and ensure that you're not confusing certain individuals for others when you're formulating your hypotheses and testing ideas, then just sort of an academic understanding of biology of sex and how this applies universally across the entire plant and animal kingdom.

Q. And tell us a little bit -- have you published in the biology -- have you published on the biology of male and female sex?

A. I have, for medical journals and in an academic textbook.

Q. And just give us a taste of about how many articles and what they've been about.

A. So I have an article in the *Irish Journal of Medicine*, and this is just outlining what the biological basis of male and females are, their gametes, the type of gamete they produce. And then I have an academic chapter in a book by the academic publisher Routledge, so it's peer-reviewed book chapter. And this just gives a very broad overview of what biological sex is, you know, universally, how humans developed, what sex is in humans, and then sort of going through a lot of common misconceptions about biology of sex and why they

don't hold -- hold weight.

Q. Have you given any presentations on the subject of male and female biological sex?

A. I have at conferences and summits and some universities.

Q. Have you formed any research yourself on the biology of male and female sex?

A. Not active research on it, but it's definitely a component of, you know, my background knowledge for when I'm designing experiments on any organism. I think it's relevant the fact that, you know, biological sex is defined the same way across all of life, whether it's plants or animals. And so having specific research in, say, human sex isn't going to give you any more insight into what sex is than if you're studying things like ants or wasps or any other animal that has males and females.

MR. ELDRED: Your Honor, his CV has already been admitted as Exhibit 4.

THE COURT: All right. Thank you.

MR. ELDRED: And we'd like to offer him at this time as an expert on the subject of biological sex.

THE COURT: Any objection?

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

THE COURT: That will be allowed.

VOIR DIRE EXAMINATION

BY MR. GONZALEZ-PAGAN:

Q. Dr. Wright, you mentioned your degrees are in evolutionary biology; is that right?

A. Yeah, evolution, ecology, and biodiversity and then evolution, ecology, and marine biology at Santa Barbara.

Q. And following your studies and your two-year postdoctoral fellowship, you have not worked in academia; correct?

A. I left formally academia in 2020, but I've been publishing as an independent scholar.

Q. You obtained your Ph.D. in 2018; is that correct?

A. Yes.

Q. And following your studies and two-year postdoctoral fellowship which ended in 2020, you have not conducted any original research; is that right?

A. I've written academic papers that are in peer-reviewed journals about the topic of what biological sex is.

Q. You referred to one article in a peer-reviewed journal and you said it was the *Irish Journal of Medicine*; is that correct?

A. I believe that's the title of the journal, yeah.

Q. Yeah. That was a -- that was a letter to the editor with one citation; is that right?

A. Yes.

Q. Okay. So it wasn't an original article of research, and it wasn't peer-reviewed; is that correct?

A. It was peer-reviewed. It's a peer-reviewed journal.

Q. Are letters to the editor peer-reviewed?

A. Yes.

Q. You're not a medical doctor; right?

A. I am not.

Q. You're not a mental health professional?

A. Nope.

Q. And you provide no healthcare services of any kind?

A. I do not.

Q. All of your original peer-reviewed publications relate to the study of insects and other arthropods; is that correct?

A. That is correct, but as far as it pertains to the biology of sex. Again, sex is defined the same way across all of life, so I could be a botanist and it would still be as relevant.

Q. Sure. You have no peer-reviewed publications relating to gender dysphoria aside from this one letter to the editor?

A. No, that is not my field. It is not in gender dysphoria.

Q. You have no peer-reviewed publications relating to transgender people?

A. That's not my area of expertise and not why I'm here.

Q. And you have conducted no original research relating to gender dysphoria; is that right?

A. That's correct.

Q. And no original research relating to transgender people?

A. That's correct.

Q. And there are species that change sex; is that correct?

A. There are some, yes.

MR. GONZALEZ-PAGAN: Your Honor, at this time -- Your Honor, at this time we would object to this witness. We don't understand the relevance of this witness.

THE COURT: Well, let me ask, Mr. Eldred -- so I tried to look back. It's an expert on biological sex?

MR. ELDRED: Yes, Your Honor. We think it's -- under Rule 702, it's a -- he's qualified as an expert in knowledge, skill, experience, training, or education in that topic, and it's useful to you because biological sex is mentioned in the statute. And again, he's not going to be testifying about things like gender dysphoria, just describe what biological sex is, which I think is important to understand to understand how the statute works.

THE COURT: And as I understood it, Dr. Wright, it's a Ph.D. in evolutionary biology and a bachelor of science in evolution ecology? Did I get that right?

THE WITNESS: So the Ph.D. -- it's a long title. The Ph.D. is in evolution, ecology, and marine biology. And then my BS is evolution, ecology, and biodiversity.

THE COURT: I'm going to allow the designation of this expert. You can continue your examination, Mr. Eldred.

MR. ELDRED: Thank you.

CONTINUED DIRECT EXAMINATION

BY MR. ELDRED:

Q. What is biological sex?

A. So at root, biological sex refers to the type

of reproductive strategy that an individual has. So in what are called anisogamous species, these are species that reproduce by fusing two gametes of different sizes. The individual that produces the larger-sized gamete is called the female. The one who produces the smaller gamete or sperm is called the male. This is fundamentally what biological sex means. It refers to these reproductive strategies rooted in the type of gamete that they have the function to produce.

Q. Would you say that biological sex is binary?

A. Biological sex is binary because there are only two gamete types. There's just sperm and there's ova. So -- so yes. So there's only two options for an individual to have with respect to sex, and that is either male or female. There's no third sex. There's no third gamete, which would be the requirement for there to be a third sex or more.

Q. Is there any sort of transitional gamete between a sperm and an egg?

A. Not even close. They are widely different in sizes. And there's never been a third intermediate gamete found in any species. And there's reasons, evolutionarily speaking, why that this is a stable strategy that has evolved independently many times across many different organisms.

Q. And when you say species, are you including humans in that?

A. Yeah, humans, any species that has two different sized gametes.

Q. Insects as well?

A. All -- all animals and many plants.

Q. Okay. How do you determine the biological sex of an individual?

A. So this is an important point to make about sort of some confusion on terminology. A lot of people, when they talk about how sex is determined, they conflate this with how sex is defined. As a biologist -- so it's a -- in developmental biology, for instance, when we talk about how sex is determined, we're talking about the mechanisms that cause an embryo to eventually develop into a male or a female, but that is very different from how sex is defined, which is based on the types of gamete that they can or would produce.

So there are many different organisms, different species that determine sex in a different way, such as -- alligators, for instance, they do it environmentally by temperature. But regardless of how sex is determined mechanistically and caused, the definition of sex across all of life, all plants,

animals, is going to be rooted in those binary distinction between gametes.

Q. Is it correct to say that in humans that biological sex is assigned?

A. I don't prefer that term because I think that suggests that it's sort of an arbitrary designation, that it's --

MR. GONZALEZ-PAGAN: Objection, Your Honor. This is outside the scope of what biological sex is.

MR. ELDRED: It's not --

THE COURT: I'll ask -- well, hold on. Hold on. Let me just take a look. I'll overrule the objection. I think you were completing your answer.

A. Yes. I think that it suggests there's ambiguity or that it's an arbitrary designation. I tend to say that sex is observed and recorded. That's -- yeah, that's what I should say.

Q. (BY MR. ELDRED) So would you say biological sex is a spectrum?

A. I would not say it's a spectrum because that would require to have a sort of spectrum of gamete sizes running all the way from the size of a sperm, which is very tiny, to the size of an ovum, which is very large. So no, sex is not a spectrum. It's a -- there's two

poles which correspond to either producing sperm or producing ova.

Q. I want to show you a demonstrative. We'll pull it up.

THE COURT: Yeah, if you've got a demonstrative, I'd prefer you show it to the other side first.

MR. GONZALEZ-PAGAN: I'm unclear on the relevance of this exhibit, Your Honor, but --

THE COURT: Sure.

MR. ELDRED: We're not offering it as an exhibit, just a demonstrative --

THE COURT: Okay.

MR. ELDRED: -- just to help the testimony.

THE COURT: Okay.

MR. ELDRED: Oh, there it is.

Q. (BY MR. ELDRED) What is that?

A. So this is a figure that I created sort of in response to this idea that sex is a spectrum and why that's sort of a misleading way to talk about the biology of sex, because sex doesn't come in degrees. You know, people aren't just degrees of maleness and femaleness. For the vast majority of people, they are just either male or female, much like when you flip a

coin, you're either -- you get heads or tails and it doesn't come in degrees. There is a very small percentage of people who have intersex conditions whose genitalia appears sexually ambiguous.

Q. I'm going to cut you off for just a second.

A. Yeah.

Q. What do the numbers mean on the demonstrative exhibit up there you created?

A. So those are just the percentage of the population that fall into these buckets of males and females and to be considered intersex, although the intersex category -- much more of those individuals in that white box are also either male or female if you just sort of investigate a little bit more about -- regarding their gonads.

Q. Well, explain a little bit more about intersex. What does it mean by intersex?

A. So intersex refers to individuals whose genitalia appears ambiguous at birth or there's a mismatch between sort of your internal reproductive organs and your external phenotype.

Q. Does the existence of intersex prove that there's a spectrum of biological sex?

A. No, it doesn't, because intersex people, they don't have reproductive organs that are sort of

organized around the production of a new third type of gamete that it would require for there to be another -- a third sex. Anyone -- to the degree that sexual ambiguity actually exists in humans -- again, sexual ambiguity is not a third sex. There's still only two sexes that a human can actually be.

Q. How do chromosomes fit into this conversation?

A. So in humans, mammals, and birds, and other organisms as well, chromosomes are a sex-determining mechanism if they have sex chromosomes. These are the causes of an individual's sex. They have certain genes that reside on them that cause the embryo to develop down the pathway that results in a male or a female. But as I mentioned earlier, how sex is determined, whether through chromosomes or environment, that doesn't define an individual's sex. So it wouldn't be completely accurate to say that, you know, your chromosomes define your sex or that XX equals female or XY equals male. It really just comes down to the types of gametes that you have the function to produce.

Q. Is it true there's more than two different type of chromosomes -- sex chromosomes for humans?

A. So there's, broadly speaking, two sex chromosomes, X and Y chromosomes, but those can vary in bodies differently. Some individuals can have different

collections of chromosomes. They're called sex chromosome aneuploidies. So, for instance, someone with Klinefelter syndrome has XXY chromosomes. This doesn't mean that they're a third sex because, again, chromosomes are just a cause of an individual's sex. People with Klinefelter have a Y chromosome. And if they have an active gene on there called the SRY gene, that makes them 100 percent male. They develop into males. These differences in sex chromosomes, whether it's XX, XY, XYY, et cetera -- there's several different combinations people can have -- those represent variation within the two sexes. They're not sort of additional sexes beyond male and female.

Q. I asked you about chromosomes. How about secondary sex characteristics such as facial hair in men, body shape of female, genitals and breasts and things like that? How does that fit into this conversation?

A. Yeah. None of those define the sex of an individual. Those are downstream consequences of an individual's sex. So if you're biologically male and you have testes, you produce higher levels of testosterone. If you're a female, you have ovaries. Those produce higher levels of estrogen. Each sex -- both has testosterone and estrogen, just in different

concentrations. But those sort of hormonal mixtures that you get when they surge during puberty, they will create the sort of sex-related secondary sex characteristics that we tend to see. Males, they grow taller. They get more facial hair, more body hair. Generally their voice deepens. Women -- females, they grow breasts.

So these are traits that are, again, a downstream consequence of sex, but they do not define an individual's sex in any way. You can't modify, say, someone's breasts and make them, you know, more male or female depending on the size that you make them. These are just sort of related to sex, but they don't define an individual's sex.

Q. And just to clarify, when you say if you modify someone's breasts it doesn't make them more or less female or male, you're talking about biological sex female and biological sex male; is that right?

A. Yes. Yeah. You can modify secondary sex characteristics. That doesn't change what sex you are.

Q. So when people say there are more than two biological sexes, do you agree?

A. No, I don't, because that would require a third type of gamete. Most people who make that claim are confused about the distinction between how sex is

determined with chromosomes and how sex is defined, which leads people to say that there's, like, six sexes because there's sort of six viable types of chromosome combinations people can have, but that's not scientifically accurate.

Q. Okay. Are there degrees of biological maleness or biological femaleness? Like, can someone be more biological male than someone else?

A. No, because, again, sex is rooted in the type of gamete that your primary sex organs are organized around to produce. So in order for you to have a degree of maleness and femaleness that's somewhere in between, you'd need to have -- you know, to produce some sort of intermediate gamete that doesn't exist.

MR. ELDRED: Judge, I'd like to show another demonstrative.

THE COURT: Okay.

Q. (BY MR. ELDRED) What is this diagram on the screen?

A. So this is a distribution of height among males and females in humans.

Q. Did you make this diagram?

A. I did not.

Q. Okay. Do you know who did make the diagram?

MR. GONZALEZ-PAGAN: Your Honor --

THE COURT: Hold on.

MR. GONZALEZ-PAGAN: -- counsel just represented that he made the diagram.

THE COURT: Hold on. Let's just get to the bottom of it. Who made the graph?

THE WITNESS: This is -- I pulled it off a paper, an academic paper. I'm not exactly sure which one. I'm sorry.

THE COURT: I don't know that we need to use it, Mr. Eldred.

MR. ELDRED: Okay. I apologize, Judge.

THE COURT: Okay. No worries.

Q. (BY MR. ELDRED) Is it true that males and females -- let me be more clear -- that humans with biological sex male and humans with biological sex female have overlapping height distributions?

A. They have overlapping distributions in height and many other different characteristics that are sort of sex related or that sex influences but not sex itself.

Q. And does that prove anything about whether biological sex is a spectrum?

A. No, it doesn't, because -- you know, I'd like to reference that distribution. I think that's important. Because a lot of people will say sex is a

spectrum based on secondary sex characteristics, like breast size, for instance, how tall individuals are, the amount of facial hair. But really when you see the distribution, these are just sort of overlapping distributions and traits between males and females, but these traits don't define an individual's sex. So if you have a bimodal distribution like in that previous slide, as you go from one side to the other, you don't -- you just get more higher or lower proportions of males and females that fall into those sort of distributions, but that doesn't mean that the sex is changing as you're going from right to left or vice versa on a graph like that.

Q. Did you read Dr. Shumer's report submitted in this case?

A. I did.

Q. And I'm just going to read part of it to you. It's in Paragraph 27. Sex is comprised of several components, including, among others, internal reproductive organs, external genitalia, chromosomes, hormones, gender identity, and secondary sex characteristics. Do you agree with that statement?

A. I do not disagree -- or sorry. I do disagree with that.

Q. Why do you disagree?

A. I think it just completely misconstrues what biological sex actually is because the sex of an individual, not just in humans but across, again, all animals and plants, is related to the type of gamete that you have the function to produce or would produce.

I would say that when he said internal sex characteristics, if he's referring to gonads, then that would be accurate. But other things like chromosomes, again, these are upstream causes of sex. Secondary sex characteristics, they're called secondary sex characteristics for a reason, because they are only downstream related effects of one's sex. And the hormones are an example of sort of the downstream consequence of one's sex either. You know, those are sex-related traits, but they do not constitute what sex -- the sex of an individual.

Q. In Paragraph 32, Dr. Shumer said gender identity, like other components of sex, has a strong biological foundation. Do you have any opinion on that, whether that's accurate?

A. You know, I'm not an expert on gender identity, so I would actually like to not comment on that one.

Q. Okay. Fair enough.

MR. ELDRED: Bear with me just one second, Your Honor, please.

THE COURT: Uh-huh.

MR. ELDRED: I'll pass the witness, Your Honor.

THE COURT: Thank you, Mr. Eldred.

Cross?

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

THE COURT: Are you going to need the screen?

MR. GONZALEZ-PAGAN: I will, Your Honor.

THE COURT: Okay. We just want to make sure. If you do, it needs to be either plugged in at the lectern or plugged in your laptop, whatever it is you want to show.

MR. GONZALEZ-PAGAN: Oh, I'm --

THE COURT: They'll take care of it for you?

MR. GONZALEZ-PAGAN: Yes.

THE COURT: Got it.

CROSS-EXAMINATION

BY MR. GONZALEZ-PAGAN:

Q. Dr. Wright, you testified that reproduction -- sex is defined based on reproductive capacity and production of gametes across all animal species; is that right?

A. It's defined by not whether you can actually produce gametes but if you have the function to, which would be rooted -- related to the type of gonads that you have that would normally produce them.

Q. Sure. And sorry. It takes --

A. And it's universal, yes.

Q. Yes. And I need to go back a little bit. My biology training as a major takes a little while to kick in.

There are animal species that reproduce without gametes; is that right?

A. Absolutely. Yes, there are.

Q. That includes aphids within your field of entomology?

A. Yes. They reproduce by budding off of one another, parthenogenesis.

Q. And to clarify, you're not offering any opinions on the biological basis of gender identity?

A. No.

Q. You're not offering any opinions on the biological basis of gender dysphoria?

A. No.

Q. You say that individuals who say that sex is defined by anything other than gametes or the capacity to produce gametes are mistaken; is that correct?

A. Yes.
Q. Okay. Would it surprise you to learn that some of the State's designated experts have testified both in court and to the Legislature that sex is defined by chromosomes?
A. I'm not surprised, but that is an incorrect assessment. Sex is not defined by an individual's chromosomes. It's determined by them.
Q. Would you agree then that your views shared today about sex are not universally accepted within the scientific community?
A. I think there's a lot of people who have misconceptions about sex in the scientific community, but I think if you get to the researchers who are studying the evolution of sex in a fundamental way, there's -- there's no disagreement about what constitutes an individual's sex.
Q. But my question was were your views accepted within -- universally accepted within the scientific community.
A. I think a vast majority if polled would agree with me.
Q. And what's the basis for that statement?
A. This has been a longstanding discovery of basic biology for a very long time, hundreds of years.

Q. And you have not published in the area of sex determination or what it means to be a biological sex in scientific literature; is that right?

A. I've written peer-reviewed book chapters on what sex is across all of -- all of life, yes.

Q. This is one book that was published this year that includes, among others, Michael Biggs and other authors, all of whom are opponents of gender-affirming medical care; is that correct?

A. I was asked to write a chapter about the biological basis of sex, and so that's what I -- what I wrote about.

MR. GONZALEZ-PAGAN: Can we pull up Plaintiffs' Exhibit 48, please?

THE COURT: It's not been admitted. Are you going to admit it through him?

MR. GONZALEZ-PAGAN: Well, I'm going to show it as a demonstrative, Your Honor, just like the other ones.

THE COURT: Okay. As long as we make sure we're clear about that and that it's a demonstrative as opposed to --

MR. GONZALEZ-PAGAN: Yes. Not a -- pre-marked non-admitted exhibit, Plaintiffs' Exhibit 48.

THE COURT: Got it. P-48, not an admitted

exhibit.

Q. (BY MR. GONZALEZ-PAGAN) Do you recognize this document?

MR. ELDRED: How is this a demonstrative, Your Honor? I don't understand.

A. Um --

THE COURT: Well, hold on.

A. -- not immediately, no.

MR. GONZALEZ-PAGAN: Well, it's an impeachment, Your Honor. He states that his views are universally shared. This is a peer-reviewed article that I'll show shows otherwise.

THE COURT: Which might be appropriate to use, but if you've got a hard copy maybe so that he can see the whole thing, that would be the way to do it.

MR. GONZALEZ-PAGAN: We're happy to provide the witness with a hard copy, Your Honor.

THE COURT: I'm sorry?

MR. GONZALEZ-PAGAN: We're happy to provide the witness with a hard copy.

THE COURT: Sure.

MR. GONZALEZ-PAGAN: And it is in the Box.

THE COURT: Is there a hard copy?

MS. DYER: It is in the Box?

MR. GONZALEZ-PAGAN: Yes.

MS. DYER: Oh. Was it updated yesterday?
MR. GONZALEZ-PAGAN: It was updated earlier today.
MS. DYER: Oh, I didn't know there was any additions to the Box.
MR. STONE: Were there other updates today to the Box?
MR. GONZALEZ-PAGAN: Your Honor, if I may, just to pause the time.
THE COURT: Yeah, let's go off the record.
(Discussion off the record)
THE COURT: And Dr. Wright has a copy of P-48. Just give him an opportunity to kind of look through it before you ask him some questions.
MR. GONZALEZ-PAGAN: Thank you, Your Honor.
A. All right. I think I've read articles that are very similar in scope to this one before that make similar claims, so I think I can address your questions.
Q. (BY MR. GONZALEZ-PAGAN) Thank you. Having reviewed Exhibit Plaintiffs' 48, which hasn't been admitted, have -- would you dispute that some scientists believe that sex is multifaceted?
A. I believe some scientists are mistaken about what biological sex is, yes.

Q. Sex can have multiple meanings; is that correct?

A. I mean, if we're going to say sex can be an act with intercourse, that's one other use of the word sex. But if we're talking about the sex of an individual, what sex a person is, that has a very specific meaning in biology.

Q. Is it your understanding that the sex on a birth certificate or a driver's license has to always be consistent with -- or a college application has to always be consistent with somebody's genitalia and their production of gametes?

MR. ELDRED: Objection. This is outside the scope of his expertise.

THE COURT: I'll sustain that objection, if you have another question.

MR. GONZALEZ-PAGAN: Sure.

Q. (BY MR. GONZALEZ-PAGAN) You earlier testified that sex -- biological sex can be bimodal; is that correct?

A. I do not think sex is bimodal. It is binary.

Q. Would you agree that some sex characteristics are multimodal?

A. Some sex-related characteristics can be bimodal and perhaps multimodal. I would need specific examples.

But again, those are downstream consequences of sex. They don't define an individual's sex.

Q. And again, aside from the letter to the editor and the chapter in the book that was published this year by individuals that harbor views against the provision of gender-affirming medical care, you have not published or researched in the area of what biological sex means?

A. Outside of the publications I have on the topic, there are no additional ones.

Q. You would agree that having a credential alone is insufficient to offer expert opinions on the subject; is that right?

A. Absolutely.

Q. Yet your opinions today are based solely on your understanding as an evolutionary biologist?

A. It's based on my understanding of the biology, again, the universal characteristics that unite all males and females across the plant and animal kingdom, not simply just looking at humans.

Q. Let me ask you this. Do you believe that being transgender is a delusion?

THE COURT: Is a what?

MR. ELDRED: Objection. This is outside --

THE COURT: I'm sorry. I didn't

understand.

MR. GONZALEZ-PAGAN: A delusion.

THE COURT: A delusion. Okay. And your objection?

MR. ELDRED: I'm sorry. What was the question again?

MR. GONZALEZ-PAGAN: Do you believe that being transgender is a delusion?

MR. ELDRED: I think that's outside -- I object that it's outside the scope of what he's been offered as his expertise.

MR. GONZALEZ-PAGAN: It goes to bias, Your Honor.

THE COURT: I'll overrule the question, if you can answer.

A. What do you mean by transgender?

Q. (BY MR. GONZALEZ-PAGAN) Do you believe that being transgender is a delusion?

A. I would need to know how you're defining the term whether I can make a claim on that. If you're asking me whether I believe someone who is one sex who believes they are actually the other sex despite the type of gamete that they can or would produce, I would say that that specific belief would be a delusional belief if they're actually identifying as the sex that

they are empirically not.

MR. GONZALEZ-PAGAN: Let's show Exhibit -- Plaintiffs' Exhibit 51, which has not been admitted to the record.

THE COURT: So as a demonstrative. As a demonstrative, P-51.

Q. (BY MR. GONZALEZ-PAGAN) Do you see it on your screen?

THE COURT: You should see it both places, but whichever works best.

MS. POLLARD: Your Honor, may I approach to retrieve the laptop?

THE COURT: Yes.

Q. (BY MR. GONZALEZ-PAGAN) Do you recognize this?

A. I do.

Q. It is a screen capture of an Instagram post by @swipewright on April 10, 2022; correct?

A. That looks like what it is, yes.

Q. And @swipewright is your Instagram account; is that right?

A. It's my Twitter and Instagram.

Q. And on this post on April 10th, 2022, you stated in part: The medical establishment has somehow convinced itself that it's more conducive to a delusional person's mental health to have all society

participate in their delusion than to bring them in touch with reality.

Is that what you wrote?

MR. ELDRED: Objection, Judge. This is not a demonstrative exhibit. This is outside the scope of his expertise. His opinions outside the scope of his expertise should not be admissible. He's not testifying as just some guy with opinions. He's testifying as an expert on biological sex. And what he thinks about -- this opinion on this tweet has nothing to do with his opinion on biological sex.

THE COURT: Well, you've put him up as an expert, and so I guess this potentially goes to bias, but I need you to offer the exhibit, sir, in order to move forward with it.

Q. (BY MR. GONZALEZ-PAGAN) Is that what you wrote, Dr. Wright?

A. That is what I wrote.

MR. GONZALEZ-PAGAN: Your Honor, at this time I would move for the admission of Exhibit -- Plaintiffs' Exhibit 51.

THE COURT: All right. And then your objection?

MR. ELDRED: Yes, Your Honor. Same objection. This is not relevant to the witness'

testimony. This is just something he wrote on Twitter, not within his expertise. He's not here testifying about his opinions on things. It's also hearsay.

THE COURT: All right. The objection is overruled and P-52 [sic] is admitted.

(Plaintiffs' Exhibit 51 admitted, as clarified later by the Court on Page 255)

Q. (BY MR. GONZALEZ-PAGAN) In this post, you're referring to transgender people; correct?

A. I'm referring to anyone who identifies with a biological sex that they are empirically not. So to the degree that a transgender person believes incorrectly that they are the opposite sex, that is the target of this tweet.

Q. And by bringing them in touch with reality, you mean having transgender people live in accordance with their birth sex based on their genitalia?

A. No. I would say that they just need to understand that their sex cannot literally be changed. So I'm okay with trans people choosing to medically transition if they would like to for adults, for instance, but I think it's important that they understand that you can't literally become the opposite sex merely by changing a host of secondary sex characteristics. So when I say in touch with reality,

that's what I mean, that they need to understand what their sex is and that they're only making cosmetic changes.

Q. Previously you stated that even asking a person what their pronouns are is a form of indoctrination.

MR. ELDRED: Objection, Judge. This is not part of his expertise. In fact, he's already testified he does not know anything about -- he's not testifying as an expert on gender identity.

THE COURT: I'll sustain that objection, if you have another question.

Q. (BY MR. GONZALEZ-PAGAN) Do you believe that being asked what pronouns somebody uses makes kids transgender?

MR. ELDRED: Objection. Same objection, Judge. This is outside of his expertise. He's not an expert on gender identity.

MR. GONZALEZ-PAGAN: Your Honor, it goes to his bias. He's never even published in this area.

THE COURT: Well, I think we're -- I don't know that we need anything more on that. So for saving time, I'm going to sustain the objection.

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

THE COURT: Do you have any other

questions?

MR. GONZALEZ-PAGAN: In that case, no more questions, Your Honor.

THE COURT: Okay. Any redirect, Mr. Eldred?

MR. ELDRED: Can I have one second to consult?

THE COURT: Sure.

MS. WOOTEN: Your Honor, while they're conferring, as a housekeeping matter, I believe that on the record it was stated --

MR. ELDRED: Your Honor, can we have housekeeping matters when we're ready to discuss them, please?

THE COURT: Well, if they're busy, let's wait.

MR. ELDRED: No questions, Judge.

THE COURT: All right. Thank you, Mr. Eldred.

Dr. Wright, you are done on the witness stand. You may be excused.

THE WITNESS: Thank you.

THE COURT: All right. Is this -- is there another witness for today or --

MR. ELDRED: We do not have one today.

THE COURT: Okay. All right. Just wanted to make sure. We can go ahead -- unless there's something else we need to take up on the record.

MS. WOOTEN: One matter, Your Honor. I believe it was stated on the record that Exhibit P-52 was admitted. It's P-51 that was admitted.

THE COURT: Okay. I thought I heard 52, but thank you. So the correction is there's no P-52, and P-51 is admitted.

Anything else we need to take up on the record before we go off?

MS. WOOTEN: No, Your Honor.

THE COURT: Okay. All right. We can go off the record.

(Court adjourned)

REPORTER'S CERTIFICATE

THE STATE OF TEXAS)

COUNTY OF TRAVIS)

I, Chavela V. Crain, Official Court Reporter in and for the 53rd District Court of Travis County, State of Texas, do hereby certify that the above and foregoing contains a true and correct transcription of all portions of evidence and other proceedings requested in writing by counsel for the parties to be included in this volume of the Reporter's Record, in the above-styled and numbered cause, all of which occurred in open court or in chambers and were reported by me.

I further certify that this Reporter's Record of the proceedings truly and correctly reflects the exhibits, if any, offered in evidence by the respective parties.

WITNESS MY OFFICIAL HAND this the 20th day of August, 2023.

/s/ Chavela V. Crain
Chavela V. Crain
Texas CSR 3064, RMR, CRR
Expiration Date: 10/31/2024
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