IN THE DISTRICT OF THE UNITED STATES OF AMERICA
FOR THE SOUTHERN DISTRICT OF ILLINOIS

JANIAH MONROE, MARILYN MELENDEZ, LYDIA HELÉNA VISION, SORA KUYKENDALL, AND SASHA REED,	)	
Plaintiff(s),	)	
vs.	)	Case **18-156-NJR-MAB**
JOHN BALDWIN, STEVE MEEKS, AND MELVIN HINTON,	)	
Defendant(s).	)	

PRELIMINARY INJUNCTION HEARING
DAY 2 OF 2

BE IT REMEMBERED AND CERTIFIED that heretofore on **08/01/2019**, the same being one of the regular judicial days in and for the United States District Court for the Southern District of Illinois, **Honorable Nancy J. Rosenstengel**, United States District Judge, presiding, the following proceedings were recorded by mechanical stenography; transcript produced by computer.

REPORTED BY: **Molly N. Clayton, RPR**, **FCRR**, Official Reporter for United States District Court, SDIL, 750 Missouri Ave., East St. Louis, Illinois 62201, (618)482-9226,
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APPEARANCES:

FOR PLAINTIFF(s):

Brent P. Ray, **Samantha G. Rose, Sydney L. Schneider, Austin B. Stephenson, and Jordan M. Heinz** of Kirkland & Ellis LLP - Chicago, 300 N. LaSalle Street, Chicago, IL 60654; **and John A. Knight and Ghirlandi Guidetti** of Roger Baldwin Foundation of ACLU, Inc., ACLU of Illinois, 150 N. Michigan Avenue, Suite 600, Chicago, IL 60601.

***FOR DEFENDANT*(s):**

Lisa A. Cook and Chris Higgerson of Office of the Attorney General-Springfield, 500 South Second Street, Springfield, IL 62701

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MISCELLANEOUS

THE COURT: The matter of *Monroe versus Baldwin, et al.*, Case No. 18-cv-156, is called for day two of a preliminary injunction hearing.

Would will the parties please identify themselves for the record.

MR. KNIGHT: Your Honor, for the plaintiffs John Knight and Ghirlandi Guidetti.

MR. RAY: Your Honor, good morning. For the plaintiffs Brent Ray. Along with me is Mr. Jordan Heinz and Mr. John Fisher, Ms. Sydney Schneider, Ms. Sam Rose and Mr. Austin Stephenson.

THE COURT: All right. Good morning, everyone. And we have Ms. Melendez and Ms. Monroe back.

And for the defendants?

MS. COOK: For the defendants Lisa Cook and Chris Higgerson.

THE COURT: Good morning, Counsel.

So the plaintiffs may call their next witness.

MR. KNIGHT: Plaintiffs call Dr. Randi Ettner.

THE COURT: All right. Come on right up here, Doctor.

Deana, if you would please administer the oath.

THE WITNESS: Please raise your right hand.

(Witness sworn)

THE WITNESS: I do.

COURTROOM DEPUTY: Please state your name for the

record and please spell your names as well.

THE COURT: Dr. Randi Ettner, R-A-N-D-I, E-T-T-N-E-R.

DIRECT EXAMINATION

Q. (BY MR. KNIGHT:) Good morning, Dr. Ettner. And you have identified yourself. Dr. Ettner, what do you do?

A. I'm a clinical and forensic psychologist with a specialty in the assessment and treatment of gender dysphoria.

Q. And, Dr. Ettner, where do you reside and work currently?

A. Currently in Evanston, Illinois.

Q. I'd like to start, Dr. Ettner, about asking you about your education and training. What degree did you receive, Dr. Ettner?

A. I'm sorry. What training --

Q. What degree did you receive?

A. I received a Ph.D. from Northwestern University.

Q. Are you licensed as a psychologist?

A. Yes.

Q. How long have you been licensed as a psychologist?

A. Since 1980.

Q. How did you begin work in the field of transgender health?

A. I volunteered at Cook County Hospital in the late '70s, when they had what was known as a sex reassignment clinic.

Q. What did that work involve?

A. It involved running groups of individuals who were applying and hoping to attain reassignment surgery, as it was then

known.
Q. And what other work or training did you receive early on in this field?
A. Early on, after I completed my degree, I did supervision with Dr. Leah Schaefer for many years, actually, until her death, and I joined the WPATH organization.
Q. Was it called WPATH at that point?
A. At that time it was called the Harry Benjamin International Gender Dysphoria Association.
Q. And when you say you began working with Dr. Schaefer after your degree, which degree was that?
A. After my Ph.D.
Q. Where did you receive your Ph.D.?
A. Northwestern.
Q. And that was in what year, approximately?
A. Approximately, I think, '79.
Q. I believe that's right from your CV.
A. Okay.
Q. Have you had any other advanced training in your field?
A. Yes. I did advanced work in forensic testing, the use of psychological tests for forensic purposes.
Q. And what do you mean by "forensic purposes"?
A. For courtroom usage and for determining if a person was able to be competent to testify and to rule out certain psychopathology and malingering and that kind of thing.

Q. Understood. Have you had any publications in this field?

A. I've had over 30 publications in this area, including two medical and surgical textbooks.

Q. Are any of those publications peer-reviewed?

A. All of those publications I would say are peer-reviewed.

Q. And how about clinical experience?

A. I've seen in excess of 3,000 individuals with gender incongruity.

Q. Do those include people with gender dysphoria?

A. Yes.

Q. Have you ever trained others to treat people with gender dysphoria?

A. I have, and I continue to do so.

Q. What kind of training have you done?

A. In addition to running a supervision group for the past 15 years and providing consultation to other mental health professionals, I'm a member of the WPATH Global Education Initiative, and we travel throughout the world training mental health and medical professionals in assessing and treating gender dysphoria.

Q. Do you -- Dr. Ettner do you consult with others about the treatment of transgender individuals?

A. Oh, yes. I consult and work as part of a multidisciplinary team at Weiss Memorial Hospital, where I'm on staff in Chicago.

Q. And what is it that you do at Weiss Memorial?

A. I consult with surgeons and with other team members about the appropriate care of people who are either undergoing surgery or have gone through surgery.

Q. What other positions do you hold related to this field?

A. I do research, which I present every two years. I teach. I am an author. I --

Q. Do you have any -- I'm sorry, Doctor. I don't want to cut you off. But do you have any positions at WPATH?

A. Yes. I chair the committee for incarcerated persons. I'm on the Global Education Initiative Committee. I'm on the Scientific Meeting Committee, and I'm the secretary of WPATH and an author of the standards of care.

Q. Dr. Ettner, have you received any recognition for your work in this field?

A. Yes. This year I received a commendation from the U.S. Congress, House of Representatives, for my work in the area. I've also been the honoree of the externally funded Randi and Fred Ettner Fellowship in Transgender Health at the University of Minnesota. And I've been an invited guest at the National Institutes of Health to participate in developing a research strategy for gender minorities. I've received the WPATH Distinctive Education Award. And I've been an invited guest to the -- by the director of the Office of Civil Rights in the human -- Health & Human Services Department in Washington, D.C.

Q. I'd like to turn to the work you've done in this case, Dr. Ettner. What work have you been asked to do in this case?

A. I was asked to provide an opinion as to the adequacy of treatment by the IDOC for individuals who have gender dysphoria.

Q. And Dr. Ettner, did that include the five plaintiffs in this case?

A. Yes.

Q. And how did you evaluate the -- what I'm calling the named plaintiffs in this case, the class representatives?

A. I reviewed their medical records. I reviewed their grievances. I reviewed the GID Committee reports regarding those individuals. And additionally, I interviewed each of them and administered psychodiagnostic testing to them.

Q. Could you say a little more about the meeting and interview then? How long did you meet with these five women?

A. Approximately three and a half hours with each.

Q. And you administered testing to all five of them?

A. Correct.

Q. And this is the testing that you talked about earlier, or is that right? Can you describe the purpose of the testing again?

A. The purpose of the testing is to assess basic psychological makeup, symptomatology of anxiety, depression, trauma, to get a vast amount of information about an individual in a short

period of time in a reliable and valid way.

Q. Does that include information about the likelihood of -- about symptoms and -- of those individuals?

A. Yes.

Q. Okay. Are these materials that you reviewed similar to the kinds of materials experts in the field of clinical psychology rely on to reach opinions on comparable questions?

A. They are.

Q. Was there anything you needed -- that you felt you needed to do to come to the opinions that you reached in this case?

A. Nothing other than what I was provided.

Q. In general, Dr. Ettner, what conclusions did you reach regarding the treatment of these five plaintiffs?

A. I reached the conclusion that the care they received was inadequate and inappropriate for the gender dysphoria they were suffering from.

Q. Did you reach a conclusion about their diagnosis?

A. Yes.

Q. What was that?

A. Each had severe gender dysphoria.

Q. You were also asked about the treatment of -- and I think you've mentioned this before in your answer, but in addition to the five women, you were also asked to evaluate the treatment of what we are calling putative class members, so the other transgender individuals in the case.

A. That is correct.

Q. Did you do that?

A. I did.

Q. And what did you do to be able to reach opinions about them?

A. I reviewed all of their medical records. I reviewed the Gender Identity Committee recommendation reports. I reviewed monthly teleconference reports. I reviewed the depositions of Dr. Reister and Dr. Puga. I reviewed the training materials. I reviewed the administrative directive, and I reviewed a -- I think that covers everything I've reviewed.

Q. Okay. And when you mentioned the monthly note -- or teleconference notes -- I believe that's what you said -- are those the teleconferences of the mental health providers that Dr. Reister conducts?

A. Yes.

Q. Okay.

A. Oh, I also reviewed interrogatory statements.

Q. The answers to interrogatories?

A. The answers to the interrogatories.

Q. Okay. Are the materials -- are these materials that you reviewed similar to the kinds of materials experts in the field of clinical psychology rely on to reach opinions similar to these?

A. Yes.

Q. And was there anything that you felt you needed to be able to reach the opinions that you reached here --

A. No.

Q. -- that you were unable to receive?

A. No.

Q. In general, what did you see? What were your opinions with respect to the putative class members?

A. I saw the same patterns that I saw with the named class members that I met with individually.

MR. KNIGHT: Your Honor, I'd like to tender Dr. Ettner as an expert in the field of transgender health, including the treatment of gender dysphoria.

THE COURT: She will be accepted as such.

Q. ***(BY MR. KNIGHT:)*** Dr. Ettner, what is gender dysphoria?

A. Gender dysphoria is a serious, but fortunately treatable, medical condition.

Q. Have there been any other medical diagnoses for this condition?

A. Previously, yes.

Q. And what were those?

A. Formerly the condition was referred to as gender identity disorder.

Q. How long has gender dysphoria been the diagnosis?

A. Harry Benjamin first described the phenomena in 1966. In 1980 it was first included in the Diagnostic and Statistical

Manual.

Q. And the gender dysphoria diagnosis itself, specifically how long has that been around?

A. Since 2013.

Q. Does everyone have a gender identity?

A. Yes. It's an innate universal sense of belonging to a particular gender.

Q. And what does "transgender" mean in your field?

A. It refers to an individual whose gender identity differs from the sex they were assigned at birth.

Q. Is having a transgender identity a choice?

A. No, it is not.

Q. And why do you say that, Dr. Ettner?

A. Because the research indicates that gender dysphoria is a result of the interaction of sex steroids in the developing brain.

Q. Have there been efforts to try to talk someone out of being -- or try to counsel someone out of being transgender?

A. Many efforts. In addition to talking, electroshock and even exorcism were trialed -- were tried in the past. All of these efforts have failed, and they're now considered unethical.

Q. You said that -- I believe you said that distress is a part of the diagnosis for gender dysphoria; is that right?

A. Clinically significant distress that impairs some area of

functioning is one of the criteria.

Q. And what are the sources of that distress?

A. The sources of that distress are the gender dysphoria, the incongruity a person experiences between their assigned sex and their gender identity and the social problems that ensue.

Q. And is that about how someone appears to themselves or about how they appear to other people?

A. Both.

Q. How is gender dysphoria treated, Dr. Ettner?

A. The treatment is outlined in the WPATH standards of care. It consists of social role transition, which is living in a role congruent to one's affirmed identity, cross-sex hormone administration to masculinize or feminize the body, surgery and psychotherapy.

Q. How do people with do people with gender dysphoria -- I'm sorry. Do people with gender dysphoria need all of these treatments?

A. Not all people require all of these treatments.

Q. And Dr. Ettner, what is the role of psychotherapy? Is that actually a treatment for the condition?

A. Typically psychotherapy involves helping people become more resilient, dealing with stigma, managing family situations and dealing with the social problems that are attendant to a gender dysphoric condition.

Q. Can counseling be a replacement for the medical

interventions or social transition, for example? For the other three treatments that you mentioned, can counseling be a replacement for those?

A. Counseling is not a replacement for necessary medical interventions.

Q. Is social transition a necessary medical intervention?

A. Yes. It's an important component of medical treatment.

Q. As a clinical psychologist, are you able to recommend treatments for gender dysphoria?

A. Yes, we recommend and we refer.

Q. And how does that work?

A. For example, when an individual is -- meets the criteria as outlined in the standards of care for surgery or hormonal administration, we write a letter of referral to the physician or surgeon, which contains an assessment of that individual and the description of the medical necessity of that particular treatment.

Q. And is this come about in the form of a plan or a treatment plan for a particular individual?

A. Qualified mental health professionals can generate a treatment plan for a gender dysphoric individual.

Q. Understand. And that comes through this clinical interview process?

A. Yes, partially.

Q. And what else is included as part of that?

A. The patient's own narrative and experience.
Q. Okay. What is social transition?
A. Social transition is living to the best and fullest of one's ability in the affirmed and desired gender role, which is not the one assigned at birth.
Q. What does that include? What are the components of that?
A. The components would be hairstyle, clothing, the social signifiers of gender, including all -- in the case of a transgender woman, female accouterments: perhaps makeup, female undergarments, female toiletries, a chosen female name and matching pronouns.
Q. Are there other aspects to it? For example, what about sex-segregated facilities? How does the social transition relate to that?
A. Social role transition, an important part of the medical treatment, involves treating a person in the same way that a nontransgender person in that gender would be treated. So it means sex-segregated facilities would be used that are comparable to the affirmed gender role. So transgender women would use female locker rooms and female restrooms.
Q. You mentioned, I believe, names and pronouns. Is that a part of social transition?
A. Yes.
Q. How does that work for -- for someone who has a different legal name and is unable to change their legal name? How would

that work for them?

A. Typically that person would choose a name and ask the people in their world to refer to them by that name.

Q. And their world could include what? Employers --

A. Whatever context they live and work in.

Q. So employment, for example?

A. Correct.

Q. How would social transition apply in a prison setting, Dr. Ettner?

A. The same way that it would apply in the community at large. A person would be afforded the accoutrements that -- for instance, in the case of someone who was assigned male at birth, but was undergoing a social role transition to a female identity, they would be afforded the same canteen items, for instance, or commissary items that female prisoners have access to. They would be referred to by a female name. They would have a means of safe and effective hair removal. And they would be permitted to wear makeup or clothing that affirmed their gender.

Q. How effective is social transition as treatment?

A. It's incredibly effective when you consider that the sine qua non of the condition is to appear and to be seen as a gender that matches one's identity.

Q. How do you know it's effective?

A. The research shows it's effective and all of our clinical

experience shows that it's extremely effective.

Q. How does it impact a patient if they are unable to socially transition?

A. It can be extremely demoralizing, it impedes their medical treatment, and it can lead to several very debilitating psychological and health effects.

Q. How common is it for persons with gender dysphoria to socially transition?

A. It's very common.

Q. And what happens if a patient's identity is challenged in some way, for example, through misgendering.

A. It's traumatic for an individual.

Q. As a psychologist, Dr. Ettner, you can't actually prescribe hormones or perform surgery; is that right?

A. That is correct.

Q. So what is your role with respect to those treatments?

A. With respect to both of those treatments?

Q. Let's start with hormone therapy. What is your role?

A. I can determine if a person requires hormone therapy. I can refer them to a provider who is experienced in providing that therapy. I can get feedback from the patient whether or not the hormone therapy is adequate or whether they require further interventions. And I can actually look at the lab values and determine if their circulating sex steroids are in the range that would be equivalent to their peers.

Q. What happens when the hormone therapy is not provided sufficient -- or according to the standards, in your experience with your patients; in other words, the ranges that you have talked about are not there, not present?

A. In the community, the patient would go back to the doctor and have the levels tested and adjusted --

Q. And how does --

A. -- if they're appropriate.

Q. And how do the low levels affect your patients in terms of their mental -- their gender dysphoria?

A. It doesn't attenuate their gender dysphoria.

Q. So you are saying it doesn't work?

A. Correct.

Q. Are the criteria for deciding whether to start someone on hormone therapy set out in the standards of care?

A. They are.

Q. What are those?

A. Persistent, well-documented gender dysphoria above the age of majority for adults. If there are significant mental health concerns or medical concerns, they need to be reasonably well controlled so that an individual is capable of providing informed consent.

Q. Can you say a little more about that last criteria you mentioned? What does it mean that it's reasonably well controlled?

A. It means that the patient can't be so delusional that they can't understand and provide consent to the treatments that they are going to undergo.

Q. How often does that occur?

A. In the more than 3,000 individuals I've seen, it's occurred twice in my practice.

Q. What role does the mental health professional play with respect to surgery?

A. The mental health professional assesses the individual to determine if they've met the criteria of readiness and eligibility, which are outlined in the standards of care. And if those criteria are met, then the individual receives a letter, which is sent to the surgeon of their choice, and a second opinion letter by an independent mental health professional is also required in those cases.

Q. What types of surgeries might be medically necessary for a person with gender dysphoria?

A. First and foremost, the reconstruction of the genitalia.

Q. And why do you say that? Why do you say "first and foremost"?

A. Because in the case of a transgender woman, the removal of the testes actually serves to remove the nascent circulating sex steroids that are kindling the gender dysphoria. And by reconfiguring the genitalia, the individual will have organs that are -- urogenital organs that are functioned and

esthetically identical to those of their peers.
Q. And how does the latter component address a piece of gender dysphoria; in other words, is that a part of gender dysphoria?
A. Yes.
Q. Can you say a little more about that? What do you mean?
A. Well, what I'm saying is that it eliminates the major source of the hormones that contribute to and cause gender dysphoria. There are additional surgeries. For instance, in a transgender man, removal of the breast and chest reconstruction would allow someone to make a social role transition, and that would be a crucial surgery.
Q. Are these surgeries medically necessary to treat some individuals?
A. Absolutely.
Q. Are they necessary for everyone?
A. No.
Q. How do you determine whether they're -- which surgery is medically necessary for an individual?
A. Like all of medicine, that's based on a case-by-case basis. But one consideration would be whether the prior interventions have been sufficiently efficacious to attenuate or eliminate the gender dysphoria.
Q. And how do you determine which of the surgeries are necessary?
A. Again, it depends on whether we're talking about a person

who was assigned male at birth or a person who was assigned female at birth. But some surgeries are more significant for some people than others.

Q. If someone expresses in a clinical interview distress about their genitalia -- for example, a woman who is transgender -- is that something that you consider in the determination of medical necessity?

A. Yes, because that would be anatomical dysphoria. For transgender women having male genitals, in addition to the fact that they produce male hormones, typically people with severe gender dysphoria detest their genitals, and so it's very important that they have the genitals that correspond with their gender identity.

Q. Dr. Ettner, do you ever evaluate the effectiveness of surgical treatments for patients with gender dysphoria?

A. Yes. We do outcome studies and we review the literature frequently.

Q. And do you have clinical experience in -- that would apply to this issue, this question of whether it's effective?

A. Yes, I do.

Q. And what does your experience tell you?

A. My experience tells me that it's extremely effective and that for some people, it is the only effective treatment, and that it is medically necessary for some individuals. And 30 years of research corroborate the efficacy of that surgery,

in addition to statements that the American Medical Association and other organizations have endorsed.

Q. What have the -- what has the American Medical Association and these other medical groups said about this issue?

A. That surgery in accordance with the WPATH standards is not elective or cosmetic, but should be considered medically necessary in certain cases.

Q. Have you had any experience working with prisoners with gender dysphoria, Dr. Ettner?

A. Yes.

Q. What kind of experience have you had?

A. I've evaluated over 40 prisoners in states throughout the country.

Q. Have you done any work -- any other work with respect to prison medical care for this condition?

A. Yes.

Q. What is that?

A. Training medical and mental health professionals in the appropriate care of transgender prisoners.

Q. As part of your work, do you ever evaluate the treatment of persons who have been treated for gender dysphoria by someone else?

A. Yes.

Q. Under what circumstances?

A. In litigation.

Q. And you -- I'm sorry. Was there more? Any other circumstances?

A. In litigation and in the supervision of the therapists that I meet with. And as part of the Global Education Initiative of WPATH, we teach and mentor and supervise mental health professionals who want to become experts in this area.

Q. Are there -- and I think you have talked about this, but just to be clear, are there established standards for the treatment of gender dysphoria?

A. Yes.

Q. And are those the ones you have talked about that are the WPATH standards?

A. They are.

Q. And are these standards accepted by groups other than WPATH?

A. These standards inform care throughout the world. They've been translated into 18 languages. The World Health Organization, the American Medical Association, the American Psychiatric Association, the American Psychological Association, the American Family Practice Association and a dozen more associations, including the National Commission on Correctional Health, all endorse the WPATH standards of care.

Q. I think the Endocrine Society is another one; is that right?

A. The Endocrine Society and the European Endocrine Society.

Q. Do the standards of care address the treatment of prisoners?

A. Yes, they do.

Q. What is different about the treatment of prisoners as compared to people on the outside?

A. Nothing.

Q. Are there -- are the standards of care related to medical treatment different for transgender men as opposed to transgender women?

A. The procedures are different, but the standards aren't different.

Q. What about the qualifications for mental health professionals? First of all, do they vary as it applies to transgender men versus transgender women?

A. The qualifications of mental health professionals?

Q. Right.

A. They don't vary.

Q. What are those qualifications?

A. The standards list the criteria for the qualifications -- the minimum qualifications that a mental health professional must attain in order to be qualified to assess and treat this condition, and they are to have a master's degree in a behavioral science area; to be familiar for the purpose of diagnosis with either the DSM or the International Classification of Diseases; to have documented supervision in

psychotherapy; to understand the variations of gender identities and gender expressions; to have continuing education in the assessment and treatment of gender dysphoria; to have cultural competence and be aware of the growing body of literature in this specialized area. And they specify that individuals who are new to the field, regardless of what training they've had in other areas or regardless of their credentials, should work under the supervision of someone with competence and someone who is regarded as an expert and has met these criteria.

Q. Dr. Ettner, is self-study sufficient to meet these qualifications?

A. No.

Q. And to be clear, are these the qualifications that are required for putting together the treatment plans that you talked about earlier?

A. Yes. Treatment plans should be generated by qualified mental health professionals or medical professionals. And treatment plans tendered by individuals who are not qualified or experienced can put patients at risk.

Q. What happens to persons with gender dysphoria who are unable to access treatment?

A. Typically there are three trajectories: either psychological decompensation, what we call surgical self-treatment, which is the removal of one's own genitalia,

typically autocastration or autopenectomy or suicide.

Q. And what is your basis for saying that, Dr. Ettner?

A. The literature and our experience with people who have not been able to access adequate or appropriate care.

Q. Does the impact of gender dysphoria change at all with age?

A. Gender dysphoria intensifies with age.

Q. Does the harm of being denied treatment go away for someone who finally gets it?

A. Not typically. It would depend on the individual, on their resiliency and how long they've gone without treatment.

Q. Can you predict, based on evaluations of a patient, how likely any of these results are?

A. Yes.

Q. And why do you say that? How do you know?

A. We know, for instance, that people who have a history of attempting suicide are more likely to complete suicides. We know that people that have attempted surgical self-treatment are more likely to attempt it again to complete a surgical self-treatment or to die in the process or to injure themself in the process. And some psychological testing is very effective at predicting these things.

Q. I'd like to talk now, Dr. Ettner, about your opinions regarding the plaintiffs.

You gave a summary of that before, so I'd just like to ask for a little more detail about that.

You evaluated the patients in -- or the plaintiffs in this case almost a year ago, May 2018; is that right?

A. Yes.

Q. Have you received any more recent information about those women?

A. I spoke to two of those women eight or nine days ago.

Q. And have you received information -- you heard the three women testify yesterday; is that right?

A. Correct.

Q. And have you received any other information, such as records?

A. I've received some records, I think, through 2018 or early 2019.

Q. Have you reviewed all records that you had that were available to you regarding these five plaintiffs?

A. Yes.

Q. And have your opinions regarding them changed since May of 2018?

A. Not substantially, no.

Q. Okay. You were asked -- and I think you talked before about gender dysphoria. I believe you said that all five women have severe gender dysphoria; is that right?

A. That's correct.

Q. And is there -- are there common factors regarding the deficiencies in what you saw with respect to the care that they

received?

A. Yes.

Q. What are those?

A. Delay in the timeliness of initiating cross-sex hormones, an inability to facilitate a social role transition, and no assessment or provision of surgery.

Q. Did you form any opinions about the reasons for these deficiencies, Dr. Ettner?

A. I did.

Q. Do you need some water or --

A. I have water. Thank you.

Q. Okay. What are your opinions?

A. I think I -- is there water in here?

Yeah, I have plenty of water. Thank you.

Q. Okay, great.

Dr. Ettner, I asked you about the reasons for those deficiencies that you saw. What are your opinions about the reasons for those deficiencies?

A. The treatment plans were being generated and are being generated by a committee of people who are not qualified to generate those treatment plans. The committee does not see or meet with the individual that they are making these assessments and basing these plans on. And finally, they're relying on a report of someone who is not qualified to assess or generate a treatment plan.

Q. What kind of treatment do these five plaintiffs need?

A. Well, I would say that they all need to have their hormones adequately adjusted and follow appropriate monitoring. They need to be provided with the necessary accoutrements to make a social role transition, with the exception of Janiah, who has already been allowed to do that. They need assessment and, in the -- with the exception of Lydia Vision, surgery.

Q. And why do you leave out or say with the exception of Ms. Vision?

A. She has not yet met the requirement of a year of continuous cross-sex hormones. She will meet that requirement in November of 2020, at which time she should be assessed.

Q. And you are saying that at that point she should be assessed, in your opinion?

A. Right.

Q. What is the impact of not getting the care they need on these women?

A. The impact is predictable and dire, an ingravescent course of psychological distress and a global reduction in functioning, high potential for self-harm, specifically surgical self-treatment and potentially suicide.

Q. Dr. Ettner, I'd like to show you an exhibit.

MR. KNIGHT: And I believe -- I'd like identify this as Exhibit 10. I think that's where we are.

Q. *(BY MR. KNIGHT:)* And Dr. Ettner, have you -- do you

recognize this document?

A. I do.

Q. What is it?

A. It's the medical records of Janiah Monroe.

Q. What do they -- what do they -- I'm sorry.

MR. KNIGHT: Your Honor, could I move for admission of Exhibit 10?

THE COURT: Any objection?

MS. COOK: No, your Honor.

THE COURT: 10 will be admitted.

(Plaintiffs' Exhibit 10 received in evidence)

Q. ***(BY MR. KNIGHT:)*** What do these records reflect, Dr. Ettner?

A. They reflect that this individual actually completed surgical self-treatment and was in a great deal of distress, stating that she would rather be dead than live with the body parts that she had been assigned at birth, and that she was attempting to remove the sutures from her penis, amongst other comments that the notes reflect.

Q. Do you know why Ms. Monroe was -- have you seen records that talk about why Ms. Monroe was first denied hormone therapy?

A. Yes.

Q. And what were the reasons given?

A. The reason was that -- the fear that others would follow

her lead.

Q. Is that a legitimate basis for denying someone hormone therapy?

A. No.

Q. Would providing Ms. Monroe top surgery adequately treat her gender dysphoria?

A. No.

Q. Why do you say that?

A. Because Ms. Monroe has anatomical dysphoria regarding her genitalia.

Q. So what kind of surgery does she need?

A. She needs vaginoplasty, genital reconstruction.

Q. Do you recall why Ms. Melendez was denied hormone therapy?

A. Yes.

Q. Why was that?

A. Because she required -- it was purported that she required counseling.

Q. And do you recall that the records reflect that she needed counseling on real-life situations of living as the opposite gender?

A. Yes, that's what I recall.

Q. Is that a basis for -- consistent with the standards of care?

A. No.

Q. Was there any significance to the fact that Ms. Melendez

delayed identifying as transgender and seeking treatment?

A. In regards to receiving treatment, no.

Q. In regards to her need for treatment.

A. No.

Q. Why do you say that?

A. Because people disclose their gender identity at different times, and particularly people who are incarcerated.

Q. Do you recall why Ms. Reed was denied hormone therapy?

A. Yes.

Q. Why was that?

A. One of the reasons was that there was a need to investigate her conceptualization of gender identity.

Q. Is that a legitimate basis for denying hormone therapy?

A. No.

Q. Let's talk about Ms. Vision. Can you tell the Court about Ms. Vision and your diagnosis of her?

A. Ms. Vision is an intelligent, high-functioning transgender woman who was denied hormones for a very long period of time and was misdiagnosed with post-traumatic stress disorder.

MR. KNIGHT: I'd like to mark these as 11, 12 and 13.

Q. (BY MR. KNIGHT:) Dr. Ettner, if you would just take a look at those three exhibits that we've labeled and tell me when you have reviewed them and seen them.

A. I've reviewed them.

Q. What are these documents?

A. These are Gender Identity Disorder Committee recommendations and then updates.

Q. And are these recommendations for Ms. Vision?

A. Yes.

MR. KNIGHT: I would like to move for admission, your Honor.

THE COURT: Any objection?

MS. COOK: No objection.

THE COURT: Okay. 11, 12, 13 will be admitted.

(Plaintiffs' Exhibits 11, 12 and 13 received in evidence)

Q. *(BY MR. KNIGHT:)* Can you look at the first exhibit, Exhibit 11. What is this? You said -- you have already mentioned there were mental health committee notes. What do these notes reflect? And first of all, let's start with the date. What is the date of this committee meeting?

A. March of 2016.

Q. And what does this committee note reflect?

A. That Ms. Vision is receiving treatment for PTSD and is denied hormone therapy, and the rationale for that denial is that the gender dysphoria may not fully manifest itself in the correctional environment and that the -- anger and aggression can be tied to PTSD and assistance with affect management and cognitive distortions impact -- it says "his actions," and that a pace that's comfortable with the offender to discuss his sexual abuse is what's the rationale for recommending no

treatment for the gender dysphoria.

Q. And on the top of the page, Dr. Ettner, does it reflect that the offender is mentally stable? Do you see where it says [as read] Describe the offender's current mental health stability? The top of the second page.

A. The top of the second page. I'm sorry.

Q. Yes.

A. Yes. Offender is mentally stable per MHP provider.

Q. Is this a reason for denying someone hormone therapy?

A. No.

Q. Let's look at the second document. And, first of all, what is the date on -- is that from November 2016?

A. Yes.

Q. And was Ms. Vision also denied hormone therapy at that point?

A. Yes.

Q. And what was the reason given at that point?

A. The reason is that she has not addressed her PTSD symptoms, among other reasons, and that she doesn't have social support.

Q. Let's look at the final document. This is 13. This is March 2017; is that right?

A. Yes.

Q. And was Ms. Vision denied hormone therapy yet again?

A. Yes.

Q. And why was she denied?

A. The committee had concerns about her mental health and the capacity to undergo the physiological changes associated with feminizing hormones in an environment where she has little or no support, and she should continue employment opportunities and slowly continue her therapy to address trauma.

Q. Are these reasons to deny someone hormone therapy?

A. No. The standards of care specifically state that qualified mental health professionals are able to distinguish between coexisting mental health issues and gender dysphoria. So even if Ms. Vision did have PTSD, which she did not, it would be not be a reason to deny her the appropriate treatment for gender dysphoria.

Q. Dr. Ettner, I'd like to turn to Sora Kuykendall. Can you tell the Court about Ms. Kuykendall and her gender dysphoria?

A. Yes. I met with her at Menard. She had attempted autocastration. She had basically imposed upon herself a solitary confinement situation. She was so traumatized by being strip searched by male individuals and by living with males that she was, at the time that I met with her, not leaving her cell. She was eating her meals in her cell and remained isolated in her cell. She has severe gender dysphoria. She is receiving hormones, although they are conjugated estrogens, and I believe that she requires an assessment for surgical treatment.

Q. And did you -- you mentioned that you spoke to

Ms. Kuykendall more recently.

A. Yes.

Q. And have your opinions about her changed?

A. My opinions haven't changed. Her condition has worsened.

Q. And I had the same question about Ms. Vision. You spoke to her recently. Have your opinions about her changed based on your more recent phone call with her?

A. My opinions haven't changed, but her mood has improved significantly since she has been receiving cross-sex hormones.

Q. So at the time you met with her before, she was not receiving hormones; is that right?

A. That is correct.

Q. Does she still need the treatment that you mentioned before?

A. She needs to be evaluated for surgery when she has met the criteria.

Q. And what about social transition?

A. She requires social transition and to be allowed to live in her affirmed and gender-congruent role.

Q. Okay. Dr. Ettner, I'd like to turn to your opinions regarding the putative class members. Did you reach opinions regarding those putative class members?

A. I did.

Q. And what were your opinions? I believe you talked about it before, but I will just ask again. What were your opinions?

A. I saw the same pattern of denial of appropriate care for reasons that had no medical basis.

Q. How recent is the information you have received about putative class members?

A. I've received some information from this year, from 2019.

Q. Have you received committee notes up through May of 2019?

A. Yes, and I've received what I believe are transcripts of monthly telephone conferences.

Q. And those are more recent?

A. Yes.

Q. And you gave a summary before of the problems, and I believe -- I just want to be clear. Those three kinds of problems, are they the same problems that you identified with respect to plaintiffs, are those the same three problems that you saw with respect to class members?

A. Yes. Delay or denial of initiating cross-sex hormones, inability to facilitate a social role transition, and no one had been assessed or received surgical intervention.

Q. And the reasons -- you mentioned that there were reasons for those changes in terms of the committee structure, et cetera. Are those reasons for these deficiencies the same when it comes to putative class members?

A. Yes.

Q. I'd like to show you some examples related to the putative class members.

MR. KNIGHT: This is 14, I believe.

Q. (BY MR. KNIGHT:) Dr. Ettner, if you could take a look at that and let me know when you are ready to talk about it.

A. I've reviewed this.

Q. And what is this, Dr. Ettner?

A. This is a Gender Identity Disorder Committee recommendation.

Q. What is the date?

A. 10/30/2018.

MR. KNIGHT: Your Honor, I'd like to move for admission of Exhibit 14.

THE COURT: Any objection to Exhibit 14?

MS. COOK: No objection.

THE COURT: Okay. Fourteen will be admitted.

(Plaintiffs' Exhibit 14 received in evidence)

Q. (BY MR. KNIGHT:) Dr. Ettner, what does this -- the history indicate with respect to this individual?

A. The history indicates this is someone who has gender dysphoria. They attempted to remove their genitals in 2018. They've previously taken feminizing cross-sex hormones, and they have a gender identity that's female, which they report since the age of 12.

Q. And I believe in the middle of the mental health history section you will see it says [as read] The gender dysphoria has been documented by NRC, which I believe is the northern

reception center. Do you see that? So that's Section 3 on the first page.

A. Yes.

Q. So you see where I'm reading about the gender dysphoria?

A. I do.

Q. And that was September 2018.

A. Correct. I see that, yes.

Q. Okay. And what does the committee do here?

A. The committee denies the initiation of hormones.

Q. Why do they do that?

A. It says here [as read] Needs to show more stability before beginning hormones.

Q. Is that a reason to deny someone hormone therapy?

A. No. There's also a note here that -- from the mental health provider that judgment and insight are intact and that the individual is stable.

Q. So that would be a further indication this person is ready for hormones; is that right?

A. That there's no reason to deny hormones for this rationale.

MR. KNIGHT: This is 15.

Q. ***(BY MR. KNIGHT:)*** Are you ready?

A. I am.

Q. Do you recognize this document, Dr. Ettner?

A. I do.

Q. What is it?

A. It's a Gender Identity Disorder Committee recommendation.

Q. What is the date of the teleconference here? Or of the meeting, it looks like.

A. November 27, 2018.

Q. What is the -- and I believe you have looked at the previous document before. You reviewed that in preparation for your testimony; is that right?

A. That's correct.

Q. And you have reviewed this one as well?

A. Correct.

Q. And you understand, then, that these are notes for the same individual?

A. I do.

Q. What is the result of this note?

A. The individual doesn't receive cross-sex hormones.

Q. And why don't they receive them?

A. The rationale noted here is that the time left in IDOC is not adequate to monitor the start of hormones with a bipolar diagnosis.

Q. Is that a reason to deny someone hormone therapy?

A. No.

Q. You mentioned delays in hormone therapy. Is this something that happens rarely in the committee records?

A. No. It's frequent.

Q. And what are the reasons that are given?

A. For delays or denials?

Q. For delays. Well, either one. I suppose a denial at the time is ultimately a delay. Sometimes someone ultimately gets started. What are the reasons given?

A. I saw lack of stability given as a reason. Faking was sometimes reported. The person needed to receive counseling. That was frequently a reason for delaying or denying treatment, among other reasons.

Q. Are these legitimate reasons to deny someone hormone therapy?

A. No, not if the hormone therapy is medically necessary.

MR. KNIGHT: I lost track. Sixteen.

Your Honor, I'm -- I'm sorry.

Q. (BY MR. KNIGHT:) Dr. Ettner, I'm giving you Exhibit 16.

THE COURT: Did you move for 15 to be admitted?

MR. KNIGHT: Oh, I'm sorry. Your Honor, I'd like to move for admission of Exhibit 15.

THE COURT: All right. Fifteen will be admitted.

(Plaintiffs' Exhibit 15 received in evidence)

MR. KNIGHT: And this is 16?

THE COURT: This is 16.

MR. KNIGHT: Okay.

Q. (BY MR. KNIGHT:) Are you ready?

A. Yes, I am.

Q. Dr. Ettner, what is Exhibit 16?

A. It's a Gender Identity Disorder Committee recommendation.

Q. What is the date on this recommendation?

A. January 8th 2019.

MR. KNIGHT: Your Honor, I'd like to move for admission of Exhibit 16.

THE COURT: Okay. Sixteen will be admitted.

(Plaintiffs' Exhibit 16 received in evidence)

Q. *(BY MR. KNIGHT:)* Dr. Ettner, what does this record reflect? Does it also reflect approval of hormone therapy?

A. Hormones were approved for this individual as of January of 2019.

Q. Had they been denied before?

A. Yes.

Q. And why were they denied -- when were they denied before?

A. They were -- the decision regarding hormone therapy was tabled on September of 2018.

Q. And why was that?

A. Because it says here [as read] She was not stable enough at that time.

Q. And what about prior to that, on March 6th 2018?

A. On March 6, 2018, a decision regarding hormone therapy was likewise tabled for this individual, based on a history of unresolved trauma and emotional sequelae and no chart evidence of emotional stabilization or progress toward goal completion.

Q. Are those reasons to deny someone hormone therapy or to

table a decision about hormone therapy?

A. No.

Q. Is there anything in this record that would support a denial of hormone therapy for this individual?

A. Not that I see.

Q. Dr. Ettner, I just want to be clear about one thing. Are you making actual treatment decisions for these putative class members?

A. I am not.

Q. What were you asked to do with respect to the putative class members?

A. I was asked to review records and to determine if there was a pattern of inappropriate care for these class members based on the medical records and the treatment recommendations that I reviewed.

Q. And those are the opinions that you have been offering already; is that right?

A. That's correct.

MR. KNIGHT: I'm sorry. Where are we?

COURTROOM DEPUTY: Seventeen.

MR. KNIGHT: Oh, you know what -- I'm sorry. I just realized this is a document we've already identified as Exhibit 4, which has already been admitted, I believe.

COURTROOM DEPUTY: So you don't need that?

MR. KNIGHT: I do want to use it, but it's already

been admitted.

COURTROOM DEPUTY: That's fine. You can have it back.

Q. (BY MR. KNIGHT:) Dr. Ettner, this is what has been previously marked as Exhibit 4. Just let me know when you are ready to talk about it.

MS. COOK: Your Honor, I don't think this is Exhibit 4, because the Exhibit 4 we have is Bates No. 260127. And then what was just handed to us is Bates No. 260155. Those are the beginning pages.

MR. KNIGHT: Okay. Then I guess I need to identify this as a new exhibit. I apologize.

COURTROOM DEPUTY: Seventeen is our next number.

MR. KNIGHT: Seventeen, yes.

COURTROOM DEPUTY: I gave you back the copy.

THE COURT: Yeah, they're definitely different, because 17 is from Western and 4 is from Dixon.

MR. KNIGHT: Okay. And I apologize for that.

THE COURT: No problem.

A. I've reviewed this document.

Q. What is this document, Dr. Ettner?

A. It's a Gender Identity Disorder Committee recommendation.

Q. And what's the date?

A. April 2nd 2019.

MR. KNIGHT: Your Honor, I'd like to move for admission of Exhibit 17.

MS. COOK: No objection.

THE COURT: Okay. Seventeen will be admitted.

(Plaintiffs' Exhibit 17 received in evidence)

Q. (BY MR. KNIGHT:) What does this record describe? What treatment is being requested?

A. The treatment being requested is what's referred to as gender reassignment surgery, what we would now call gender-affirming surgery.

Q. Anything else?

A. I'm sorry. What's the question?

Q. Was there anything else requested?

A. It appears that a showering accommodation was approved and a bra was approved.

Q. And, I'm sorry, was there also a request for electrolysis? I'm sorry. I may have completely pulled the wrong document.

A. I see that she continues to request a sports bra.

Q. Let's move on. I apparently have pulled the wrong document, so I'd like to turn to a different one.

Dr. Ettner, I'm showing you what we've marked as Exhibit 18.

A. Yes.

Q. Have you seen this document before?

A. I have.

Q. What is it?

A. It is the -- it begins with an e-mail regarding the

transgender teleconference of January 26, 2018, and it contains recommendations for three prisoners. And then there is the Gender Identity Disorder Committee recommendation for one of those.

Q. I believe that's for three individuals on the second page. Is that what you're talking about on Page 2, Page 195353?

A. Yes.

Q. So those are the recommendations that are found on Page 2 of this document; is that right?

A. Page 2 of --

Q. Of the exhibit, Page 2.

A. Page 2 of the exhibit is a summary of the recommendations.

Q. Correct. And then following that, are there the forms, the Gender Identity Disorder Committee recommendation forms?

A. Yes.

Q. Okay.

MR. KNIGHT: And I'd like to move for admission of Exhibit 16.

COURTROOM DEPUTY: Eighteen.

MR. KNIGHT: Eighteen. I'm sorry.

MS. COOK: No objection.

THE COURT: Eighteen will be admitted.

(Plaintiffs' Exhibit 18 received in evidence)

THE COURT: So on Page 2, that's referring to three different individuals?

MR. KNIGHT: Yes.

THE COURT: Okay.

Q. (BY MR. KNIGHT:) Dr. Ettner, I'd like you to take a look at the third individual, the notes for this person, which began on Page 195363 Bates number at the bottom.

A. Yes, I see those notes.

Q. And is it your understanding that this is a transgender male housed at Logan Correctional Center?

A. Yes.

Q. And do you understand that Logan Correctional Center is the female facility for prisoners?

A. Yes.

Q. And what does this first page indicate about this individual?

A. That the individual had a cross-gender identification prior to puberty.

Q. And what does it say -- are there other indications that relate to gender dysphoria or the diagnosis of gender dysphoria on that first page?

A. Yes. That the individual had a strong desire to be treated as a gender other than the gender assigned at birth, which is one of the criteria for gender dysphoria; that they've strongly desired to have the sexual characteristics of the gender of the opposite gender that they were assigned at birth.

Q. What does the second page of this record indicate for you?

What is significant about that?

A. That this individual has attempted suicide in excess of or at least 20 times, through -- including method switching.

Q. And what about in No. 8? What does it indicate?

A. That the individual's plan is to commit suicide upon release.

Q. And then in the description of the mental health stability, what does it indicate?

A. That the individual describes the effect of not receiving masculinizing hormones as creating a mood disorder.

Q. And turning back to Page 2 of Exhibit 18, I guess -- yes -- what does that indicate is the recommendation of the committee?

A. Too unstable to start transgender interventions.

Q. So it's your understanding that this committee has decided not to allow hormones to this individual; is that right?

A. That's my understanding.

Q. Is it your understanding that the committee is asked to -- for -- about social transition treatment? Have you seen records in which the committee has been asked to prove social transition?

A. Are you talking about this particular --

Q. No, I'm talking in general, Dr. Ettner, at this point.

A. In general, the items that would be required for social role transition, with the exception of a bra, for transgender women seem to be denied.

Q. The committee denies those?

A. Yes.

Q. And is it your understanding from reviewing records that they always deny those accommodations?

A. Yes.

Q. Other than bras, as you mentioned?

A. Yes.

Q. And what about surgery?

A. Surgery has never been provided.

Q. You talked earlier about the training and expertise, Dr. Ettner, that mental health professionals are required to have. Do the committee members meet those requirements?

A. No.

Q. Do they have that competence, in your opinion?

A. In my opinion, no.

Q. And why do you say that? Let's talk about the specific members of the committee. Why do you say they don't have that expertise?

A. Because they haven't met the minimum criteria, which I outlined earlier, which are delineated in Section 7 of the standards of care.

Q. And that's true for all of the medical providers on that committee?

A. Yes.

Q. And those include the medical director, mental health

director, and the chief of psychiatry; is that your understanding?

A. That's my understanding.

Q. And from your review of the records, you don't believe that any of them are qualified?

A. I do not.

Q. And is that because they don't have the -- those -- meet the elements of the standards of care, or is there anything else about what you have seen that leads you to that opinion?

A. They haven't made treatment decisions based on an assessment of the individuals personally and the decisions that they've made are oftentimes poor decisions that have placed the patients at risk.

Q. So the decisions -- so from your review of the records, the decisions the committee makes are outside the standards of care? They're not consistent with the standards of care; is that your understanding?

A. That's my opinion, yes.

Q. What about Dr. Reister? And I believe you understand Dr. Reister is not a member of the committee?

A. I understand that, yes.

Q. Do you believe that Dr. Reister -- from what you've read, that Dr. Reister is an expert in the treatment of gender dysphoria?

A. I don't believe he's an expert.

Q. I should be clear. Do you believe he meets the minimum qualifications set out in the standards of care?

A. I do not.

Q. And why do you say that?

A. For one thing, his defense of the denial of hormones to Lydia Vision was outside of the standards of care and not a decision that an expert would have made.

Q. And did you come to that conclusion by reviewing Dr. Reister's deposition?

A. Yes.

Q. And do you recall him saying the following in the deposition? He was asked whether the committee follows the standards of care. And by that, I think he understood that's the WPATH standards of care. And he was asked whether he followed them or the committee followed them in making this decision with respect to Ms. Vision.

A. Yes.

Q. And I believe he said the following, because the individual did not have sufficient stability in terms of the coping skills and so they were going to work on the PTSD symptoms to get better control, that that was a legitimate basis for denying care.

A. That is not. The standards of care specifically state when coexisting conditions are present, they, along with the gender dysphoria, should be treated. By analogy, if someone has

diabetes and hypertension, you treat both conditions. And Lydia Vision did, in fact, have excellent coping strategies, earned a college degree while she was incarcerated, and is now working on a paralegal degree and did not have PTSD.

MR. KNIGHT: I'd like to mark this as Exhibit 19.

Q. (BY MR. KNIGHT:) Have you seen this document before, Dr. Ettner?

A. I have.

Q. What is it?

A. It appears to be a transcript of a monthly transgender case teleconference which occurred on January 22nd of 2019.

MR. KNIGHT: And I'd like to move for admission of this document, your Honor.

THE COURT: Any objection?

MS. COOK: No objection.

THE COURT: Nineteen will be admitted.

(Plaintiffs' Exhibit 19 received in evidence)

Q. (BY MR. KNIGHT:) What does this record describe, Dr. Ettner? I believe you said it's the monthly committee notes. Is this the committee -- these committee notes you talked about earlier -- that Dr. Reister hosts?

A. This appears to be a conference among other individuals discussing various prisoners.

Q. Right. And I'm sorry my question was wrong. You talked earlier, I think, when you were talking about what you had

reviewed in this case about teleconference notes among the mental health providers.

A. Correct.

Q. This is what that is; is that right?

A. Yes.

Q. Okay. And you reviewed several of those, I believe.

A. I did.

Q. Okay. So this is one of those. And taking look at Page 2 of this record, I'd really just like to direct your attention to the paragraph starting with Ms. Howell.

A. I see that.

Q. Do you see where I'm talking about?

A. I do.

Q. What does this indicate, Dr. Ettner?

A. It says that Ms. Howell is describing offenders -- recruiting other offenders to request transgender diagnoses.

Q. Just -- I'm sorry.

A. And Dr. Reister comments that in the past some offenders have fabricated transgender symptoms and goes on to recommend that professionals proceed with evaluations slowly.

Q. Does that make sense to you, Dr. Ettner, based on your experience?

A. It does not.

Q. What does it suggest to you about the competence of Dr. Reister and the mental health provider?

A. It makes me question the competence of Dr. Reister.
Q. And what about the mental health provider who is making this statement with respect to people recruiting?
A. I would also question whether that individual was qualified to assess or treat transgender prisoners.
Q. Dr. Ettner, would it fix the problems, the systemic problems you identified, if people with the right expertise were on the committee, the Transgender Committee?
A. It would certainly help.
Q. But would it address the issue you pointed to of having a committee decide treatment plans without meeting prisoners?
A. No.
Q. Did you reach opinions regarding the competency of the mental health professionals at the actual prisons?
A. Not specifically, but generally.
Q. In other words, not a specific individual, but in general, what did you conclude about the mental health staff at the facilities themselves?
A. They were not experts in assessing or treating gender dysphoria.
Q. And what do you base that on?
A. Based on the recommendations that I read that they provided to the committee.
Q. And did you also review medical records that were written by those individuals?

A. I did.

Q. And what did that -- did that lead you to the same conclusion?

A. Yes, in some cases, they didn't even have the accurate name of the diagnosis. They misgendered the clients. They often conflated sexual identity with gender identity. And I saw other errors that an expert in gender dysphoria would not have made.

Q. Does IDOC hire outside experts to provide care for transgender individuals?

A. According to what I saw, what was provided to me, experts had not been hired as consultants.

MR. KNIGHT: Let's see...

COURTROOM DEPUTY: Twenty.

MR. KNIGHT: Twenty.

Q. ***(BY MR. KNIGHT:)*** Would you take a look and let me know when you have reviewed this, Dr. Ettner.

A. I've reviewed this document.

Q. And what is this document, Dr. Ettner?

A. It is a discussion and what's called a psychological autopsy, a discussion of an individual who's completed a suicide.

Q. And is this from the Suicide Task Force Committee meeting? If you will look on the first page.

A. Yes, from a meeting on October 14th of 2015.

MR. KNIGHT: Your Honor, I'd like to move for admission of this document.

MS. COOK: Your Honor, I object to the admission of this based, again, on the relevance. It's from 2015, and this is a motion hearing for a preliminary injunction.

THE COURT: Well, that objection will be overruled. I certainly think it is relevant, and 20 will be admitted.

(Plaintiffs' Exhibit 20 received in evidence)

Q. (BY MR. KNIGHT:) What is significant about this document, Dr. Ettner?

A. What is significant to me is the note that states that the woman that killed herself requested an evaluation for her gender dysphoria on May 14th of 2014 and a year passed and she still -- her case had still not been presented to the gender dysphoria committee. And I believe it's Dr. Hinton who states that this delay may likely have been responsible for the patient's suicide. The note says [as read] so lapse in presentation to Transgender Committee could have been a reason for the suicide.

Q. Dr. Ettner, do you believe -- do you believe these problems have been solved, that individuals are no longer at risk of suicide?

A. I do not.

Q. Why do you say that?

A. I don't see evidence that individuals are receiving the

necessary medical treatment for gender dysphoria in a timely and adequate way to resolve the gender dysphoria. And as I mentioned before, the harms of not providing those treatments in a timely way do often lead to suicide, self-harm, or psychological decompensation.

Q. We've talked about this some, but how can these problems be addressed, Dr. Ettner?

A. By qualified individuals who assess and generate treatment plans based on their knowledge and experience and do a in-person assessment of the patient and generate a treatment plan.

Q. Now, I believe counsel raised questions or suggested in their opening that this would be a problem to do that at every one of these facilities. Are there ways to address this problem other than hiring a competent individual at every one of the prison facilities in Illinois?

A. Yes, there are prison systems that send individuals who have gender dysphoria to meet with a trained expert, and that expert and colleagues that they work with, who are also trained, evaluate the prisoners. So there is not an expert at each facility.

Q. And how do you know that, Dr. Ettner?

A. I know that because one of my colleagues performs that role in New York State.

Q. Can individuals be -- in the current system be retrained?

A. Yes.

Q. Is that going to be sufficient immediately to stop the immediate problem that people are facing?

A. Training takes time, but some individuals -- for instance, colleagues at WPATH do provide training to medical doctors on the appropriate administration of hormones, and that could be done rather quickly using the endocrine guidelines. And mental health professionals can be trained and can undergo certification, although that does take a certain amount of time.

Q. And what is involved in that recertification, Dr. Ettner?

A. Attending WPATH global education trainings. There is a foundation course, an advanced course, and supervision is offered.

Q. And what kind of supervision? I believe you said someone can't just do self-training. How would they ultimately be trained, other than attending the course that you mentioned?

A. Other than attending the course?

Q. Yes. In other words, is attending a course going to be enough or is there --

A. No. Then they're provided with mentoring and they take a test covering the standards of care. And they're provided with some clinical cases and their work is supervised. So they could work under the supervision of someone with competence.

Q. Okay. And again, Dr. Ettner, if something is not done

about these problems, what's the result going to be, in your opinion?

A. Continued harm to the people who have this serious medical condition.

MR. KNIGHT: No further questions.

THE COURT: All right. Let's take about a 10-minute break, and then we will resume with cross examination.

(Recess)

THE COURT: Be seated everyone. We will resume and go until about five till. I have to take a conference call in another case at noon back in chambers, so we'll break at five till so Molly can get set up and then take about a 30-minute break for lunch.

So you may proceed.

MS. COOK: Thank you, your Honor.

CROSS EXAMINATION

Q. (BY MS. COOK:) Dr. Ettner, I want to go back and start with some of the exhibits that you have in front of you and ask you some more questions about that, if that's okay.

MS. COOK: Can I have the ELMO turned on, please? Thank you.

Q. (BY MS. COOK:) So I'll just go and start for the beginning. I'm not going to ask you about Exhibit 10, but Exhibit 11, Ms. Vision. I know you were asked about whether she suffered --

A. I'm sorry, but my exhibits aren't marked by number, so --

Q. If you look on your screen, that's why I have them up.

A. Okay.

Q. So hopefully it will make it easier.

A. Thank you.

Q. Okay. And so I know that you questioned whether they had made the appropriate decision denying hormones. But I do see here in the records for GID history [as read] He considered himself on the male side of the spectrum, especially in prison, where he has to identify as a male.

Would that be the type of thing that you would consider when making decisions about the care for a patient?

A. That's in the history section. And there are many reasons why, particularly in a prison, a person may not initially want to present as a female or they may want to wait until they've had the assistance of hormones, which would aid in their presentation as female.

Q. But a history, a self-report of a person saying maybe they're not sure, is that something that you would consider when deciding whether to prescribe or to allow somebody to take hormones at that time?

A. I would consider all of the history. I would also consider the history that this individual thought of getting rid of their male genitals at the age of eight, which is prepuberty.

Q. So yes, that is something that you would consider?

A. Yes.

Q. And then you discussed about the -- whether you believed it was appropriate to diagnose Ms. Vision with PTSD. But it's my understanding that that was a self-report, that -- quote, [as read] that he has become aggressive and violent towards others as a result of his PTSD, per self-report.

A. PTSD is a diagnostic term, 309.81 in the DSM-5, so the patient reported sexual abuse and trauma, but the patient could not have diagnosed themself, I don't believe, with PTSD. And aggressive and violent symptoms are not necessarily characteristics of PTSD.

Q. So are you saying that when making these assessments, that they should disregard some of the self-reporting for other self-reporting?

A. No. What I'm saying is the patient should have been assessed for PTSD and the patient should have been assessed for gender dysphoria. If the patient had PTSD, that should have been treated along with the gender dysphoria. So co-occurring conditions are more common than not in gender dysphoric patients, and all need to be treated. This individual, however, did not have PTSD.

Q. And based on what you reviewed from the records, were you able to tell whether this patient had actually been diagnosed with PTSD by a mental health provider?

A. The records appear that someone made that diagnosis, yes.

Q. And you disagree with that diagnosis?

A. Yes, and I did testing to rule out that diagnosis.

Q. And then looking further through this record, they did make recommendations. Even though hormone therapy wasn't recommended, the recommendations made did include mental health and support needs, correct?

A. I'm sorry. Support for what?

Q. Mental health and support needs recommendations.

A. It looks like, from the record I'm seeing, that there's a referral for general support for living as a transgender person in a prison setting, which would not be a recommendation for the treatment of gender dysphoria. It might be something that a person might choose to attend a group or to talk to mental health about, but it wasn't the appropriate recommendation for this individual.

Q. And so referring somebody for individual treatment to discuss gender dysphoria treatment, support and monitoring would that be an adequate or an appropriate recommendation?

A. Not in lieu of medical treatment.

Q. The types of treatment that are available for patients, they don't work -- they're not taken in isolation; is that right?

A. I'm sorry. I don't understand the question.

Q. The types of treatment that may be available for a transgender person, one of the types does not necessarily take

the place of all the others, correct?

A. For a person with gender dysphoria?

Q. Correct.

A. They can undergo several treatments at once. Social role transition and hormone therapy, hormone therapy will continue throughout a lifetime.

Q. So just the fact that somebody was not recommended for hormones at a particular time doesn't mean that they're not receiving any care for their gender dysphoria?

A. If they're only receiving counseling and they have severe gender dysphoria, that would fall short of the standard of care.

Q. The WPATH standard of care?

A. Correct.

Q. And it's your understanding, though, that Ms. Vision currently does receive hormone therapy?

A. Yes.

Q. So I want to move on. This is Exhibit 14. I'll put it on the screen for you.

And you discussed, you know, the treatment that was provided to this individual, but again, they noted [as read] This offender has discussed reproductive implications options and decisions related to use of feminizing/masculinizing hormones.

Is that correct?

A. Yes.

Q. Is that something that should be considered when deciding whether to give a patient hormone treatment?

A. Every patient should be informed about the fertility ramifications of hormones.

Q. At what point if somebody is expressing concern does a medical provider recommend that they wait and take some additional time to think about it?

A. Expressing concern about what?

Q. Let's say it's for hormones and somebody comes in and asks their provider for hormone treatment, but they really seem on the fence about it. Should that provider just go forward with the hormones as initially requested, or should that provider take some more time to do more assessment?

A. Every case is individual. I think it depends on if the provider is a medical provider or a mental health provider.

Q. Okay. I want to move on to Exhibit 15. And for this document, you noted that you did not see a reason to deny hormone therapy because -- and I'm going to turn to Page 2 of the document -- [as read] the rationale given was time left in IDOC not adequate to monitor the start of hormones with a bipolar diagnosis.

But even though -- do you know how much more time the inmate had in the Department of Corrections?

A. I do not.

Q. It's noted there [as read] To set up a connection to begin hormones in psychiatric care after discharge.

Doesn't it make sense to have the patient go to a provider who can provide the care and the follow-up care?

A. By analogy, if a patient needed insulin, we wouldn't say that we're not going to provide it now because you are going to be moving to a different place. And so it would make sense to wait until you start there. Providers provide the treatment that's needed at the time that it's needed, and then hopefully the followup is communicated and continued.

Q. Does the length of the delay matter, in your opinion?

A. Yes, as does the severity of the condition.

Q. So if this particular inmate was going to be released in a week, would that week delay be, in your opinion, you know, incompetent or inadequate care?

A. Are you saying that hormones would be initiated in a week?

Q. No. They would be released in a week to see another provider.

A. But when would the initiation of hormones begin, I think, would be the pertinent question.

Q. Okay. So if I'm understanding -- what you -- what you need to know to make a decision about that would be how long would the delay be in the implementation of hormones, not necessarily in making the connection with another provider; is that accurate?

A. If the patient requires treatment, then the treatment should be given with the least amount of delay possible. So that would be a question that I would be asking, How soon will this individual receive the necessary treatment and why can't this individual be bridged? Why can't hormones be started now and continued at a subsequent facility?

Q. In the WPATH standards of care you have recommended qualifications for treatment providers, correct?

A. Yes.

Q. So when you use the analogy of the insulin, is that really a true analogy?

A. Yes, it is, because both are medical conditions with endocrine treatments.

Q. So even though WPATH has recommendations for the qualifications of providers for gender dysphoria, any medical provider can actually -- who is licensed too can provide the treatment that's needed?

A. No.

Q. So what's the difference?

A. Medical professionals can initiate hormones without the approval of a mental health professional if they have the competence, the experience, and the confidence to do so.

Q. And that's under the WPATH standards, correct?

A. Under standards of care 7.

Q. But under their licensing, medical doctors are licensed and

capable of prescribing hormone medication, correct?
A. If they have the training to do that. If they've learned how to do that.
Q. And so because you don't know for this particular patient in Exhibit 16 what time frame is at issue, whether any connections were made, whether any prescriptions were made, while -- for care after this patient's release from DOC custody, can you really say whether the delay caused any harm?
A. I can't say whether the delay caused harm. I can say that the time left not being adequate to monitor the start of hormones is not an acceptable reason to not provide hormones. Because hormones can be bridged. They can be provided and they can be prescribed by a subsequent provider.
Q. Do you know how long after the Gender Identity Committee in this case would have made a decision how long those -- it would have taken for the hormones to actually be given to the individual?
A. No, I don't. I imagine that there would be baseline testing, which can be done rapidly, and that a starting dose could be administered.
Q. And I know from hearing from Mr. -- Dr. Tangpricha yesterday, there are lab tests required to follow up on the progress of the hormones. From a mental health perspective, are there any other follow-ups that are required after somebody begins hormones?

A. Mental health follow-ups?
Q. Correct.
A. No, they're not required.
Q. I want to move on -- and I'm sorry I marked up my Exhibit 19, but I will show you my marked up version. And you mentioned that this -- the notes pertaining to Ms. Howell from Pontiac regarding other individuals recruiting each other to request a transgender diagnosis. You noted that you questioned the competence of both Dr. Reister and Dr. Howell based on this exchange, correct?
A. Yes.
Q. And you mentioned that, you know, you actually testified based on the document, [as read] Dr. Reister recommends that professionals proceed with the evaluation slowly. And you ended there, but there is more to the statement, correct?
A. Yes.
Q. So Dr. Reister actually recommended that professionals proceed with evaluations slowly, gather as much information as possible, and have open discussions. Is that inappropriate?
A. It's not necessarily a reason to slow down an evaluation of a patient who is eligible for medical cross-sex hormones. Evaluations can be made in a timely way, and proceeding slowly and gathering a lot of information is often to the detriment of the patient, who requires a timely initiation of hormones.
Q. So when you read this, did you interpret "proceeding

slowly" to mean delaying?
A. Proceeding slowly and gathering as much information as possible and having open discussions doesn't sound like the typical way in which assessments are made for hormones.
Q. So should the evaluations be done with gathering less information?
A. They should be done with gathering the appropriate information, which isn't necessarily a slow or protracted process.
Q. Well, you'd agree it doesn't say protracted in there, correct?
A. It doesn't say protracted. I agree.
Q. Do you know on average how much time mental health providers in the prison setting are able to meet with their patients?
A. In this particular institution, or are you talking in general?
Q. Just in general, and in the state of Illinois.
A. No, not -- I don't know exactly how long they spent.
Q. In your practice when you are meeting with individuals diagnosed with gender dysphoria, how long does an average session last?
A. An average session with a patient lasts an hour.
Q. And if somebody came to you and they wanted to begin hormone treatment, how long would it take for you to make that

determination in an average setting?

A. That depends on the patient. There are informed care clinics throughout the country where people can get hormones simply by demonstrating that they have a diagnosis of gender dysphoria and that they're able to sign an informed consent procedure.

THE COURT: All right. Ms. Cook, I'm going to stop you there. We will break until 12:30.

MS. COOK: Okay.

(Lunch recess)

THE COURT: All right. You may proceed.

MS. COOK: Thank you. May I have the ELMO?

Q. (BY MS. COOK:) Dr. Ettner, just to resume, I was going to move on to Plaintiffs' Exhibit 20, which was the meeting minutes from the Suicide Task Force Committee meeting. And I'll show you -- I know it is several pages, so I'll show you here, where it starts on 5/22/15. In that paragraph they do mention a lapse in presentation to the Transgender Committee could have been a potential reason for the suicide at issue; is that correct?

A. Yes.

Q. And so when you discussed this, is that what you were basing the discussion on?

A. When I discussed it this morning?

Q. Yes.

A. I reviewed what was said by Dr. Hinton, and that the other comments that she waited a long time for her case to be presented to the Transgender Committee.

Q. But there were other reasons, potential reasons, discussed in these meeting minutes, correct?

A. There were other suppositions, yes.

Q. Yes. So it wasn't just the delay that had been noted, but she'd also had an incident at the facility just days prior to the completed suicide; is that correct?

A. Yes.

Q. And that was unrelated to gender dysphoria?

A. As far as I know.

Q. And so even though the -- when discussing this, department representatives included information about the delay in being presented to the Transgender Care Committee, they also discussed the troubles that she was having that were unrelated to gender dysphoria?

A. Correct. But they noted that a delay of a year before even presenting to the committee was an inordinately long delay.

Q. Well, can you look back through the document? Was it a year of a delay?

A. They said she requested the evaluation on the 14th, and over a year had passed in which her case had still not been presented. I'm reading from a document that says Lindsey.

Q. I understand. Okay.

THE COURT: Wait. Let me catch up with where you are. Okay. I'm with you.

Q. And Ms. Lindsey also noted that she was given a year of segregation time for a pre-evaluation allegation she recanted?

A. Yes, and then someone noted that that was an inordinately long period of time.

Q. And they also noted that in April of 2015, so a month before the suicide on May 31st of 2015, she was seen by a mental health provider concerning GID concerns, correct?

A. She was seen and then her assessment was reviewed by Kay Gleiss *[ph]*.

Q. And so do you know, based on these notes, what she wanted to see the committee for?

A. It's my understanding that she wouldn't get to see the committee, that her case would be presented to the committee.

Q. And can you tell what she wanted to ask the committee for?

A. I don't know specifically, but I'm presuming that she was requesting treatment for gender dysphoria.

Q. In your testimony you noted multiple times earlier that in your opinion, it was inappropriate that GID committee members were not doing the personal meetings with the patients, correct?

A. Correct.

Q. And so do you -- is it your opinion that they cannot provide recommendations or a determination as to what the

necessary care is without having a face-to-face meeting with the individual?

A. My opinion is that's not the standard of care to make a recommendation based on a patient that hasn't been seen by physicians.

Q. But there are mental health providers and physicians who actually see the patients, correct?

A. And give reports to the committee.

Q. Yeah. They give their reports to the committee, and based on what you have seen, have they made recommendations to the committee?

A. Yes.

Q. And so it's your opinion that it's still necessary for the committee members to actually personally meet with...

A. Yes. I actually saw times when the committee overruled the recommendations of the person that had seen the patient.

Q. But if they're just going to accept the recommendation, is it necessary for the committee members to meet with the individuals?

A. Yes. In fact, there are certain legislative bodies, such as the APA and the American Psychiatric Association, that have ethical standards that prohibit making recommendations without seeing a patient.

Q. And under what circumstances would that be prohibited?

A. Under what circumstances? In terms of providing care or

generating treatment plans and making diagnosis as well. The American Psychiatric Association has something called the Goldwater rule, where psychiatrists are not permitted to make diagnoses about people they haven't personally evaluated.

Q. Did you see any instances where they made an actual diagnosis to the underlying -- a diagnosis of a particular medical or mental health problem?

A. I saw instances where they contradicted diagnoses that had been made.

Q. And what were those diagnoses that were contradicted by the committee?

A. Gender dysphoria.

Q. And in your review of the records, when those contradictions were made, nobody from the committee had spoken with individuals?

A. Spoken or seen the individual?

Q. Seen or met with, done their own personnel evaluation.

A. I'm not certain. I would have to go back and review all of those records.

Q. So off the top of your head, you just don't remember?

A. I remember them questioning and in some cases ruling against a recommendation that a mental health provider who had actually seen a patient had recommended.

Q. And what was that?

A. So for instance, when a mental health professional stated

that a patient was stable, the committee might have added a note denying hormones and stating the stability piece isn't there or not stable enough to begin hormones.

Q. Dr. Ettner, can you tell us -- I don't expect you to know this number to an exact number, but do you know approximately how many records you reviewed for this case, the number of documents?

A. Over 200,000 documents.

Q. And the exhibits that have been presented here, aside from those, were there any other records that you noted in support of your opinion, any specific records that have not been introduced as exhibits?

A. Not been introduced as exhibits today?

Q. Correct.

A. I'm sorry. Would you repeat the question.

Q. In your review of the records, were there examples of items that you had pulled out or noted that were not introduced as exhibits today?

A. Yes.

Q. So approximately how many times did you notice a treatment decision being overruled by the committee?

A. A treatment decision or a mental health provider's recommendation?

Q. I'm sorry. A mental health provider's recommendation.

A. I don't know. I can't say without guessing.

Q. Did you have any documentation as to the individual qualifications of the mental health and medical providers involved in the care in the records?

A. Of the mental health providers? Only what Dr. Reister had said in his deposition and the answers to the interrogatories about the qualifications of the committee members.

Q. So you mentioned the WPATH recommended qualifications for treatment providers for gender dysphoria.

A. They're not considered recommended qualifications. They're the criteria that they list in order to consider oneself a specialist in gender dysphoria assessment and treatment.

Q. Okay. And you take that from Section 7 of the standards of care?

A. Right. Those are the minimum that they require.

Q. Well, so who tracks the qualifications? Like if somebody meets all those qualifications, how would a patient know that?

A. If, for instance, the provider had attained certification through WPATH or had been grandfathered in, was a mentor in WPATH, was a member of the board of WPATH, or had met the qualifications to run for an election in WPATH, there is certain minimum criteria that's required.

Q. Do they register with any body?

A. They're on the provider page of the WPATH website. So for instance, Dr. Reister is a member of WPATH and has attended one initial training.

Q. But is there anybody -- you know, like let's say to be -- well, to get your law license you have to take an exam and receive a professional license. Is there anything like that?

A. Yes, there's a certification process.

Q. Aside from the WPATH certification, would there be any other specialized certificate or license for treating gender dysphoric patients?

A. No, not that I'm aware of.

Q. So when you say you have a specialty in transgender care, is that the same as having a certificate from WPATH?

A. It's the same as having a certificate and having 30 years of experience and holding various positions in the organization and having been awarded their Lifetime Distinction in Education award.

Q. I merely wanted to check and make sure there was no extra certificate. So there is no extra certificate for a specialty, correct?

A. Other than the certification process through the Global Education Initiative.

Q. So when the standards of care say, The following are recommended minimum credentials, you're saying those are mandatory credentials?

A. I'm saying those are the minimum requirements.

Q. And the WPATH standards of care are to promote the highest standards of care for transgender or gender nonconforming

individuals; is that correct?
A. I would say the evidence-based care for transgender, nonconforming, transsexual or gender diverse people, yes.
Q. And the stated function is to promote the highest standard of care?
A. The standard of care is how it's referred to.
Q. So when the standards of care say one of the main functions of WPATH is to promote the highest standards of care for individuals -- of health care for individuals through the articulation of standards of care for the health of transsexual, transgender and gender nonconforming people, correct?
A. Yes, providers aim to promote optimal care in their clients.
Q. And you're familiar with the standards of care?
A. I'm an author of the standards of care.
Q. You're an author, yes, so you know that that's its stated goal, right, the highest standard of care?
A. That's one of the stated goals.
Q. And prior to giving hormone therapy, the WPATH standards -- the WPATH standards indicate that significant mental health concerns must be reasonably controlled and stable, correct, before hormones?
A. Reasonably well controlled, I believe, is the language.
Q. Before hormones may be given, they must be reasonably

controlled?

A. Reasonably well controlled.

Q. You mentioned that in your experience, you'd only had a few patients who did not have the capacity to make an informed decision; is that correct?

A. Two.

Q. In your practice, do you have a high number of patients who are considered severely mentally ill?

A. I have some patients who have or have had serious mental illness.

Q. Can you give an estimate of the number over the course of your career?

A. I've had patients who have had schizophrenia, major depressive disorders, psychoses. My colleagues have treated patients who have had dissociative disorders, what we used to call multiple personality disorders, and those people have successfully been treated once their conditions were controlled.

Q. Do you think that overall -- in your -- in the population of patients you see or have seen in your practice, is it half of -- you know, 50 percent have a serious mental illness or less?

A. I would say that the majority of patients that I see, in 30 years in all contexts, have commonly coexisting mental health concerns, most frequently anxiety, depression, or a

history of trauma. It's more common for people to have coexisting mental health concerns than to not have them.

Q. What about the more serious range of mental health issues?

A. If the person is requesting the removal of reproductive organs or genital organs, then those conditions must be well controlled.

Q. You mentioned some of the common coexisting conditions that your patients have had. Are those considered serious mental illness?

A. It depends on the condition. So depression can be dysthymia. It can be a mood disorder. It can be a major depressive disorder. What's depression to a layperson is different to a clinician, so that depends on a case-by-case basis.

Q. So in assessing the severity of a coexisting condition, you really can't -- you really have to take that on an individualized basis?

A. Depends on the medically necessary procedure that we're considering initiating. In the case of the initiation of hormones, hormones due to sex steroid receptors in the brain were first and foremost on the brain and tend to attenuate depression and anxiety. So they actually tend to improve those conditions. So we don't typically hesitate to avoid initiating hormones unless the person cannot consent to treatment.

Q. And, you know, we saw -- I'm going to pull it out for you.

One of the exhibits, one of the people had attempted -- been on crisis watch 15 times within an eight-month period. I mean, is that a severe thing that should be stabilized before treatment?

A. Oftentimes that is a reason to provide treatment and not a reason to deny it. It is very often an indication that the person is not receiving treatment.

Q. I'm sorry. I'm having some difficulty finding which one it was.

It's part of Exhibit 18. And so this record is from -- well, this was in an e-mail in February of 2018. And they noted that since 6/7/17, the individual had been on 15 watches.

Now, you noted that this person had indicated an intention to commit suicide upon release and you contributed *[sic]* that to gender dysphoria; is that correct?

A. I don't think I attributed it to gender dysphoria. I thought that the individual should have hormones initiated, since they said that the effect of not receiving hormones was a mood disorder.

Q. So would hormones, in your opinion, help with a mood disorder?

A. Hormones typically can attenuate a mood disorder to some degree, yes.

Q. Is there any guarantee that it will attenuate a mood disorder?

A. There's no guarantees, but the research show that people

who are on hormones have less psychopathology than people who have gender dysphoria and are not receiving hormones.

Q. And somebody suffering from gender dysphoria alone and no other coexisting mental health diagnoses, is it common for somebody to have that many crises in such a short amount of time?

A. If they have that many crises in such a short time, I think it's reasonable to assume that they're in considerable distress.

Q. This person had been diagnosed with schizoaffective disorder and borderline personality disorder. Is there any way for you to know what effect those are having on this patient?

A. There's no way for me to know specifically about this patient since I've not personally seen this patient.

Q. So no, there is no way for you to know?

A. Specifically the effects of those diagnosis on this individual, no. I can't say that borderline and other personality disorders are lifelong. So the ability to -- the idea that we would delay hormones until those conditions are corrected is fallacious, because those conditions are characterological and lifelong.

Q. Well, and even the WPATH standards don't require that those conditions be corrected, but that they be stabilized, correct, or well controlled?

A. Depending, again, on the procedure that the person is

requesting. So for removal of reproductive organs and general reconstruction, yes, well controlled. For top surgery, reasonably well controlled.

Q. And the initiation of hormone therapy, correct?

A. Yes. And would you agree that if someone plans on committing suicide upon release that there's probably no reason to deny hormones, since they have an intention of killing themselves and there's a possibility that hormones might improve their mental well-being?

Q. Well, I'm not answering the questions. I'm asking the questions. And so I hear your point.

However, there's no way -- just based on these records you have seen, there's no way for you to know whether hormone therapy would actually help this particular patient to stop having suicidal ideations, correct?

A. There's no way to know how it would affect their ideations. There is, however, a note here that says the effect of not receiving hormones is causing a depressed mood. And I think it's safe to conclude that a depressed mood can contribute to suicide attempts.

Q. You mentioned earlier today that you've evaluated 40 -- over 40 inmates with gender dysphoria, and you mentioned that some of those were for litigation. How many of those were for litigation purposes?

A. All of those were for litigation purposes.

Q. And were they all on behalf of the person with gender dysphoria?

A. They were all in regards to whether or not individuals were getting the adequate treatment for gender dysphoria.

Q. Were the inmates in those cases the plaintiffs bringing the suits?

A. Yes.

Q. And were you consulted by the plaintiffs in all of those instances?

A. Yes. No, I was consulted by the attorneys, not by the plaintiffs.

Q. I'm sorry. Were you consulted by the plaintiffs' attorneys?

A. By the plaintiffs' attorneys.

Q. And for how many of those inmates, the over 40, how many of those did you agree with the care that they were receiving?

A. In many cases I agreed with the care that they were receiving, and my presence was to determine if they required or if they were eligible for an additional treatment. But they may well have been receiving very good care in the facility.

Q. Were there any that you did not recommend additional care for?

A. Yes.

Q. Approximately how many?

A. I think approximately three people were getting adequate

care and didn't require additional care.
Q. Were all of those concentrated in one state or were they in different locations?
A. States throughout the country.
Q. You mentioned -- and I'm going way back to the beginning of this morning, but you explained that everyone has a gender identity; is that correct?
A. Yes.
Q. And as natural it is for us to have our own gender identities, is it natural for other people to ascribe us with gender identities?
A. Can you restate that in a different way?
Q. Sure. When you said that this morning, that everyone has a gender identity, isn't the flip side of that based on the perceptions of other people in society, and everybody who you meet, they come up with their own idea just based on a first impression of what your gender identity may be?
A. I don't know if that's universal or not. I think that there are some individuals who consider themselves nonbinary or who are gender nonconforming where their gender might not be apparent from social signifiers.
Q. You also mentioned that efforts to counsel people out of identifying with another gender or being gender nonconforming are unethical. But are people allowed to change their own minds about their gender identity?

A. I think people are allowed to change their minds about many things. But efforts to get people to conform or to identify with the gender they were assigned at birth if they have gender dysphoria have proven to be futile.

Q. But let's say there's no one trying to dissuade them from living how they wish. They are allowed to change their minds about how they feel about it, correct?

A. Typically gender identity is stable over a lifetime.

Q. In your experience, has anybody changed their mind?

A. People have changed their mind about whether it was safe for them to present in their preferred gender, whether it was a -- advisable for them to switch occupations so that they could, you know, make a gender transition or whether or not they, for instance, should wait until their children were older before transitioning. So people make many decisions about when, if, and how far to transition. But I've not had anyone who has actually changed their mind about what gender they are in my experience.

Q. And you were asked about instances where people are unable to change their legal names, that they're able to ask people to refer to them by their preferred name, correct?

A. Yes.

Q. But if they don't change their legal name, they can't change their driver's license, right?

A. In this state I think that's a legal question. I'm not

going to answer that.

Q. That's fair. The people who you have worked with who don't change their legal names, do their records still show up under the legal name?

A. I'm not sure what records you are talking about. Identity documents?

Q. I will move on. I don't need to ask you about that.

Is surgery a cure for symptoms of gender dysphoria?

A. Surgery can be a cure for gender dysphoria.

Q. Is it always?

A. Not always. It depends on the surgery.

Q. Is there widespread agreement that gender-affirming surgery is appropriate in the medical community?

A. Yes.

Q. So you don't believe gender-affirming surgery to be controversial at all?

A. I don't. In 2014 the Medicare determination was that gender-affirming surgery, which was then still referred to as sex reassignment surgery, was declared to be medically necessary for certain individuals and it was not experimental and it was not dangerous.

Q. Was that always the understanding?

A. No. That changed in 2014, based on the literature and the scientific assemblage of research that has accumulated in the past decade.

Q. Based on your experience, is it considered a major surgery like reconstructive surgery?

A. Based on my experience, phalloplasty is an extremely major surgery. Inversion vaginoplasty, which doesn't invade any other symptoms, yes, it is a major surgery, but it is a surgery that has a relatively low complication rate and is a fairly straightforward surgery that's done very frequently in the United States.

Q. Is the surgery reversible?

A. No surgery is considered reversible. However, some aspects of surgery can be modified.

Q. If you get one component of surgery -- so let's say a patient really wants breast surgery, breast implants to have their Adam's apple shaved and they want to have genital surgery, is there any way to do just one component of that and satisfy the patient, or does it depend on the circumstances?

A. I think it depends on the circumstances and on the individual.

Q. In your experience, have any of your patients had to go forward with one procedure at a time?

A. I think most patients go through one procedure at a time because there's -- most plastic surgeons or urologists are reluctant to do -- to spend too much time in the operating room because the length of time can become very protracted. So a procedure like phalloplasty typically takes place in two parts.

First, there's the removal of the internal reproductive organs, and then there's often a graft that's done. So the procedures themselves are staged.

Q. Does having gender-affirming surgery always solve issues of dissatisfaction in gender dysphoria?

A. If you're talking about regret, the recent studies show that the rates of regret are approximately .06 percent.

Q. And where is that study?

A. I believe that's in the journal -- I believe that's in JAMA. The author is Berli, et al. I'm also one of the authors, but there are several authors. And rates of regret are -- throughout the world are less than 1 percent following genital reconstructive surgery.

Q. And how far after the surgery does the study follow the people?

A. Some studies follow up decades after surgery.

Q. Are you aware of studies that have indicated that there are higher rates of dissatisfaction or regret?

A. Not in recent years. Surgeries have improved dramatically, particularly in the past decade.

Q. Is there still a high risk of suicide and self-harm after surgery is complete?

A. Suicide rates go down dramatically, and a recent article by Bauer in 2015 cites the epidemiology of how medical treatments and surgical treatments can dramatically reduce suicide.

Q. And is that in all people with gender dysphoria?

A. Yes.

Q. And are you aware of studies that suggest the opposite?

A. No. If I am, I don't -- I'm not aware of them being legitimate studies that are well accepted by the scientific community.

Q. Are you aware of a study that suggests that people who have this surgery still have the same instance of incidents of suicide and self-harm?

A. No. What study is that that you are referring to?

Q. Out of Sweden.

A. Dr. DiCeglie's *[ph]*? Is that Dr. DiCeglie's study that you are referring to?

Q. I don't know the author.

A. If it's the DiCeglie study out of Sweden, she has twice presented and written papers saying that that's a mischaracterization of her research. And she is a colleague of mine who presents frequently at our meetings. And the study that's being mischaracterized was based on Swedish individuals who were operated on, I believe, in the '80s and the '90s. And her first name is Cecilia, and Dhejne is her last name.

Q. Is there a difference in gender dysphoria and body dysmorphia?

A. Yes.

Q. And do they overlap at all?

A. No. They're two completely different disorders.
Q. Do cosmetic changes alone get to the root of the problem with patients suffering from gender dysphoria?
A. I'm not certain what you mean by "cosmetic changes."
Q. Having surgery, wearing gender-affirming clothing, do those alone, without counseling or mental health treatment, help ameliorate the symptoms of gender dysphoria?
A. Gender-affirming general surgery is not a cosmetic surgery. It's a medically necessary surgery. It's not considered elective or cosmetic. Social role transition, where an individual lives in a role congruent to their gender identity, is a precondition to genital surgery and does have an ameliorative effect on gender dysphoria.
Q. And forgive me, because when I said "cosmetic" I didn't mean elective or -- I meant just like on the outside. But is social and family support important through this?
A. It's very important for young people who are gender dysphoric to have family support. For making any kind of gender transition or even identifying as being gender incongruous, it's tremendously helpful if they have family support.
Q. And you mentioned young people, but even for adults, is family support important?
A. Not necessarily.
Q. Is it important that they have -- people with gender

dysphoria, regardless of what other treatments they're receiving, is it important that they have access to mental health providers?

A. If they have mental health issues other than gender dysphoria that require mental health support, coexisting concerns, then yes, it's important. But the standards of care for the treatment of gender dysphoria no longer require that people have mental health evaluations or mental health treatment prior to undergoing hormonal initiation. They do require mental health referrals for surgery, however. They don't require psychotherapy or counseling.

Q. Based on your experience, at the current moment, what is the cost of a typical gender-affirming surgery? So just any -- you can explain to us what the typical patient that you see would have done and how much that would cost.

A. I really can't address what any particular surgeon would charge for a procedure. I know that many insurance carriers are covering gender-affirming surgeries, including such corporations as Starbucks, because WPATH helped them draft that insurance policy. So I'm aware of that, but I can't quote cost for surgeries.

Q. Is there aftercare involved after surgery?

A. The patient requires dilation at home and will for weeks, if not months, but they don't require surgical aftercare.

Q. Based on your experience, is there a one-size solution for

somebody with gender dysphoria?
A. Based on my experience, there's a well-established, evidence-based protocol for the treatment of gender dysphoria. Not everybody needs all components of that treatment protocol, but many people do require all components.
Q. And you found for all five of the plaintiffs in this suit that without eventual surgery that they could remain in severe mental distress or at risk of suicide, correct?
A. Some I opined, yes. Absent surgery, that would lead to an ingravescent course. And as I mentioned earlier, one of those individuals is -- has not met the criteria for surgery, so I can't opine on whether or not she would require surgery, but she would require assessment after November of 2019.
Q. Is WPATH a universal consensus? Does that represent the universal consensus?
A. WPATH is the -- is an international organization. We also have chapters throughout the world, so there's EPATH, which is a European chapter of WPATH. There is USPATH, which is the United States chapter of WPATH. So there are different chapters throughout the world.
Q. You mentioned that the treatment of gender dysphoria and the diagnosis itself has been changing and evolving rapidly, correct?
A. Would you repeat that?
Q. The treatment for and the diagnosis of gender dysphoria has

been changing and evolving rapidly over time, correct?
A. Our understanding of the cause of gender dysphoria has evolved. The treatment has remained the same. The procedures have improved as surgical technique has improved and as surgeries in general have improved over time.
Q. Even the procedures haven't been widely accepted even as recently up to 2014, correct?
A. No, that's not correct.
Q. So surgery was not widely accepted as a treatment?
A. In 1977 there were 20 clinics in the United States performing surgery. So surgery has always been seen as a treatment for severe gender dysphoria. It hasn't always been construed as a medical condition, and the etiology of gender dysphoria has been further explicated as time has gone on.

So initially it was thought to be a mental disorder, but with the advent of advanced technology, functional magnetic resonance imagery and genetic studies and twin studies, our understanding of the origins of the origins of the condition have changed. And now it is considered a medical condition and has been removed from the mental and behavioral disorders in the World Health Organization classification of diseases and in the DSM-5.

So our understanding of this most misunderstood area of human behavior has evolved considerably. But the treatments have by and large remained the same, although the techniques

have improved dramatically.

Q. And from your experience and based on what you have seen, are there still providers who don't accept the WPATH standards of care?

A. There are a few outliers, people who still most likely do not accept the standards of care, and there are also some outliers who don't accept the DSM-5 as well.

Q. Is there any way, sitting here today, to know if the WPATH standards of care will become outdated?

A. The standards of care 8 are currently in process, and they're being updated as we speak. So we have had seven iterations of the standards of care, and we are now in the process of developing the eighth iteration of the standards of care.

MS. COOK: That's all I had.

REDIRECT EXAMINATION

Q. (BY MR. KNIGHT:) Dr. Ettner, I'll try to be brief and just hit a few points.

Earlier on you were asked about Ms. Padilla *[ph]* and about her PTSD. Is PTSD a reason to deny someone hormone therapy treatment?

A. No.

Q. Was there anything else in her records that indicated that she should not have had hormone therapy treatment when she first came before the committee?

A. There were reasons that were recorded, but they're not legitimate reasons.

Q. Okay. When you mentioned that you saw evidence that the committee overruled or rejected treatment decisions recommended to them, how -- was that something that you saw often or was that rare? How often did that happen?

A. It seemed to happen earlier, in the earlier set of records that I reviewed, where there would be cases where people were -- diagnoses were questioned or someone had been diagnosed, but they hasn't been diagnosed by an IDOC psychiatrist, or someone had conflated sexual identity with gender identity. Those were some of the things that I saw.

Q. And -- I'm sorry. But to be clear, in those notes, were -- how common was it that a treatment recommendation was denied?

A. What was common was for a provider -- a mental health provider to say that a person was stable and for the committee to say the person wasn't stable enough or the person needed counseling prior to initiation --

Q. And was the --

A. -- of hormones.

Q. And was the result of that denial?

A. Denial or delay.

Q. Okay.

A. Some of those people, the recommendation was that they be re-presented in three months or something like that.

Q. You mentioned a change in 2014. And I believe you were referencing Medicare, the Medicare decision.

A. May 30th of 2014.

Q. And so it was the change in Medicare coverage that occurred in 2014; is that right?

A. Yes.

Q. That's what you were talking about before?

A. Yes.

Q. So it was not -- so how many years has there been research supporting the efficacy and safety of surgical treatment for gender dysphoria?

A. I think it was in the '90s that a meta analysis of studies spanning 30 countries over 30 years was one of the first to demonstrate the efficacy of surgery. And since then, there have been countless studies, numerous studies, many of which I have pointed out in my declaration, that actually follow up and demonstrate the efficacy of surgery for the treatment of gender dysphoria.

Q. Dr. Ettner, can prisoners socially transition in prison?

A. Yes.

Q. And have the five women you examined, with the exception of Ms. Vision, have they sufficiently socially transitioned that they're eligible for surgery, in your opinion?

A. They have not been -- they haven't completely socially transitioned, with the exception, perhaps, of Ms. Monroe, who

has been allowed to have access to more female accoutrements to facilitate a transition.

Q. They have all been on hormone therapy for a year; is that correct?

A. Yes.

Q. So they are -- in fact, I think you had said before they're eligible and surgery is medically necessary for them at this time. Is that your opinion?

A. An assessment and then --

Q. An assessment for --

A. An assessment and then surgery.

Q. But they're ready for surgery now? Is that your opinion?

A. With the documentation of the assessments.

Q. Correct. And you said that requires two evaluations from competent medical and mental health professionals.

A. That's correct.

Q. One last point. You were asked about what I believe is Exhibit 20. I don't know if you still have those in front of you or --

A. I have the exhibits.

Q. Okay. Would it be best if I show --

A. I do not have the number.

Q. Well, how about -- I think I can use the ELMO to show this to you this. Counsel showed you before.

This is the -- do you remember seeing this record before?

A. I do.

Q. And you were -- I believe you were asked in cross examination whether or not you knew whether Ms. -- whether this individual had requested evaluation for gender dysphoria a year prior to her death.

A. I was asked that question.

Q. Do you see indication here that, in fact, she had requested evaluation for gender dysphoria in this document?

A. Yes, I do.

Q. And is this where -- where I've highlighted there, where it indicates that to you?

A. Yes.

Q. And this was May 14th 2014. Obviously, her date of death was a year later.

A. 5/31/2015 was her date of death.

MR. KNIGHT: I have no further questions.

THE COURT: All right. Do you have any additional witnesses for us?

MR. KNIGHT: Plaintiffs do not.

THE COURT: Okay. All right. And the defense?

MR. KNIGHT: I'm sorry, your Honor. I apologize. There is one issue, which is that we had spoken earlier to counsel and they've agreed that we could seek admission of Ms. Vision's declaration which was submitted with her -- with our papers, with our motion --

THE COURT: Okay.

MR. KNIGHT: -- and also Ms. Kuykendall's, the two women who have not appeared as part of the hearing today.

THE COURT: Okay. And the defendants have agreed to that?

MR. KNIGHT: That's --

MS. COOK: Yes, your Honor.

MR. KNIGHT: Yeah.

THE COURT: Okay. All right. So those will be accepted as well.

MR. KNIGHT: Thank you, your Honor.

THE COURT: Okay. And so you may step down. Thank you.

THE WITNESS: What do I do with these?

COURTROOM DEPUTY: Here. Thank you. And then -- so then the plaintiff rests and then you have Dr. Puga?

MR. HIGGERSON: Yes.

THE COURT: Why don't we just take about a 10-minute break and then we will resume with Dr. Puga's testimony.

(Recess)

THE COURT: Call your next witness.

MR. HIGGERSON: Dr. Puga.

THE COURT: Dr. Puga, come on up to the stand.

And Deana, if you would please administer the oath.

THE WITNESS: I do.

COURTROOM DEPUTY: Please state your name for the record and spell your first and last names.

THE WITNESS: William Puga, W-I-L-L-I-A-M, P-U-G-A.

COURTROOM DEPUTY: Thank you.

DIRECT EXAMINATION

Q. (BY MR. HIGGERSON:) What is your occupation, Dr. Puga?

A. I am a physician specializing in psychiatry.

Q. And where are you employed?

A. I am employed for the Department of Corrections.

Q. In what position?

A. Chief of psychiatry.

Q. How long have you been in that position?

A. Since March 1st of last year.

Q. What did you do before that?

A. I worked with Wexford Health Care, which was a provider for psychiatric services, and I was on psychiatric staff at Pontiac Correctional and I also saw people out of Stateville.

Q. How long were you working for Wexford and doing those other functions?

A. About a year.

Q. What did you do before that?

A. Multiple things, including private practice. I was a hospitalist, a consultant to OSF HealthCare, a consultant to a high school district. Through my time at the hospital I directed multiple units, residential units, inpatient units,

outpatient units. Also taught on staff at University of Illinois. I taught medical students for the psychiatric portion of their clerkships.

Q. Prior to working for the Department of Corrections, did you have experience treating transgender individuals?

A. I have -- I did have some transgender individuals on my caseload, yes.

Q. Do you know how many?

A. Depending on -- in all my capacities, I would say at least six or eight.

Q. And what type of treatment did you provide to them?

A. Some of it -- psychiatric treatment. Some of it was oversight and consultation at the high school -- there were several students with gender dysphoria -- and in the practice helping people along their gender dysphoria issues.

Q. Okay. Is there any particular board specialization in transgender care?

A. Not that I'm aware of.

Q. During the time in private practice when you were treating transgender patients, did you ever recommend hormone treatment?

A. I can't say that I have. I didn't recommend it necessarily, but some of them sought out hormone treatment.

Q. How did they seek it out separate from your treatment?

A. Through their physician, primary care physician.

Q. Did you ever make any recommendations for surgery?

A. I wrote a letter on behalf of one of my patients, supporting her surgery.

Q. That would be --

A. His surgery. I'm sorry.

Q. -- a letter to who?

A. To the surgeon who was going to perform it. I think he needed to gather her -- his team for the recommendations, and so he requested a letter from me.

Q. Did that patient ultimately get the surgery?

A. Yes.

Q. Did you provide any treatment to the patient after the surgery?

A. Yes.

Q. Okay. Was that just in the form of therapy?

A. Medication management for depression.

Q. What specifically are your functions as the chief of psychiatry for the Department of Corrections?

A. I oversee the psychiatric treatment throughout all 31 facilities. I make sure that the psychiatrists are doing what we expect them to do. I set policies for them. I do clinical case reviews periodically. I have asked to be the chairman of the committee of the Transgender Care Review team -- Review Committee.

Q. When did you start working with the Transgender Care Committee?

A. Shortly after I started I sat on a couple of meetings, and then beginning in about August of last year, they asked me to be the chairman.

Q. About how often do they meet?

A. Once a month, on a monthly basis for the review of treatment and care.

Q. And how many cases do they review at each meeting, roughly?

A. Roughly 20 or so.

Q. And do you provide direct care to any patients as the chief of psychiatry?

A. No.

Q. So how exactly involved are you in care or what is your role in the treatment of patients as part of the Transgender review committee?

A. We oversee the treatment, and so we review treatment plans. We review history. We review the requests that the offender may have. We -- at the meetings there's the therapists. There's also the clinician, the physician, and there are various other people on the committee. So we also give them our opinion. If we see that something may need to be adjusted or looked at or reviewed, we sometimes will ask for further information. Sometimes we'll ask for clarification. Sometimes we'll just -- if everything is going smooth, we will just acknowledge the presentation and move forward.

Q. Okay. You use the term "opinion." When the Transgender

Care Review Committee looks at a patient's care, do you give advice or do you make decisions about the care?

A. We give advice. It's -- well, you know, and sometimes, for example, if we think that something else may be necessary or another treatment or medical intervention or what have you, sometimes we'll ask them to seek that out and gather more information for the next meeting, and so we will reschedule a meeting to review information that sometimes we may not have at the time of the meeting.

Q. What is the composition of the committee? Who is on it?

A. At a minimum, the composition is the -- Dr. Hinton, who is the chief of mental health and addictions; Dr. Meeks, who is the agency medical director; Chief Eilers, who is security; Chief Robinson, who is now over women's division; Dr. Reister, who is the regional -- southern regional psychology administrator. We actually have all three of our regional administrators involved. Dr. Fairless in central region and Dr. Horn *[ph]* northern region. We have a transfer coordinator also involved.

Q. Are all of those people members of the committee or do they participate in the committee proceedings?

A. They participate in the committee. There's a minimum of a -- minimum requirement in our AD, but then there again, that's a minimum requirement and then, you know, others as invited. We think that Dr. Reister is a very valuable part of

that committee, and so we want to proceed with him. If he is not available in that meeting, we will postpone it. But at a minimum, there will be Dr. Hinton, Chief Eilers, a transfer care coordinator, Dr. Meeks and myself.

Q. The transfer coordinator, the person from the transfer coordinator's office, is that a medical person?

A. No.

Q. What is their role on the committee?

A. The committee makeup was determined before I came on. So I'm not 100 percent sure. Certainly if there are transfers that occur between one facility and another, that's when they become involved. So there are times when we've -- when -- for treatment needs we've transferred an offender from one facility to another and -- and as we have recently transferred people to -- from a male division to a female division, they are actively involved because there are a number of changes that need to happen at that point.

Q. Does the transfer coordinator have a role in deciding mental health treatment?

A. No.

Q. Or medical treatment?

A. No.

Q. I think you mentioned the chief of security is also a member.

A. Yes.

Q. What is that person's role on the committee?

A. Well, the way the Department of Corrections works is that it's a collaboration of a lot of people. There are the medical personnel, the therapeutic personnel, but there's also the personnel that work with our offenders on a day-to-day basis. And so there are things such as the offender -- specific needs that sometimes involves our -- the chief to be involved in, such as showers or such as special housing arrangements or movement arrangements, search arrangements, that type of thing, and so that's why they're involved.

Q. Does the chief of security have a role in determining mental health treatment?

A. No.

Q. Or determining medical treatment?

A. No. You know, they will be important in -- sometimes when it comes to movement and housing, and if that's -- if that's something that's essential, you know, they're there to help us with that to accommodate therapeutic needs.

Q. You mentioned Dr. Reister being important. Why is Dr. Reister an important part of the committee?

A. Dr. Reister has probably the most experience out of everybody as far as working with this population. He takes a special interest in this. He's on the WPATH -- he has WPATH membership and so he provides some specialty consultations when we are looking at this. He also does the -- as has been

mentioned, the monthly oversight of the therapists who work with the transgender offenders, and so he has more intimate knowledge of what goes on on a day-to-day basis in the groups and in the -- among the therapists that are working with the offenders, with their patients.

Q. Since being on the committee, have you done any additional work to learn about transgender care?

A. Yes, I have.

Q. What have you done?

A. Well, you know, as I mentioned, I've had some experience with it previously, and so I'm always learning, I'm always reading. And in order to do this job, I have to prepare by becoming familiar with the WPATH standards, with, you know, reading about the endocrinology issues, reading about surgical issues, reading about other states' work with the offenders. There's a number of things that I've had to do for that.

I also am involved in working with the psychiatric staff as well, so I've actually worked on a newsletter and an article in the newsletter, kind of defining, you know, psychiatrists' role in the treatment and evaluation of transgenders. So I've had to do some research on that and present that to our staff.

Q. Is there an administrative directive that guides the care of transgender patients in the Department of Corrections?

A. There is a -- there are two areas that describe how we do things, and one of them is the administrative directive and the

other one is the SOP, standard operating procedures that we have for mental health.

Q. Now, when we submitted our response to the summary judgment in June, there was a draft of that administrative directive. Has that since become official?

A. Yes, as of July 1st.

MR. RAY: Your Honor, I object. We have not received a copy of any final document whatsoever. And we also served an interrogatory response that asked for all directives defining care for gender dysphoria in IDOC. They have not supplemented that, nor have they sought to modify in any way Dr. Puga's testimony in the 30(b)(6) deposition from earlier this year, where he testified prior directive was the one currently in place. This is highly prejudicial. Whatever directive they're talking about we haven't seen.

MR. HIGGERSON: They have seen the directive in its draft form. All I asked was if it has been made official at this point.

MR. RAY: We haven't seen the official. We have no idea how it has changed in the draft. We haven't had a chance to examine it. Neither have our experts. It hasn't been produced.

THE COURT: Were there any changes made from the draft to the final?

MS. COOK: There were some paragraphs moved around

that I saw.

MR. HIGGERSON: I don't believe there's any substantive changes.

MR. RAY: That's great that counsel is able to represent that, but we haven't had a chance to see it.

THE COURT: Do you have it here?

MR. HIGGERSON: I do have a copy. I wasn't planning to go any further with this other than just noting that what we submitted before has now become -- it's been implemented.

THE COURT: Well, let's move on then, but give them a copy of that later today. And if we need to take it up later again after his testimony, we will.

Q. (BY MR. HIGGERSON:) How are issues regarding specific inmates' care, transgender inmates' care, brought before the committee?

A. It usually goes to the therapists working with the transgender offender, and they will bring it up at the committee meeting. They will request some time for us to review it. So it will -- it is just a matter of requesting, and they get put on the schedule for the meeting.

Q. Okay. Where are those treating mental health professionals? Where are they located?

A. At the various facilities.

Q. If they don't raise issues with the committee, does the committee have its own way of bringing inmates' cases before

the committee?

A. There are two requirements. One is when a person first acknowledges that that's an issue, brings up that that is an issue, whether that means upon intake or upon being at the facility, then it gets brought up to the committee. Then when there is a transfer and an inmate may go from one facility to another, at -- upon transfer they get put on the schedule at the next facility. So we review how they're doing as far as that's concerned. You know, the goal of our committee is to make sure that our patients get what they need, and we want to make sure that they're getting an adequate amount of services, and -- and that's a way of looking at that.

Q. Okay. When a specific inmate's case is being reviewed by the committee, does that inmate appear before the committee?

A. No.

Q. Why not?

A. This is, you know, a treatment review committee. It's a -- you know, we -- I think that would be very difficult to do and review all the people that we have on our caseload, quote/unquote, but it is usually -- it's brought forward by a representative.

Q. That was my next question. How do you learn anything about the specific case if the inmate is not there?

A. The representative is -- will present their case, and so it -- the people that are involved on the facility level is

going to be the therapist that works with them, someone from health care, usually the physician that's treating them, and usually a warden -- one of the wardens on the warden team. And those are the people that at a minimum from the facility are present at the meeting or present by -- they're usually by teleconference, but they're present at the meeting and they all give input on the care on the case.

Q. Does the committee receive any information other than what's presented in the in these teleconferences?

A. Prior to having the conference, everybody gets a copy of the -- what's called the 0400 form, which is the information on the evaluation of the offender, the transgender individual. They also send over the treatment plan. And so everybody gets that ahead of time. Sometimes when we are meeting and if we want other information, they usually have the chart available there, and so we'll ask about -- you know, perhaps sometimes we'll need to learn about labs, learn about other situations, so we will have that available.

Q. After the committee reviews a case, if they make a decision, who is responsible for carrying out whatever that decision is?

A. The therapist who is primarily working with the offender.

Q. Are they required to report back when they've complied with that?

A. Sometimes we do ask them to re-present, depending on the

situation. If it's something relatively simple, we may not. If it's something a little more complicated that we want to make sure that it's something we keep up with, we might ask them to come back in a month or two or three months to review the situation.

Q. Is one thing that the committee considers is whether or not an inmate should be started on hormone therapy?

A. Yes. For the most part, yes. If a person is coming in through the receiving center and they're already on hormones, we'll continue it. It just needs a phone call, typically to Dr. Meeks or, if he is not available, to me, and we generally approve it and they will continue their medication. If it's a new presentation, then we'll want to make sure that it's -- that it's appropriate, that it's safe enough and -- and, yes, the committee will weigh in on that.

Q. Do you know how many inmates within the department are on hormone therapy right now for transgender issues?

A. I did see that number not too long ago. I can't tell you specifically. I don't recall. It might be close to 70 or so. I don't remember.

Q. Does the committee ever determine that patients should not begin hormone therapy?

A. That has been the case periodically, yes.

Q. What are some of the reasons why the committee would make that decision?

A. Well, first of all, you have to understand that the reason that we meet and review this is not to stonewall. You know, the reason that we meet is to make sure that we are looking at safety issues in our offender population. If we see some things that may be problematic -- like, for example, there are certain things that make hormones, you know, not appropriate. For example, if they've had a history of embolisms or if they have a history of liver disease or -- you know, certain things will make it -- we will probably say this is not medically appropriate. There are times when -- you know, as has been mentioned in previous testimony, you know, there's instability. You know, when there's instability, psychiatric instability, for example, and -- you know, if you are adding a hormone, sometimes you will have potential effects.

Sometimes that can be positive, as has been mentioned, sometimes it can be negative. So in order not to confuse that, you know, we -- that's a reason why I think that the WPATH says there should be some stability. So you take care of this -- you work at stability and then you add the hormone.

So we have it -- have sometimes said, you know, right now this isn't -- you know, we have some things to work on, let the offender know that, you know, work on these things, we want you to work on stability, and then let's re-present again in a couple of months and see if -- see where they're at at that point. You know, that's -- so sometimes we've done that,

depending on the situation.

Q. Okay.

A. And -- I'm sorry.

Q. Is it correct that there is about 39,000 inmates right now in the Department of Corrections?

A. Yes, about that.

Q. Do you know how many are considered mentally ill?

A. There are about 13,000 or so on our mental health caseload, and psychiatrists see about 9,800.

Q. Do you know how many are considered seriously mentally ill?

A. Of the 13,000 I'm not quite sure. I think the numbers may be close to 10 or 11. I think it's -- I can't really say. I'd be guessing, but I think it's -- not all the 13,000, but -- less than 13,000.

Q. Okay. Is there a higher incidence of mental illness and serious mental illness in the Department of Corrections than there is in the population at large?

A. Yes, it seems to be so. That and substance abuse.

Q. Do inmates ever refuse hormone treatment, even when it's been recommended and allowed?

A. Yes, there are times when someone is being presented and they're asked whether -- and so the question is, you know, are they requesting hormones because everything seems like there's no red flags, there's nothing that would prohibit them, but they're told no, that they'd rather not. You know, some people

do because they say, You know what, my family isn't on board and I don't want that to happen without my family -- without working on this. Some people do it because they say, Well, I don't know if I want to feminize in a male facility or a -- being in a -- you know, a facility that other people would notice.

There are various reasons why people will say they would not like to be on hormones, and we are going to honor that.

Q. Are there times when hormones are contraindicated?

A. Yes. A time recently, I think, there was somebody that had a cardiac history. It was actually a transgender female to male, and she was -- he was older, in her -- in his 50s, and because of cardiac history and age, it was -- you know, their physician said that they would not recommend it, they think that that would not be a good -- it would not be good medically for her -- for him. And that was -- you know, we asked them to have that conversation with the -- with the patient and certainly review the medical recommendation.

Q. Have there been times when hormone therapy has started and it's led to problems for a patient?

A. Yes. In April of this year we had one of our transgender females have a stroke. And she is paralyzed. Her left side is paralyzed and she has difficulty ambulating. And she has physical therapy and she has difficulty with speech and -- yes. And there was no other reason that was noted why she had that

stroke, but it was -- the conclusion was that it was because of the hormones.

Q. Did you do any further followup with that patient?

A. Well, I have personally been on the phone with the mental health authority at the facility on several occasions, yes.

Q. Is that person still wanting to pursue hormone therapy?

A. No. Well, first of all, the doctor did not -- and now it's contraindicated and the person said no -- well, actually, she said no, she doesn't want hormone treatment and she wants to go back to being a male. And so she didn't want hormones. She wanted to be -- actually, he wants to be, you know, addressed with male pronouns.

Q. I'm going to show you what's been marked as Defendants' Exhibits 5 and 6.

MR. RAY: Your Honor, before the questioning begins on this, I'd like to note that we received these documents a few days ago following our expert declarations in this matter. We would like to reserve the right to submit short expert declarations addressing these documents, particularly from Dr. Tangpricha as they relate to his subject matter, but we didn't have time to do that before the hearing.

THE COURT: All right. I will give you time to do that.

MR. RAY: Thank you.

Q. (BY MR. HIGGERSON:) Do you recognize those documents,

Doctor?

A. Yes.

Q. And what are they?

A. They review what I feel are important -- what I feel is important information for someone to consider when accepting hormone therapy for their transition -- the cross-gender transition.

Q. Who created these documents?

A. I did.

Q. Where did you get the information that went into them?

A. Various sources. There were -- something similar is produced by a couple of other states. And through my literature review and all, that's how I put these together.

Q. Okay. And how were these documents used?

A. When they first came out, I asked our team to ask everybody who is -- at all the -- the next gender -- transgender group therapies that this be presented so everybody gets a copy. And then from then on out, if anybody is prescribed medication or prior to being prescribed -- or -- that the therapists give this to the patients. The doctors also are aware of these forms, and they're encouraged also to give those to their patients to review.

Part of this also I came up with a consent form for medication. That hasn't gone through the process of being approved just yet, but I wanted to make sure that -- that

people had clear informed consent and an ability to talk about anything that's on this page with their clinicians, with the psychiatrists, with their medical doctor, with their therapist, and, you know, I want them to do this in a safe fashion.

Q. How long have these been being used?

A. Not long. I -- you know, this was an internal document, so it was easy to get out. But I believe they may have come out either April or May of this year.

Q. Has there been an increase in the number of concerns raised by inmates who were receiving hormone therapy based on this information?

A. Not that I've heard of. Certainly, you kn ow, we want to encourage discussion and -- you know, that's very important because as -- you know, as we mentioned, you know, these are not benign medications. These are -- you know, if you can have a stroke over this, if you can have other complications arising from any medication, it is important for you to be very clear about knowing what your risks are and -- you know, not to discourage it. Certainly when I prescribe any kind of medication, I tell people the risks. And even if it's a small risk, if it's a serious risk, I'm going to be telling them about it. And I wanted that to happen with the hormone therapy as well. So if you're going to do this, take a look at this; talk to your doctor about these type of things that are problematic; you know, make an informed decision, because if

something bad happens, I -- you know, it's a rare situation, but I don't want that to happen to anybody.

Q. Do you know about conjuncted hormones, Doctor?

A. I'm sorry. What's the term?

Q. Conjuncted.

A. Conjugated?

Q. Conjugated.

A. I don't know much about conjugated hormones, but I do know -- I mean, I've obviously heard about it and know a little bit about it, but not enough to really be --

Q. Once an inmate is approved for hormones, who would make the decision what type of hormone would be given to them?

A. Their medical doctor.

Q. Is that the physician at the facility?

A. Yes.

Q. Does the committee also make decisions regarding surgery for transgender inmates?

A. Do we make recommendations? We will entertain requests for it. And as I mentioned, I've been on the committee for a relatively short period of time, but -- we have had some requests, but at this point it's something that -- I'm still working on some of these -- the whole concept.

Q. Have there been specific inmates who have been reviewed at all considered for this type of surgery?

A. Not today. I have an interview with somebody coming up in

this -- sometime this month. And we were -- we will look at that specific question. But there were three from Dixon that had requested, orchiectomies, castration, and two were leaving relatively soon and the other, when we approached them again, they said they had decided not to pursue that.

Q. Why is the fact that two of them were going to be getting out, why did that affect the decision?

A. Because it was a relatively short time until they were leaving, and to do something like this it takes multiple -- it's a process. And there would be no way of being able to follow up with them and to give them adequate care with what we have available today. You know, if we were to do that, it's very much of a stretch of what we've done so far, and there are a lot of intervening things that would need to be done in order to make something like that happen. So we wouldn't have enough time.

Q. Does the Department of Corrections have a bar against ever providing this type of surgery?

A. No, not that I'm aware of.

Q. Are you aware of how strip searches are performed for transgender inmates?

A. No, not specifically.

Q. Is that an issue that the committee considers?

A. We can, yes. As I mentioned, the security -- our chief of security -- chief of operations, actually, is the technical

term -- he's there and available to discuss that if it were to come up.

Q. Is that not considered a mental health or a medical decision?

A. No, it's -- well, we certainly weigh in on it. And, you know, we certainly want to be respectful of our transgender population and -- and that's of utmost importance. And whatever is respectful is what we want to promote and what we want to do. So when -- in addressing something like that, certainly that's the underlying expectation.

Q. Okay. Does the committee consider issues of transgender inmates needing to transition to their preferred gender?

A. Transitioning in what ways? Hormonally certainly. You mean as far as --

Q. Social transition.

A. Social transition. Yes. You k now, we have groups that will address the social transitions in all the individual therapy and sometimes we will say -- you know, certainly work with this individual, you know, on those issues because those things are going to be important. And yes, I mean, there have been recommendations for bras. I think in the -- in the -- during the time I've been in this position, we have moved from -- bras initially were based on medical need; in other words, they had to see the doctor, had to see if there's breast tissue, what have you, that would kind of necessitate a bra. I

think we've moved to an understanding of the fact that sometimes bras are there for psychological comfort, and so we no longer have that requirement.

And we've also let the facilities -- that be decided on a facility level. And so the facility can make that decision. It doesn't have to come to committee. You know, some things used to have to come to committee: showering permits, showering differences, whatever. That's too essential to have to wait for a committee decision. You know, we've left that to the facilities. So we are -- you know, we're in transition. We're changing things to be more accommodating and be more respectful, and that's our goal.

Q. How about which types of items, hygiene or other items are available through the commissary? Is that part of what the committee would consider?

A. You know, that -- that tends to be in the operations department more so. You know, I think we've been a little more lenient about that. I -- you know, that's something that I haven't yet addressed with everyone. There's mixed thought about that, and so...

Q. What type of therapy is available to transgender inmates in their facilities?

A. Well, certainly individual therapy is available to everybody. And there are some that -- we do have some people that say, No, I don't want to go to those groups because

everyone is going to see me going with that group and they'll label me. I'm not ready to come out and make it public, so I only want individual therapy. And that's okay. You know, we will accommodate to their readiness. Otherwise, we do have groups that occur during the course of the week. That's Dr. Reister's department, so I've kind of let him deal with that. So he would probably be better at describing at what facilities, what has -- you know, there are -- some facilities have a little more than others and we've transferred some of the offenders -- some of the transgender offenders to facilities where they can have a little more transgender groups and treatment and when there's larger population. So we will do that to accommodate their needs.

Q. Has misgendering been something that's been raised as a concern within the Department of Corrections?

A. Yes. You know, certainly we have -- and I don't know how many thousands of employees we have, but we have 31 facilities, and people come from varying different backgrounds and we've -- we have been -- we've -- we've started education for all the correctional officers, and misgendering is very much of an important topic that we have been very strongly emphasizing that, you know. And there again, they need to ask what -- how they would like to -- be how the individual would like to be addressed. Some would rather not be addressed by a different gender just because of the other people who hear them and

potential social consequences or what have you. So they have to be respectful of that.

But, yes, that's something that we as a department have been pushing and trying to change the culture within our department.

Q. Is anything being done directly about officers who are potentially verbally abusive or insensitive?

A. Yes. You know, there have been some that have been fired. And I think the wardens themselves know that this is an emphasis that we've placed that this is something that we will not tolerate. So, you know, they -- I believe there's a -- Chief Eilers has put out -- they do daily call or roll call, and so sometimes there are some things that are read for a couple days or whatever so everybody, you know, hears it. And I think that was one thing I think that he put out some time ago I remember seeing. But, yes, that's very important. It's not an easy thing to address, but we are trying to address it.

MR. RAY: I'm going to object that this is hearsay. He has not been on these calls or said he has been. This is all thirdhand information.

THE COURT: Well, to the extent he knows with his employment in the Department of Corrections I think it is appropriate.

When did this start, when you said they started the training and --

A. Earlier this year. It must have been, you know, some of this, I think, was -- came from the mandate out of a court with Ms. --

THE COURT: Hampton?

A. Ms. Hampton, yes.

THE COURT: That would be me.

A. Oh, thank you. So that's -- that prompted that. And so from there we've -- you know, we've kept with it and we're training other people, continue to train, and it's become an important initiative for us. So thank you.

Q. (BY MR. HIGGERSON:) What about preferred names for transgender inmates? They can't change their legal name, but how are they referred to within the department as far as their preferred names?

A. At each facility, certainly they're -- I think that's kind of done on more of an individual basis. I mean, we certainly encourage them to -- encourage the people that work with our population to ask them their preferred name. I know there was -- I'm sorry. I think there was a nice name that is from one of our offenders here, and when I got to the facility I think they -- you know, they were, you know, very respectfully calling her by a different name. And so that was -- seemed like it was very well respected there, and I liked that. At Pontiac.

Q. I think you mentioned earlier that there have been

transfers approved by the committee of somebody who is in the male side over to -- and it would be Logan Correctional Center for a female facility; is that correct?

A. Yes. With -- from the time that I've been in the department -- in this role, I -- we have had two transfers. Prior to that there were two others, but from my knowledge, my direct knowledge, there have been two.

Q. Is there any information about the two prior ones that has affected the committee's ability or willingness to make transfers?

A. No, not willingness, but I think there is certainly caution. You know, I think of the two previous. I think one seemed to be fairly successful and went without ripples. The second one I think, from what I understand, stopped taking hormone medications and became very sexually active with the females in the -- at Logan, and that was a problem. That -- certainly, you know, the -- you know, that situation was difficult and people, you know, have talked about how do we prevent something like that from happening in the future.

Q. What considerations are taken into account when you are determining if somebody can be transferred to Logan?

A. Several things. You know, we look at -- we look at -- we look at a number of things. Certainly, you know, what is the reason that they're asking for transfer I think is very important to consider that from their perspective. Are there

safety factors, because there again, you know, going to a female facility, there's potential -- you know, we stir things up in a female facility, and we want to make sure that this is safe not only for the individual that goes over to Logan, but also the receiving facility.

So, you know, the security factors are important. You know, we always review, for example, the PREAs and the grievances and the disciplinary file and the medical file. So we look at all that and we present it to the committee and the committee makes the decision of what direction to go in.

Q. You mentioned the facility itself. How well received are transgender inmates at Logan?

MR. RAY: Calls for speculation. He's talking about an entire prison population.

THE COURT: Well, to the extent that you can answer based on your experience with inmates there, you can answer.

A. Okay. You know, I think in the two individuals that I've been involved with, you know, their desire has been to go into a more accepting, more safe place where they can be -- where they can do some of their treatment and be able to be accepted. And that's been their expectation. And I think they've -- I think what they've found -- from what I understand -- and there again, this is feedback that I'm getting from the warden, from the psychologist staff, from -- you know, from what I understand, you know, they haven't been well received.

The women have had -- have filed false PREAs. Some may be legitimate PREAs, but there again, a lot of false PREA allegations, a lot of -- I think unfortunately, the problem that we have to look at is if you look at the literature, about 60 percent of the female population has been exposed to domestic violence and physical violence, physical and emotional violence in the prison population, about 60 percent. So we are putting in individuals that sometimes scare the women that are there. And they're not used to that. They're not -- you know, it's -- and, you know, it's been rather difficult for that transition for them.

You know, some of what we have to learn from this is how do we soften this up, how do we make this better, how do we make this a better situation, because I think sometimes for our two individuals, they haven't been welcomed with open arms. You know, one individual seemed to transition fairly well. The other one has had a lot more difficulties. And so those are things that we've had to deal with.

Q. Is there still consideration of sending further inmates -- transgender inmates to Logan Correctional Center?

A. We are going to take it on an individual basis. Just because we have had difficulties doesn't mean we're going to stop necessarily, but I think we're going to -- you know, we're going to learn from our mistakes and we're going to see if we can avoid problems. You know, right now -- you know, if you

would have asked me who out of the two offenders that I've facilitated sending would be successful, I would have picked the wrong person. So I was -- you know, so I don't know how -- you know, I've got -- you know, I've got to -- perfect or improve my way of kind of looking at red flags, looking at what type of things would be problematic, what type of things wouldn't. But, you know, it has -- it's been difficult.

Q. Are there additional steps you are taking when somebody is being considered for transfer?

A. Yes. What we ended up doing -- learning from the situation is -- you know, I have been looking at those grievances and the -- tickets come to mind, but the -- the -- the disciplinary reports. And I -- now we have somebody on our committee that's going to look at it on a security basis and make sure that they look at this and feel like it's a good match to come over. So we added somebody else.

But I'm in the process of trying to create a better way of looking at, you know, what would make a person successful. Because there again, if a person is not successful, it doesn't do that individual any good and it doesn't do the females at the accepting facility any good. It makes everybody's life a nightmare, and we don't want that to happen. You know, we want to do this because it's the right thing to do, it's important for the individual that's going over and it would be helpful for the individual going over and that individual be

successful. If we if -- obviously, you know -- at this point we are still learning what makes a successful transfer.

Q. Do you have any direct contact with the inmates who are being considered for transfer?

A. Yes. What we've started to do -- and there again, this has been two people and I have evaluations for three more. This is -- I've -- it's taking up a lot of my time -- three more coming up in the near future that I'm going to be evaluating. But what we've done is Dr. Reister and myself have gone to the facility and have reviewed all the records, looked at the charts, spoken with the warden, spoken with the therapists, and gathered as much information as we can and then we bring that to the committee.

Q. And then just turning to the two specific inmates who have been transferred to Logan, the first was Ms. Hampton?

A. Yes.

Q. And what was the feedback you got after that transfer happened?

A. Well, the followup, because we had -- we asked her to be presented again, and the feedback that we got from the warden was that it was -- there were some difficulties. There again, not a warm welcome from the other -- the existing patients at Logan, people at Logan. But -- and some difficulties, some acting out difficulties. There were some difficulties. But Warden Austin said he is very on board with trying to work on

her adjustment and work on helping her and that he wasn't giving up on this and he was going to continue to work. So that was our initial feedback that first month. After that, I think we got feedback the following month that said that -- I think the following second or third month, because it did take at least a couple months before things began to settle down, and things seemed to get better. And so we have started to get more -- you know, better feedback. She was fitting in and doing better.

Q. Is she still at Logan Correctional Center?

A. She has been released.

Q. And then the second inmate who, since you have been on the committee, has been sent to Logan is Ms. Monroe?

A. Yes, uh-huh.

Q. And what feedback have you gotten on that situation?

A. Well, difficult feedback from the beginning. I think we had a followup within a month, and the feedback was that there were -- there again, the false PREAs against her or PREAs, many PREAs against her. And after investigation, it seemed like most of them were false. There were -- there was, you know, feedback of threatening staff, threatening other females, intimidating, I think, the females. And Warden Austin was surprised that because she is, you know, 6-foot-1 and large, that I think people felt a little more intimidated by her size, and she's got some muscular physique. And so I think from what

I was hearing was that people were feeling very intimidated and very scared.

And so we had a meeting with him and so at that point -- with Warden Austin, and so then we wanted to follow up in the transition.

And the next follow-up meeting -- unfortunately, I think there was -- I think one of the TV channels was doing something there and he couldn't be at that meeting. But then the following -- about a month and a half later, then that's when we had reports that she was having sex with another female inmate at the prison, and so -- which kind of baffled me, because in our interview she said she was only interested in males and that her genitalia wasn't functioning because she had been on hormones for a long time. And when I looked at her disciplinary record over the last three years, she had been doing better. So I didn't anticipate, you know, what we were hearing and what we were seeing.

And at the last meeting we had, I think Warden Austin was very exasperated with his attempts to try to keep things stable and keep things safe. And his what he reported was, you know, the only way to keep her safe -- she had been in segregation because of some of the -- because of some of the intimidation and threats and all, and she said -- he said, I don't know if there's any other -- what else we can do to keep her safe. But segregation, obviously that's not okay. And so it was a very

difficult meeting and -- yeah. So it had not been going very well, and I think, you know, certainly they were pointing to the fact that, you know, she has a very significant past history of violence and aggression and maybe she is not the kind of person that we should have had over.

You know, at that point, you know, that's a long -- you know, to me, I thought, well, three years of much improved status would say that yes, that happened in the past and what have you, but let's give her another trial. So I don't know. I'm baffled and I just -- I -- I'm trying to learn from the situation. And like I said, I think we've been trying to be very accommodating, trying to be very -- you know, working with the population. But, you know, obviously this type of a situation really kind of sours things and we need to kind of figure out how do we make things safe for everybody. And, you know, I -- we're still working on the answer to that.

MR. HIGGERSON: Thank you. That's all the questions I have.

THE COURT: All right. Cross examination.

CROSS EXAMINATION

Q. (BY MR. RAY:) Dr. Puga, good afternoon.

A. Good afternoon.

Q. Thanks for your patience today.

Dr. Puga, you are a licensed physician, correct?

A. Yes.

Q. But you would agree with me that not every physician is qualified to treat every type of condition, right?

A. Correct.

Q. You wouldn't go see a dermatologist for a toothache, correct?

A. That's dentistry, and I wouldn't think -- although same ectoderm creates both teeth and skin. But I would not go to a dermatologist to treat dental issues.

Q. Neither would I. You would not visit a podiatrist to have a stent placed in your heart, would you?

A. Correct.

Q. That's because doctors have specialties, right?

A. Correct. Podiatrist is very different. You don't go to medical school for podiatry. You don't go to medical school for dentistry.

Q. And certain conditions demand specialized doctors, right?

A. Yes.

Q. You would agree with me that a transgender individual with gender dysphoria has a serious medical condition that demands specialized care, right?

A. Not always.

Q. So you can have a transgender individual suffering from gender dysphoria who can simply be treated adequately by a generalist?

A. Sometimes, yes.

Q. What aspects would be adequately treated by a general physician to treat someone with gender dysphoria?

A. Sometimes they have depression. Sometimes they'll have anxiety. Sometimes -- you know, all -- for example, all psychiatrists deal with anxiety, depression, family issues, social issues. So in general, psychiatrists do that.

If you look at -- if you are talking about medication treatment, more antidepressants are prescribed by nonpsychiatrists than psychiatrists.

Q. But isn't part of being at a minimum qualified to treat gender dysphoria being able to separate out other mental health conditions from gender dysphoria?

A. Whenever you are addressing a patient, you always have what we call a differential diagnosis. So you have several things that you consider. You should never just consider one thing, because if you do, you miss out on a lot of other issues that may be there. So a good physician looks at a number of possibilities in their diagnosis.

Q. My question is slightly different. Somebody who meets the minimum standards of care that we've been through today knows how to separate out the symptoms, diagnoses for gender dysphoria versus other mental health conditions, correct?

A. Most people will have that in their curriculum as far as their learning and training, as far as being able to identify some of that.

Q. Again I'll ask my question. Somebody who meets the minimum standard of care to treat gender dysphoria can separate out the diagnoses of gender dysphoria and treatment of that versus other mental health conditions, correct?

A. They should be able to look at gender issues as well as other disorders, yes.

Q. You chair a committee that oversees the care of transgender prisoners in the state of Illinois, correct?

A. In Department of Corrections, correct.

Q. And you are joined in that committee by several other individuals, right?

A. Yes.

Q. And together, you oversee the care of all transgender prisoners within IDOC?

A. Together we do, yes.

Q. Let's talk about your qualifications. I'm trying not to be repetitive of what's been covered before.

You graduated from medical school in 1985, right?

A. Correct.

Q. And during medical school, gender dysphoria did not come up, right?

A. During medical school? I don't recall. It was so long ago. But certainly, you know, sexual development is something that -- and sexuality is something that was covered. I don't remember specifically -- the topic specifically.

Q. Okay. So sitting here today, you don't remember gender dysphoria coming up in medical school?

A. Not that I recall, but that was a long time ago.

Q. Since medical school, you have had exactly two transgender patients in private practice, correct?

A. Two in my private practice. One in -- at least one as far as inpatient. When I was with Department of Corrections, at least two in Department of Corrections a year before I started this position. At least three or four transgender in the school system --

Q. Dr. Puga, if I may, we're going to go in order here, and I'm just trying to take this step by step.

So in your private practice you had two patients who were transgender, right?

A. Yes, I believe so.

Q. And when you worked as a hospital physician from 2000 to 2017, you had three patients who were transgender, right?

A. I believe so.

Q. And then when you were consulting with the school district, I believe, in Crystal Lake, Illinois, you consulted on approximately three additional transgender students, making eight in total, correct?

A. At least three, yes.

Q. Okay. But you didn't treat any of these eight patients for gender dysphoria, did you?

A. That was part of what we talked about through our consultation.

Q. Okay. Do you remember giving a deposition earlier this year in April?

A. Yes.

Q. Do you remember talking about these experiences?

A. Yes.

Q. Do you remember being asked if you had treated these patients for gender dysphoria?

A. I believe so.

Q. And do you remember what your answer was?

A. No.

Q. It was [as read] They see therapists. They've seen -- they had seen therapists. My role was more limited as far as dealing with their mood disorders.

You weren't treating their gender dysphoria; you were being consulted to assist with other psychiatric needs, correct?

A. It depends on how you describe treatment. They weren't my primary -- it wasn't my primary goal. I always do supportive psychotherapy, and I've talked to them about their gender issues, their social adaptation, their school adaptation. You know, it's not as though we have only talked about medicines or specifically about anxiety, depression, what have you. You know, when I see people in my outpatient practice, I usually see them a minimum of a half an hour and we discuss a lot of

things, and globally their adaptation and all.

Now, is that considered treatment? You know, I don't see them weekly as a psychologist would. I don't see them regularly as a psychologist would. I might see them every three to four months or so. And so, you know, how do you define treatment? Was I the primary treating person? I wouldn't say I was the primary treating person. However, did I, you know, do some supportive psychotherapy along the way, help them with some of their transition, help them look at some of their issues? Absolutely. That's part of it.

Q. So at least we can agree on this: For the eight patients you saw before you began work on the committee that you currently serve, you did not serve as their primary treatment medical professional for gender dysphoria, correct?

A. That's correct.

Q. Okay. And now as chair of the committee on which you sit, you are entrusted to make medical decisions regarding the care of every transgender person within IDOC, correct?

A. Psychiatric decisions, yes.

Q. Well, you are entrusted to make decisions on hormone therapy, correct?

A. I collaborate with Dr. Meeks and the other facility doctor on the hormone piece, yes.

Q. And you are, as a committee, interested and make decisions on surgical treatment?

A. If it arises, yes.

Q. And you are entrusted to make decisions on social transition, which is a medically necessary item for transgender individuals, correct?

A. I contribute along with everybody, yes.

Q. Do you agree with me, then, on the IDOC committee you are entrusted with making medical decisions such as the ones we've just talked about regarding the care of every transgender prisoner within IDOC?

A. As part of the committee we share that responsibility, but I chair that committee.

Q. Okay. And you are familiar with WPATH, which has been talked about a bunch today, correct?

A. Yes.

Q. And you are familiar with the WPATH standards of care?

A. Yes.

Q. Would you agree with me that the WPATH standards of care are the authoritative guidelines on medical care for transgender individuals?

A. I think that's one -- one association that has taken upon themselves to make standard of care, et cetera.

Q. Are you aware of any other association that rises to the level of universal international acceptance and respect in this area?

A. I'm not familiar with that, but -- there may be, but

certainly they may have.

Q. Sitting here today, you can't think of anybody?

A. I haven't done enough research to be able to tell you.

Q. Okay. You are aware that the WPATH standards of care were first published in 1979?

A. I don't know the history.

Q. Okay. You are aware there is a recent version that was published in 2012, version 7?

A. Yes.

Q. Are you aware that's the current version today?

A. Yes.

Q. And so in other words, these standards of care, whichever version they've come at, have been around for a long time, correct?

A. If they're on the seventh version, yes. Probably, yes.

Q. Did you contribute to the creation of any version of WPATH's standards of care?

A. Nope.

Q. Okay. And you are not a WPATH member, are you?

A. That's correct.

Q. And you are not WPATH certified, are you?

A. That's correct.

Q. And you have never trained under a WPATH-certified physician, have you?

A. That's correct.

Q. And other than Dr. Ettner, who you saw testify earlier today, can you name one other WPATH-certified physician?

A. No.

Q. You've never cared for a transgender individual while under the supervision of WPATH-certified physician, have you?

A. That's correct.

Q. And while you plan to attend a WPATH conference later this year, today you have never attended one?

A. That's correct.

Q. Now, you have engaged in some continuing medical education for gender dysphoria, correct?

A. That's correct.

Q. All right. But that was limited to two conferences you attended in the last year, right?

A. That's correct.

Q. And across those conferences, the combined lecture time relevant to transgender issues was between three and four hours?

A. Probably, yes.

Q. And you have also attended a few transgender group sessions in Illinois prisons since you have been on the committee, right?

A. That's correct.

Q. But you have attended two of these?

A. That's correct.

Q. That's it?

A. That's correct.

Q. You have never prescribed hormones to a transgender patient, have you?

A. That's correct.

Q. You have never personally been involved in monitoring hormone levels of a transgender patient receiving hormone therapy, have you?

A. Not directly.

Q. You have never personally approved surgery to treat gender dysphoria, have you?

A. The letter that I wrote for my patient, is that considered approval? That was part of what he needed in order to have the surgery.

Q. So you wrote a letter of recommendation for one patient. Other than that instance, have you ever personally approved surgery to treat gender dysphoria?

A. No.

Q. You've never personally presided over the social transition of an individual with gender dysphoria, have you?

A. That's correct.

Q. Okay. Dr. Puga, you do not hold yourself out as an expert in the treatment of gender dysphoria, do you?

A. I do not advertise that, no.

Q. And you do not meet the minimum qualifications that are set

forth in the WPATH standard of care that were outlined today for the treatment of gender dysphoria, do you?

A. I don't know, because I think what I read as far as qualifications were rather minimal qualifications as far as treatment, so --

Q. Let me ask you a question. Before today, were you aware that there was a list of minimum qualifications within the WPATH standards of care?

A. I -- I would -- I think I've seen it, but I don't recall.

Q. Have you ever measured yourself against the minimum requirements to see if you meet them?

A. No.

Q. Okay. And you are the person now, however, who is in charge of overseeing all of IDOC's psychiatrists, correct?

A. That's correct.

Q. And it is these psychiatrists who were responsible for the diagnosis of gender dysphoria within IDOC, aren't they?

A. That's correct.

Q. And you're chair of the committee that makes final decisions about the treatment of transgender prisoners diagnosed with gender dysphoria, correct?

A. I'm the chairman of that committee, yes.

Q. Let's talk about some of the other members of the committee. There are five voting members, including yourself, correct?

A. Yes.

Q. Let's talk about Dr. Meeks. He is a medical doctor, right?

A. Correct.

Q. And do you consider Dr. Meeks an expert in the care of transgender individuals?

A. Is that a statement or question?

Q. That's a question.

A. He is a medical expert and he has medical training, and I look to him for medical advice, advice on the medical side.

Q. My question was a little bit different.

Do you consider Dr. Meeks an expert in the care of transgender individuals?

A. He's had more experience than I have on that.

Q. Understand completely. My question was slightly different.

Do you consider him an expert in the care of transgender individuals?

A. He's had a lot of experience and he's chaired this -- or been in this committee for a lot longer than I have and I -- like I said, I look to him for that guidance, for the medical guidance.

Q. Do you know if he meets the minimum qualifications under the WPATH standard of care that we talked about earlier today?

A. That I don't know.

Q. Are you aware that Dr. Meeks gave some testimony in the Hampton case last year?

A. I'm aware that he did, but I don't know what that was like.
Q. Well, one of the things that he said -- he was asked [as read] You are no expert in providing care to trans people, correct? And his answer, I would not consider myself an expert in this area.

So Dr. Meeks himself has admitted under oath he's not an expert.

And do you know if Dr. Meeks has ever overseen the administration of hormones to a transgender individual?
A. That I don't know.
Q. Well, he hasn't. He was asked [as read] So you, yourself, have never overseen the administration of hormones to a trans person; is that right? His answer --

MR. HIGGERSON: Your Honor, I think he is being impeached with somebody else's statement. I don't know what the --

MR. RAY: The purpose is that Mr. Meeks is a defendant in this case. It's an admission, and I couldn't get an answer out of the witness as to whether or not he considered himself an expert. I'm simply confronting him with the testimony of the person on these relevant questions.

THE COURT: Well, the objection is overruled.
Q. (BY MR. RAY:) The question was [as read] So you, yourself, have never overseen the administration of hormones to a trans person; is that right? His answer, No. I do not provide

direct medical care. That's correct.

Do you know if Dr. Meeks has any expertise on how hormones affect an individual's reproductive system?

A. I don't know.

Q. He was asked in the same transcript, quote:

You do not know how these hormones would affect an individual's reproductive system; is that correct? Answer, I would have some basic knowledge just by virtue of being a physician, but I would say I have -- I do not -- do I have expertise in that area? Answer, No.

Psychiatrists such as yourself do not prescribe hormones, do they?

A. Correct.

Q. So in other words, Dr. Meeks, the only medical doctor on the committee who could hypothetically prescribe hormones, admits he is not qualified to do so, right?

A. If what you read was accurate, that stands on its own.

Q. Yet the committee is responsible for overseeing the IDOC physicians who prescribe hormones to transgender persons, isn't it?

A. Yes.

Q. Dr. Hinton is on the committee as well. He is not a medical doctor, is he?

A. That's correct.

Q. Do you consider Dr. Hinton an expert in the care of

transgender individuals?

A. He's extremely knowledgable of the care, yes.

Q. So you'd consider him an expert?

A. Yes.

Q. Okay. Were you aware that Mr. Hinton gave a deposition in the Hampton case?

A. No.

Q. Okay. He was asked [as read] So do you have an understanding of what the general treatment is for gender dysphoria? His answer, General treatment, no, I do not.

Chief Eilers is also on the committee. Am I pronouncing that right? Is it Eilers?

A. Eilers.

Q. Eilers. He is the chief of operations?

A. Correct.

Q. He has no medical training at all, does he?

A. That's correct.

Q. Do you consider Chief Eilers an expert in the care of transgender individuals?

A. No.

Q. And finally, we have Ms. Wortly she is the transfer coordinator.

A. Yes.

Q. Do you consider Ms. Wortly an expert in the care of transgender individuals?

A. No.

Q. And similar to Chief Eilers, Ms. Wortly has no medical training at all, does she?

A. I don't think so.

Q. Okay. So just to summarize, then, there are five voting members of the committee and not a single individual is an expert in providing care to transgender individuals, are they?

A. It's depends on how you describe expert, but if it's by WPATH standards, if that's how you -- what you consider an expert, I -- I haven't looked at it, but, you know, they may not meet that criteria. If you look at how all of us have dealt with transgendered individuals for years and have been -- have participated in their treatment and have, you know, a lot of working knowledge and self-study and what have you, I think that -- you know, I think we're -- you know, we're -- I think we're very capable people.

Q. You were in the courtroom earlier for Dr. Ettner's testimony, correct?

A. Yes, I was.

Q. Do you remember she was asked if self-study counted towards being qualified to render adequate care for transgender individuals?

A. Yes.

Q. What was her answer?

A. Her answer was no. That was her opinion. But at the same

time, you know, we physicians do a lot of research on our own and we continue to learn and we continue to grow and we continue to expand our knowledge on different things. And that's -- that's what we do as physicians, and we stretch our knowledge. And so that's -- that's what I expect of myself. That's what I expect of other people as well.

Q. You also mentioned Dr. Shane Reister, who is a fellow colleague within IDOC; is that right?

A. He's a psychologist, yes.

Q. Okay. And do you consider him to be an expert in the care of transgender individuals?

A. I do.

Q. He is not a medical doctor, though, is he?

A. That's correct.

Q. He is not WPATH certified?

A. I don't know that.

Q. Well, he -- I think it was mentioned he is a WPATH member. He has been to only one conference his career, correct?

A. I don't know.

Q. Are you aware if he meets the WPATH standard of care minimum qualifications?

A. I would have to look at that list. I know he does a lot of research on his own. I think he meets with the community -- with community people as far as he's very knowledgeable of what kind of services are available after people leave our

department. I think he does a lot of extra work on his own and he is very knowledgeable.

Q. Dr. Reister doesn't get a vote on your committee, does he?

A. I highly esteem his input, and so he would -- you know, I would want his input at every committee meeting and -- and I would very much -- I really need him to be available.

Q. He doesn't get a vote though, right?

A. You know, I've been looking at this. Those -- voting is not defined in our AD and in our SOP, and I -- and that's something that I have to take a look at, because I -- I think that's a point well taken. I think he should have a vote.

Q. He doesn't have a vote, though, does he?

A. Can you define the votes?

Q. Well, I'll go back to your testimony that you gave earlier this year. You were asked [as read] I believe you said, then, that the committee, by five members of the committee, will make decisions by vote? Your answer was, Yes.

Five members do not include Dr. Reister, do they?

MR. HIGGERSON: Can we have a page number?

MR. RAY: Sure. That's Page No. 42, Lines 8 through 11. If you would like, I can put it right up here on --

A. The AD says that there are minimum participants. So "minimum" means we can add more. So does that mean we can give them righting votes -- voting rights? You know, that isn't defined, and I think -- like I said, among a number of things

that I have to take a look at as chairman of this committee, that's something that I need to take a look at and make some decisions about.

Q. As we sit here right now, August 1st 2019, does Dr. Shane Reister have a vote on your committee? Yes or no?

A. I would give him a vote on my committee.

Q. Does he have a vote?

A. I would give credence to his opinion. I would -- I'd have to take a look at what we've done previously and -- to tell what you we've done previously. But I am going to make it a point to give him a vote on our committee in the near future.

Q. And you need to do that in the near future because he doesn't have a vote now, right?

A. I don't know. I don't know if I've given him the right. There is no definition of who gets a vote in our system right now.

MR. RAY: Could I have the ELMO on, please? Thank you.

Q. (BY MR. RAY:) And like some of the other attorneys before me, I'll apologize for putting some notes on here. Do you see on Page 42, Line 8 --

A. Line A?

Q. It reads [as read] I believe you said then that the committee, the five members of the committee, will make decisions by vote? Answer is, Yes.

Correct?

A. Yes.

Q. And the five members there are yourself, Dr. Meeks, Dr. Hinton, Ms. Wortly and Chief Eilers, correct?

A. Correct.

Q. Not Dr. Reister?

A. Yes. But that hasn't been defined, and so because it's left undefined, I'm going to take the privilege of adding him as -- because I see that that's fitting.

So with no guidance on that, based on our administrative directive or our SOP, that's something that I need to take a look at and it's something that I've been considering.

Q. Your committee was created for the purpose of overseeing the care of transgender prisoners, correct?

A. That's correct.

Q. And it was created in 2013?

A. I don't know the history. Sorry.

Q. It's a formal committee, though, right?

A. Yes.

Q. And you're not aware of any other formal committee within IDOC created to oversee the care of any other group of prisoners, are you?

A. I don't know about the medical side. I know there are certain specialty clinics, but I don't know how those are run.

Q. And the committee makes medical decisions on transgender

individuals by vote of the five people we've talked about earlier, including yourself, correct?

A. Well, as I mentioned before, the people that have voting rights have not been defined just yet. But we vote as a committee.

Q. And however the majority of the five people vote, that's the medical decision, correct?

A. I believe that the reason that this committee was formed was to ensure the good care of the transgender individuals. And if you look at how the WPATH standards of care are written, you know, when I -- as I read through that, it looked to me like, you know, this is what they were defining. They wanted to -- they wanted to -- they were describing a collaborative group of multidisciplinary individuals who are putting in their input to make important decisions. Because there again, a psychologist can't make a decision for hormones. A psychiatrist should probably have some weigh-in in hormones, but not make the final decision. Medical doctors should be someone who is there and helping with that decision. When it comes to surgery, a surgeon should be there.

So we have, in essence, a group of multidisciplinary people who are overseeing something that few people in the free world have available to them. It's very common that in the free world people don't talk. Psychologists and psychiatrists don't talk. Medical personal and psychiatrists don't talk.

Therapists and medical personnel don't talk. And we have a distinctive opportunity for all of us to put our heads together and contribute to the care of this population.

So it's more than what we do with any other population. You are absolutely right. We take -- we do a lot for this population that we don't do for everyone else. It would be wonderful if we could do this for everybody else, absolutely wonderful to be able to weigh in on people's psychiatric, psychological, medical, safety needs. If we could do that with all our mentally ill, this would be an ideal system. We don't have that, but you are absolutely right, we are providing a wonderful opportunity for -- to oversee and try to make the best decision for our transgendered individuals.

So yes, I agree that we are doing -- we are doing above and beyond what we are doing with anybody else.

Q. I'll ask my question again. However the majority of the five people vote on the committee, that's the medical decision, correct?

A. That's the recommendation that's given.

What happens is that we -- you know, we have a medical doctor that actually prescribes their working with us. We have the psychologist who is working with them there. We have -- you know, we have that team, and sometimes we have other people. We definitely have somebody from the warden's office. And so we are -- for example, if we say, you know, Boy they

are -- they are not physically or mentally psychiatrically stable enough, let's do this first, and then we will introduce hormones, then at that point, you know, that's the feedback that we give to the providers.

Now, they could say -- they could counter that. There's evidence or there's testimony that was brought up before that -- where they said that the person was stable. We as a committee ask more questions. Well, what about this? What about this? Are they doing this? Are they participating? Are they getting tickets? Are they doing whatever? And sometimes what happens is that the information that we gather in that meeting contradicts the initial presentation. So we are going to override it. We are going to make good decisions based on what we gather in that committee.

Q. Dr. Puga, I totally understand the notion that you were gathering information from the other nonvoting members. I get that. But the buck stops with the committee, right? You are the final word?

A. For the most part. Not always.

Q. Well, there's really no appeal available for a decision out of the committee, right? You have not seen that?

A. There have been people who have re-presented yes. And we in a sense form our own appeal in that usually when we say no to hormones we will say, you know, no because of such and such, but come back in 30 days, 60 days, 90 days, re-present and see

how they are doing and then we're going to reevaluate. So we generally don't say no. We oftentimes say, you know, not right now, but meet these criteria and then we'll take a look at it again.

Q. My question is slightly different. You have not seen an appeal of a committee decision, however, since you have been there, have you?

A. I've seen people bring things up again. So is that an appeal? They're always welcome to bring up another situation or what have you with the -- through their therapists.

Q. You gave some testimony, again, earlier this year, in April. If you look on Page 106 -- and apologies for the markups, but maybe it's even easier, I guess, to get through it.

You were asked [as read] There's no appeal of a committee decision, is there? And you surmised that there could be. And I'm paraphrasing, but the testimony is in front of you, so you can tell me if I've gone wrong on this. And you said that it could be appealed. And you were asked: Has it ever happened -- at Line 10. And you say, Not that I know of. I'm relatively new to the committee, and so not that I've seen.

So has that changed? Have you seen an appeal that you have not seen as of April 19th 2019?

A. I'd like to see the page before that because I don't know what we are describing as far as appeal.

Q. Of course. If we follow on the bottom here of Page 105, the question you were asked before: [as read] Then does the Committe -- is there -- The committee is the final word, though, right? And your answer, Yes.

So all I'm asking you, Dr. Puga, since April, have you seen an appeal of a committee decision that you have not seen as of that point in time?

A. Yes. Yeah. And like I said, I think people have brought up other things -- yes, through their -- through their therapists, yes.

Q. But you are talking about representment. I'm talking about an appeal of your decision.

A. I think that's -- how do you define "appeal"? Reconsideration? Because when they bring it back up, it's a reconsideration.

Q. You clearly understood the question in April. You were testifying on behalf of the defendants as a 30(b)(6) witness. You didn't ask for clarification then, but -- I'll move on.

THE COURT: Well, so let me just ask. So like when I issue a decision, it can go to Chicago and there is an appeal -- an appellate court that then says, well, I was right or I was wrong. Is there anybody above the committee that the committee's decision can go to?

THE WITNESS: It can go to the director. But what happens, though, is that -- you know, some things have kind of

come back up for reconsideration and we've accepted that and we've made modifications -- one thing that comes to mind that just happened last month -- and we are going to act differently based on new information or what have you.

So is that an informal appeal? If they want to do a formal appeal, yeah, because the committee answers to the director. If something were to happen within our committee that we were going to make a recommendation, we recommend it to the director and the director will then --

THE COURT: But who would take it to the director, the medical provider who was recommending something to the committee or the inmate?

THE WITNESS: Yeah. And frankly right now, we don't have a formal set way. I mean, when I inherited this position, it was a skeleton, and so I'm trying to put some meat on the bones and I'm trying to make it workable. And that's something, frankly, that we haven't built in at this point that we will need to build in. But we have reconsidered and -- something recently came up and we are going in a different direction because they brought it back up with their therapist.

THE COURT: Okay. Sorry to interrupt. Go ahead.

MR. RAY: Thank you, your Honor. Anytime.

Q. (BY MR. RAY:) Your committee meets typically once per month, right?

A. Yes.

Q. For two hours?

A. Yes.

Q. Via phone?

A. Two hours or more. Many times it goes over, yes.

Q. Via phone?

A. Yes.

Q. And when the committee is making medical decisions, prisoners are given a default six-minute time slot for their case to be heard, correct?

A. They're scheduled every six minutes. It goes over all the time, you know, based on, you know, what the need is. So if the need is more, then they'll go over. And if it goes over, there are -- there have been at least one situation where we've said, you know what, we have to take this separate from what we are doing here because this is something that we have to look at apart from this. So -- but -- but six minutes is what they're slated for, but that's a soft six minutes. We've been over an hour. You know, our two-hour slot has gone three hours sometimes.

Q. But six minutes is the default.

A. The default, yes.

Q. And when the committee is considering a prisoner's case, the prisoner himself or herself is not appearing before the committee, are they?

A. That is correct.

Q. That's actually never happened since you have been on the committee?

A. Right.

Q. And the committee does not have the prisoner's full medical records on hand, does it?

A. Yes, it has it available. In the room where it's being presented on the other side, there is a medical doctor and he has the chart in front of him.

Q. My question is slightly different. Does the committee have the patient's full medical records on hand when it is discussing the patient at a committee meeting?

A. Not directly, but it has access to it through the eyes of the medical doctor.

Q. Okay. Again, the committee members themselves don't have the patient's full medical records on hand during the committee meeting, do they?

A. They only have partial records.

Q. And they don't have the full mental health records of the prisoner at hand during the meetings, do they?

A. That's why the therapist is there on the other end, to be able to give that information.

Q. Right. But the committee members, the ones who are voting and making the decisions, do not have the patient's full mental health records on hand during the committee meeting, do they?

A. We have a summary in the DOC0400, and that's -- at a

minimum we have that and the treatment plan, and sometimes we have the medical -- the medication administration records.

Q. You don't have the full mental health records, though, do you?

A. Not typically in front of the committee.

Q. But despite the constraints of one meeting per month, two hours, can go longer, six minutes per patient, can go longer, your committee is entrusted with making important decisions on behalf of transgender prisoners, correct?

A. Yes.

Q. For example, the committee must be consulted before a transgender prisoner can have access to hormone therapy?

A. That's correct.

Q. The committee must be consulted on questions of social transition?

A. No. That's a decision that can be made at the facility.

Q. Has that changed since April 2019?

A. In what -- what are you defining as social transition? Because if you are talking about groups, social transition groups and help with that, that's something that is done, you know, at a facility level.

Q. Your testimony again from April 2019, starting, if I may point here, Page 81 -- let's go up to, actually, Page 80, Line 22.

[as read] Question, And they're the ones who would be

prescribing the hormone therapy? You were talking about the medical staff in the prior question. Your answer is, Correct. Question, And ultimately there in terms of their medical treatment, with respect to hormone therapy, they are ultimately answering to the committee? Answer, Correct. Question, So with that caveat, would the remainder of these things come before the committee, starting prisoners on hormone therapy? Answer, Yes. Social transition? Answer, Yes. And surgical treatment? Answer, yes.

Speaking of surgical treatment, that is something that comes before your committee as well, correct?

A. It could, yes.

Q. Let's talk a bit about hormone therapy. Do you agree that hormone therapy is medically necessary for many transgender individuals with gender dysphoria?

A. For many? Yes. Not all, but many, yes.

Q. But IDOC requires the approval of the agency medical director -- who himself or herself ultimately answers to the committee -- before hormone treatment can begin, correct?

A. That's -- the Treatment Review Committee, if they're not coming in from the free world on hormones, will take a look at and make sure that there are no barriers, there's nothing that would be, you know, prohibitive in safe usage of the medications.

Q. I'm not talking about bridging necessarily. I'm talking

about if somebody who is a ward of the state wishes to start -- makes the request to start, they've got to come to the committee to start?

A. Yes.

Q. Okay. And are you aware of -- I already know the answer. You are not aware of any other medication or therapy for any prisoner, transgender or otherwise, that requires a sign-off of the agency medical director before treatment can begin, are you?

A. That I don't know, because there's some medications that are very -- you know, very delicate and very -- some nonformulary medications certainly the medical director looks at, I look at. There are some things that we are more cautious of than others.

Q. Can you think of any other medical treatment that requires a sign-off of the agency medical director before it can begin?

A. I don't know the medical aspect of it. Psychiatric, like I said, there are things that are nonformulary that need to get approval in order to be used. And -- but we do have extra precautions with certain medications, yes.

Q. Now, sometimes when a hormone treatment request comes before your committee, it's granted, right?

A. The majority of times, yes.

Q. Sometimes, though, it's denied, correct?

A. They have been denied or postponed, yes.

Q. Okay. And the committee can delay or deny hormone treatment when, for example, a patient has not completed counseling, right?

A. The counseling piece sometimes has interfered in starting it when there's been a lot of ambiguity and indecisiveness of the patient. And as I mentioned, hormone treatment is a very serious undertaking, as is any medication that's foreign to the body. But there are times when what we hear is someone that's not so sure, someone who doesn't seem to fit the criteria of transgender, of is this not transgender, but is this something else going on. You know, is -- let's make sure they're clear about this. There are some people that will say, you know, my family doesn't agree with this and I'm going to do it anyway. You know, that could be a legitimate decision. But at the same time, are they -- you know, do we want them to make sure that they are taking care of anything that's going to be problematic in the future? You know, oftentimes we will say, You know, these are some issues, make sure that they're pretty clear about doing this, and if they're sure and all that as you go through it with them, then let's re-present after a month or two or three of therapy and let's see about doing that. So --

Q. So the answer is yes? You can delay or deny hormone therapy, and you have done so in the past, when the patient has not completed the counseling that you want them to complete?

A. That's not across the board, because it really is -- it's

on an individual basis. I wouldn't say that if they didn't have therapy they can't have hormones. That's not the stance of the committee. But the committee sometimes says, You know, in order for this to be safe and effective, what have you, that this is what they are going to need to make this the right thing for that person. And like I said, we're looking at trying to be -- do the right thing for our patients and we're not trying to stonewall, and -- but there's usually a good rationale and logic behind making those decisions.

Q. The committee can delay or deny hormone treatment when a patient is obese, correct?

A. I don't know. You know, they would have to -- that would be a decision that would be talked about by the medical personnel and looking at risk factors. So I don't know. And what if that obesity is because of -- of, say, a medical condition like polycystic ovarian syndrome or something like that, that it has to be taken care of before they look at hormones? So you know, there's -- you know, I -- there isn't a blanket, if you are obese you cannot take this medicine.

Q. Dr. Puga, I'm not trying to suggest that there is. I'm just trying to see what the committee has done over time. Let me move on to a related topic.

The committee can delay or deny hormone treatment when a patient is HIV positive and on medication treating the same, correct?

A. I don't know. That's something that we'd have to take up with the other medical specialists. Is there a contraindication to that as far as will it negate a very vital medicine? Certainly if it negates that -- the medicine, it's not in their best interest to do that.

Q. Are you aware of whether or not it is a contraindication against starting hormone therapy?

A. No, but I'd have to ask my medical colleagues if they know.

Q. Which medical colleagues are you talking about?

A. The -- the -- Dr. Meeks and the doctor that's on the other line treating the patient.

Q. Dr. Meeks, who admits he is not an expert in this field and does not --

A. That's not about expertise in transgender. It's an expertise on HIV and hormones, and that's something that certainly he probably has some knowledge about. And whether you are -- whether you are transgender or not, those are issues that medical people look at.

Q. I want to go back to Dr. Meeks' testimony that we reviewed already. It was, again, from the Hinton transcript, day two:

[as read] Question, So you, yourself, have never overseen the administration of hormones to a trans person; is that right? His answer, No. I do not provide medical care. That's correct.

A. But at the same time, I'm sure he knows a whole lot about

HIV treatment and about the disease and about contraindications with HIV medications. And so he would weigh in on some of that and that would be an important contribution. And I'm sure there are females who get prescribed oral contraceptives when they have HIV medications. I don't know. He probably knows a lot more about that or whether there is any contraindications there. So, you know, that's something that we'd seek some consultation on.

Q. The committee can also delay or deny hormone treatment because, in their view, the prisoner delayed in identifying himself or herself as transgender, correct?

A. There was one situation that came up where -- where we weren't sure about the transgender diagnosis, because as was mentioned in the doctor's testimony this morning, you know, transgender begins very early on. And so a transgender issue that comes up when you are in your 20s or 30s, you have to question, is this really transgender or is there something else going on. And so a delay -- you know, can the delay be because, you know, the person is just coming -- feels comfortable enough to talk about and come out? It could be. Or could it be that, you know, this person has been perfectly fine all along as far as in the gender that they were born with and now is having difficulties, that may not -- that would not fit the criteria of transgender.

So the question is -- we would have is go back and clarify

this diagnosis. Take a look and see, is this really, truly a transgender issue or is it something else.

Q. Would it surprise you to learn that none of the considerations that we just spoke about -- counseling, obesity, treatment for HIV, or timeliness in coming out as transgender -- are indicated as contraindications for hormone therapy under the WPATH standards of care?

A. But it is.

Q. Says you?

A. Says the standard of care.

Q. Which standard of care is that?

A. Number 1, it has to meet the criteria for transgender. You have to have the right diagnosis. If you don't have the right diagnosis, then you shouldn't treat.

Q. What does it have to do with obesity, HIV positive?

A. That has to do with being identified when you are older and maybe not necessarily meet the criteria. And it's far as relative medical stability. The obesity -- you know, if that obesity is leading to an increased probability of thrombosis because they are sedentary and they're not walking very much and their legs are dangling because they're -- you know, and they're not moving, then you're going to set that person up for some major mishap to occur. So if -- you know, you have to understand the medical piece to it in order to be able to consider hormone treatment.

The HIV, like I said, if they weren't sure whether it would interfere, first you've got to check it out. If you don't know, you've got to contact pharmacy, whatever. You know, I wasn't in on that one, but if it would come up when I was chairman, I'd say, We need good data first. Let's go back. Let's find out. Let's contact our pharmacy. Let's do whatever and make sure that this is okay.

So it's one of those things that all those scenarios that you are describing could possibly have a good rational reason. And we on our committee, at least since I've been on the committee, we try to do things in a very rational way with a lot of foresight and a lot of, you know, thinking of today and thinking about tomorrow and the next week and the next month and what have you. We want to make sure that we are making the best decisions for our patients. We are not trying to make it worse for them. We are not trying to create a very difficult scenario for them. That's something that -- you know, our decisions have to be based on what is appropriate for our individuals. And sometimes medications, people will say, I have this condition, I want this medication or what have you, and as a physician, sometimes I'm going to have to say no, that's not appropriate for you.

But then that's the between the patient and me, and I have to educate and whatever. And you know what? He or she might go doctor shopping and get it somewhere anyway, but I'm still

not going to do something that is going to be hurtful to that patient.

Q. Are you aware that delays in prescribing hormone treatment have led to self-castration attempts by transgender inmates?

A. I heard about it today.

Q. Even once the committee finally approves hormone treatment, do you agree that it's important to monitor a patient's hormone levels?

A. I would imagine so, yes.

Q. It's important to make sure the patient is receiving the right dosages, right?

A. Yes.

Q. And the committee relies upon the Endocrine Society guidelines for the frequency of blood testing and monitoring of hormone levels, right?

A. That I don't know. That's the medical side. You would have to ask Dr. Meeks.

Q. I'm asking about the committee, though. You are in the committee meetings. Is that what --

A. And Dr. Meeks is on the committee too, so -- so I don't know what standards he has -- you know, he oversees the medical doctors. I oversee the psychiatrists. So I'm not sure what guidance and what expectations have been placed on the other medical side.

Q. So that's Dr. Meeks' job?

A. Yes.
Q. So do you know anything about those guidelines at all?
A. I've looked at them and I've -- yeah, I've -- that's something that I have on my -- or I had on my agenda to take a look at.
Q. Yeah. And those guidelines recommend blood testing every two to three months for the first year of treatment, right?
A. I don't recall, but it sounds like it may be accurate.
Q. And then one to two times per year thereafter, right?
A. From what I remember, I think that's accurate, but like I said, I haven't looked at that in a little while.
Q. And yet were you aware that you have transgender prisoners in your care that have gone many months, even years, before being tested at all after starting?
A. I have recently been made aware of that, yes.
Q. And one of the reasons for checking hormones, you would agree with me, is to make sure they're actually at a therapeutic and effective amount, right?
A. Yes.
Q. Make sure the hormones are working as intended?
A. Yes.
Q. And this is difficult to tell if you don't take the patient's blood, right?
A. You can see the signs of it working or not, but you have a more objective way of looking at things with levels.

Q. The guidelines say to take the blood at certain intervals so you can tell what the dosage is and whether it's working, right?

A. Like I said, I just -- I read it, I looked at it, but I can't tell you exactly.

Q. You testified earlier, I believe, that it was medical staff that's responsible for prescribing hormones, right?

A. Yes.

Q. But you are not aware of any standards in place for the medical staff to actually prescribe hormone therapy in the proper manner, are you?

A. I don't know what the medical guidelines are. For psychiatry I have guidelines for medications that we prescribe, but I don't know how medicine works, frankly.

COURT REPORTER: Could I have just one moment. You folks have run my machine battery out.

COURTROOM DEPUTY: We can take a short break?

THE COURT: Yeah. Why don't we take about a 10-minute break.

MR. RAY: Okay.

(Recess)

THE COURT: You may proceed.

MR. RAY: Thank you, your Honor.

Q. (BY MR. RAY:) Dr. Puga, let's talk about surgery now. This is another medical decision that's subject to vote by the

committee, correct?

A. Yes, it's a committee decision.

Q. And you'd agree with me that the WPATH statement of care states that gender-affirming surgery can be an essential and medically necessary treatment for gender dysphoria for some patients, correct?

A. It can be, yes.

Q. And do you also agree with me that incarceration is not a valid reason to deny surgery, right?

A. I don't think that's a reason to deny surgery necessarily.

Q. Do you think it can be a reason to deny surgery?

A. I don't know. Certainly with a decision, for example, like we made with the medical -- starting medication right before discharge, you know, certainly if we didn't have enough time to adequately take care of a patient and do you start something that may be potentially complicated and potentially have serious implications and then let the person out because you have to by law? You know, certainly there's going to be some things that we need to take into consideration, and everything has to be case by case.

Q. Okay. So it's your opinion that incarceration can, in fact, be a valid reason to deny surgery; is that right?

A. Well, as I mentioned, I think, there may be some exceptions that need to be considered.

Q. Okay.

A. So I wouldn't make that a blanket statement and say that it would. It may not be a factor, but I think it is a case-by-case thing. You have to look at things in total and look at -- when you are making a decision, you have to make things -- you have to look at a number of things. In the medical world when we make a decision, we just don't look at one thing. We look at, you know, an interaction and interplay with a lot of other things, and especially -- and when we are dealing with things on an administrative level, I think the same type of care and precautions need to be made. So, you know, I --

THE COURT: Doctor, I'm going to cut you off. Just try answer the question because we have to finish up today.

THE WITNESS: Okay. I'm sorry.

Q. (BY MR. RAY:) Were you aware that in the WPATH statement of care there is an entire chapter on the care of transgender individuals who are incarcerated?

A. Yes.

Q. And do you know that in that chapter it says that somebody's current institutional situation is not a valid reason to deny treatment?

A. I'm aware of that.

Q. Thank you. At least up until recently, the directive that was governing your committee stated that surgery could not performed, quote, except in extraordinary circumstances, right?

A. That's what the AD refers to, yes.
Q. And you are aware of no other surgery within IDOC that requires this level of approval, are you?
A. I'm not familiar with the medical aspect of our side or the -- and medical side of the department.
Q. And the fact is that under this directive and under the operation of this committee, no prisoner has ever been approved for gender-affirming surgery, have they?
A. From what I understand, that's correct.
Q. And the committee has actually never brought in a specialist to evaluate any prisoner for gender-affirming surgery, have they?
A. Not that I know of.
Q. Even though the WPATH statement of care says that surgery for some individuals can be essential and medically necessary, correct?
A. For some, yes.
Q. Let's talk about social transition. These are additional medical decisions that can be subject to a vote by the committee, correct?
A. Yes.
Q. And for example, at least maybe perhaps until recently, if the policy changed, the committee considered whether or not to permit transgender prisoners to have access to a bra?
A. Correct. It's changed now.

Q. And this may have changed recently too, but the committee considered whether or not prisoners could have accommodations on their showering arrangement at their prison?

A. Correct. Facility level now.

Q. And the committee still considers whether or not to transfer a transgender prisoner to another facility that matches with the prisoner's gender, correct?

A. Correct.

Q. And you mentioned that there have been, to your knowledge, four transgender inmates that have been transferred along these lines, correct?

A. Correct.

Q. Okay. And there is two that you have mentioned, Ms. Hampton and Ms. Monroe, correct?

A. Yes.

Q. And each one of those individuals was transferred after a lawsuit was filed, right?

A. We were in the process with Ms. Monroe of doing due diligence and we had not -- we had started the process before the lawsuit went through.

Q. But they were transferred after the lawsuit was filed, each one of them?

A. Yes.

Q. And for the other two prior transferees, they had -- at least you had thought -- had achieved gender-confirming surgery

prior to incarceration, right?

A. I don't know details about the prior to.

Q. Okay. Were you aware that once it was discovered that one of the inmates who was transferred, in fact, had not had surgery, they were sent back to the original prison? Did you know that?

A. No.

Q. The committee also considers whether to permit transgender prisoners to have access to feminine underwear, correct?

A. I believe that's come up.

Q. And the committee considers whether or not to permit transgender prisoners to have access to grooming items that are consistent with that prisoner's gender identity?

A. That's come up.

Q. And other times the committee considers whether to grant a transgender prisoner hair removal or electrolysis, right?

A. Yes.

Q. And the committee has never approved that request, have they?

A. That's correct.

Q. Okay. Now, you would agree with me that permitting a transgender prisoner to socially transition is an important part of treating, from a medical standpoint, their gender dysphoria, right?

A. There are reasonable accommodations that should definitely

be made.

Q. And yet the committee, for some of the things I've just listed, either part of the time or all of the time in the case of electrolysis, denies these requests, doesn't it?

A. On the basis of -- that electrolysis is cosmetic and -- yes. And there are other options for hair removal, yes. And the fact that hormones sometimes take as long as three years before you start having significant hair reduction on the male to female patient, yes.

Q. Now, it's been your testimony earlier today that the committee is really just overseeing different medical decisions by people that are working below, correct?

A. Correct.

Q. Okay. But, for example, the decision between injectable versus oral hormones, that comes before the committee, right?

A. It has.

Q. And you've considered that and you've denied it, right?

A. I know sometimes we've approved it. You know, sometimes the -- what happens is that the literature indicates that there is no difference between the efficacy of oral and injectable, and at this point only the oral is available on formulary.

Q. My point is, though, that the question of whether or not the patient is permitted to take injectable versus oral hormones, that's a medical decision that comes before the committee, right?

A. That has come before the committee.

Q. And that's something that the committee has the final word on?

A. Yes.

Q. Other things such as hormone dosage, trying to increase dosage, that's something that comes before the committee, right?

A. Well, it shouldn't, but sometimes it has.

Q. Okay. And the committee is the final word on decisions of whether or not hormone dosage should be increased or decreased, right?

A. No.

Q. No? Okay.

A. That's left to the provider.

Q. I'd like to refer to a document that's already been admitted into evidence as Exhibit 4, which I know you don't have before you -- or maybe -- Dr. Puga, do you have the prior exhibits before you?

A. No.

Q. Let me hand you another copy of this one, sir.

MR. RAY: Do you need another copy, Counsel?

MR. HIGGERSON: No.

MR. RAY: Okay, great.

Q. *(BY MR. RAY:)* Here, Doctor.

Dr. Puga, I've put before you what's been previously marked

as Exhibit 4, which is a Gender Identity Disorder Committee recommendation. If you turn to the last page, it's dated April 2nd 2019, and your name and, looks like, signature is on it; is that right?

A. That's correct.

Q. Okay. And so -- and I'll go ahead and put this up on the screen -- in this particular instance, you had a -- under the Section 2 heading of Hormone Therapy, you had an offender requesting an increased dosage of hormones, correct?

A. Yes.

Q. And if you turn to the second page under Recommendations, it says under hormone therapy that it was denied, right?

A. That's what it says.

Q. Okay. So here's an example in the last six months of somebody asking to have their hormone therapy increased dosage and the committee denying the request.

A. Yes. There was a recent hanging attempt four or five days prior to this meeting. Oh, I'm sorry. I'm sorry. No, that's wrong.

Yeah. I'm not sure if that date is accurate or not. So I -- yeah, I'm not sure exactly why. Not currently stable. I think that probably meant medical issues to address.

Q. Well, in fact, if you -- glad you mentioned that, because if you go to Section 3 of mental health history on here, it says [as read] Describe the offender's current mental health

stability.

It says right here they are currently stable, aren't they?

A. Yes.

Q. Dr. Puga, we talked a number of times about the standard of care today, but you don't know as a matter of fact whether the committee follows the standards of care on questions of social transition, do you?

A. As it relates to incarceration, I'd have to take a look at what it says as it refers to incarceration.

Q. You don't know as a matter of fact whether the committee follows the standards of care in questions of hormone therapy, do you?

A. I think we try to abide by that. I think -- and like I said, I'm looking at continuing to modify what we do and improve what we do.

Q. You don't know as a matter of fact whether or not the standards of care are followed relating to hormone therapy, do you?

A. You know -- and like I said, because of the medical piece of it, you know, I drew up the patient information sheets. And my next step was to take a look at the hormones and giving some structure to that. Because this is really outside of my area, and I would do that with referencing endocrine and referencing other literature, most current literature, you know, it really -- you know, I don't know how the medical doctors are

guided by their -- by the medical side. I don't know what the requirements are. I don't know how they do things. It's very different than what I do.

And so now that we have a deputy chief of medical, you know, I asked him to take over and kind of take it from there because, you know, there again, I'm not as familiar with that system. I can tell my psychiatrists what to do and how to do it. You know, that's a different system. And so, you know, I think that we need some structure and we need -- we need to be doing something more consistent, but there again, like I said, it's really not my lane and it's something that I want to -- you know, I need to share it with them, so...

Q. You don't know as a matter of fact whether the committee follows the standards of care on questions of gender-affirming surgery, do you?

A. We have not had anybody have surgery at this point.

Q. You don't know as a matter of fact whether they follow the standards of care, though, on the consideration of the issue, do you?

A. The surgery is a very complicated situation and it requires a lot of consideration and a lot of planning. And we can't just do surgery on somebody and leave it at that. It's not as simple as that. You know, surgery can potentially have a lot of complications. You know, surgery -- you know, can we -- can we adequately prepare or what do we need to do to adequately

prepare for postoperatively and for the continued need the people have. It's a big question.

THE COURT: Hold on, Doctor. You are digressing again.

Q. (BY MR. RAY:) Let me try and rein this back a bit. Let's assume that you actually did follow the standards of care on those three major items. There's no quality assurance review performed by the committee regarding the treatment of gender dysphoric patients within the Illinois prison system, is there?

A. Our quality assurance program is relatively new and still developing.

Q. Is it something that actually exists today?

A. Yes.

Q. You have a quality assurance program to make sure that the standards of care are being followed?

A. Yes.

Q. Well, we'd love to see it.

Last question for you, Dr. Puga. Would you agree with me that the transgender prisoners across the state of Illinois, including the two sitting in this room today, rely on you and your committee and the people that you oversee for their care?

A. Yes.

MR. RAY: No further questions.

THE COURT: All right. Any brief redirect?

MR. HIGGERSON: Very quickly.

THE COURT: Oh, before I forget, Mr. Higgerson, I don't think you moved for the admission of your Exhibit 5 and 6. Did you intend to do that?

MR. HIGGERSON: I would do that at this time, yes.

MR. RAY: Subject to the objection about being able to submit a later declaration, that's fine.

THE COURT: Okay. And you may do that.

Five and six will be admitted.

(Defendants' Exhibits 5 and 6 received in evidence)

REDIRECT EXAMINATION

Q. (BY MR. HIGGERSON:) How formal is the voting process that takes place with the committee?

A. Well, we -- at this point, we've only voted on, from my knowledge, two or three serious matters, so I've only conducted a vote three times in this year.

Q. So in the year that you've been on the committee?

A. Yes.

Q. How are most matters resolved?

A. A discussion and coming up with a group think, quote/unquote.

Q. And I think you explained earlier that the nonmedical people wouldn't vote on medical issues; is that right?

A. Right. There's no reason why they should have any input on that. And usually they don't. They usually remain silent on those questions.

Q. You have testified that issues related to social transition can come before the committee; is that right?

A. Yes.

Q. Do they always come before the committee?

A. No. Many are taken care of on a facility level.

Q. And then who -- from who do you hold your license to practice medicine?

A. State of Illinois.

Q. Do they have a specialty in caring for transgender inmates?

A. No, not that I know of.

Q. Does your license allow you to treat transgender inmates in the state of Illinois?

A. Yes, it does.

Q. Is WPATH part of that licensing scheme?

A. No.

Q. Are you required to hold a certificate or anything else from WPATH in order to treat transgender inmates?

A. No. That's considered more of an independent organization.

Q. That's not part of any official licensing, right?

A. Correct.

MR. HIGGERSON: Thank you. That's all I have.

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

Well, here's what -- and you don't have any more witnesses, correct, Mr. Higgerson?

MR. HIGGERSON: Your Honor, Dr. Reister's deposition

was attached to our response to the motion, and I think by agreement that's going to be taking the place of his testimony.

We also have a transcript of Warden Austin's testimony, which was taken knowing that he was unavailable for this, and we would offer that at this time.

THE COURT: Okay. And Dr. Reister's is already in --

MR. KNIGHT: I'm sorry. Your Honor, we had agreed to only certain pages, so not the entire transcript.

MR. HIGGERSON: There's redactions in it for the things that neither side wanted to offer, yes.

MR. KNIGHT: So no objection.

THE COURT: All right. I'll take that.

MR. HIGGERSON: But we didn't mark it, right?

THE CLERK: Yes, it's marked.

THE COURT: Okay. Defendants' Exhibit 7. So that will be admitted.

(Defendants' Exhibit 7 received in evidence)

THE COURT: So defendants just had 5, 6 and 7, correct?

MR. HIGGERSON: Yes.

THE COURT: And then plaintiffs had 1 through 20?

MR. KNIGHT: Correct.

THE COURT: Anything else, Mr. Higgerson?

MR. HIGGERSON: We had Exhibits 1 through 4 that were part of our motion -- or our response to the motion. There are

four.

THE COURT: So they are already in the record?

MR. HIGGERSON: Yes.

THE COURT: Okay.

MR. HIGGERSON: But other than that, we have no further evidence.

THE COURT: Okay. Any rebuttal evidence?

MR. RAY: Your Honor, may I have just a moment?

THE COURT: You may.

MR. RAY: Nothing further.

MR. KNIGHT: Nothing further, your Honor.

THE COURT: All right. Well, here's what I'm going to do. It's been a long day. I appreciate everyone working hard and getting this done in two days. And my tank is drained. I know Molly's is. So what I'm going to do is ask you to submit to me proposed findings of fact and conclusions of law which essentially can incorporate any closing argument you would have given me today as to what you think the evidence has shown. And I'll give you three weeks from tomorrow, so that would be the 23rd to submit those. Submit those to my proposed document folder. It's njrpd -- as in proposed documents -- @ilsd.uscourts.gov. Deana will put that in the minutes so that you have it, and I will then take those for writing my order.

The motion is taken under advisement at this time. And if there's anything further that you wish to supplement,

you will have three weeks to do that as well.

So anything else we need to take up at this time from plaintiffs?

MR. KNIGHT: Your Honor, there was one issue which is there is a document that was mentioned in testimony which we have not seen. And we would like to get that document and can submit a request directly to counsel, but we would like to be able to get that and, if necessary, respond to it, since it is not something that we've seen.

THE COURT: Okay. Ms. Higgerson, sounds like that was just a final copy of a draft, so --

Is that what you are talking about?

MR. KNIGHT: There was -- I'm sorry. There was a medical records that was referenced of a --

MR. HIGGERSON: Oh I'm sorry. It was the one that we hadn't redacted that was further of Inmate B, I think. Is that what you are talking about?

MR. KNIGHT: I believe this is somebody who you said had had a stroke or something.

MR. HIGGERSON: Okay. I would have thought that would have been in the 200,000 pages, but I will check and --

THE COURT: Check on that, and then also get them the final adopted version of the policy that was mentioned. And you should be able to get those to them by Monday, you think, Mr. Higgerson, if they're readily available?

MR. HIGGERSON: Yeah. The stroke records may take a little bit longer because they're recent and they -- I guess haven't been given to us yet. But the others, I can do that by Monday, yes.

THE COURT: Okay. Well, do the policy by Monday and the stroke records within a week. If you need more time, then we will take that up.

MR. RAY: And not to pile on with that, but obviously there's additional documents about the quality assurance program that we heard about today, and we would request those in advance of the briefing.

THE COURT: Okay. So also anything with the quality assurance program that Dr. Puga, if that exists, also provide that by Monday.

MR. KNIGHT: Thank you, your Honor.

MR. RAY: Thank you.

THE COURT: Okay. Anything else?

IDOC, do you need anything from me?

COURTROOM DEPUTY: I'll take care of that. I'll be with you.

MR. HIGGERSON: Your Honor, is there going to be a response period for this, or are we just doing our proposed findings and conclusions of law and that's it?

THE COURT: What do you mean? Can you respond to what they've --

MR. HIGGERSON: Can we respond to each other or --

THE COURT: I'll give you a week to respond to each other.

Okay. Court's in recess.

(Court adjourned)

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REPORTER'S CERTIFICATE

I, Molly N. Clayton, RPR, FCRR, Official Court Reporter for the U.S. District Court, Southern District of Illinois, do hereby certify that I reported with mechanical stenography the proceedings contained in pages 225 - 417; and that the same is a full, true, correct and complete transcript from the record of proceedings in the above-entitled matter.

DATED this 8th day of August, 2018.

s/Molly Clayton, RPR, FCRR