IN THE UNITED STATES DISTRICT COURT

FOR THE WESTERN DISTRICT OF WISCONSIN

ALINA BOYDEN and SHANNON ANDREWS,

Plaintiffs,

v. Case No. 17-CV-264

STATE OF WISCONSIN DEPARTMENT OF EMPLOYEE TRUST FUNDS, et al.

Defendants.

Deposition of LAWRENCE S. MAYER

Laguna Niguel, California

Friday, June 15, 2018 - 9:17 a.m.

Reported By:

Patricia Y. Schuler

Job no: 21911

1
2 Deposition of LAWRENCE S. MAYER, taken on behalf
3 of the Plaintiff at 23175 Avenida De La Carlota
4 Laguna Hills, California 92653, beginning at 9:17 a.m.
5 and ending at 3:51 p.m., on June 15, 2018, before
6 PATRICIA Y. SCHULER, Certified Shorthand Reporter
7 No. 11949.
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1 APPEARANCES OF COUNSEL:
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1 I-N-D-E-X

2 WITNESS: EXAMINATION
3 LAWRENCE S. MAYER
4 MR. KNIGHT 5
5
6 E-X-H-I-B-I-T-S
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9 Mayer submitted on behalf of the
10 state defendants
11 Exhibit 2 Curriculum Vitae of Lawrence S. 7
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22 Stephanie Budge, Ph.D.

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4 LAGUNA NIGUEL, CALIFORNIA; FRIDAY, JUNE 15, 2018
5 10:00 a.m.
6
7 LAWRENCE S. MAYER,
8 having been administered an oath, was examined and
9 testified as follows:
10
11 EXAMINATION
12 BY MR. KNIGHT:
13 Q. Dr. Mayer, I'm one of the attorneys for the
14 plaintiffs, and we are here for your deposition today.
15 You have been named as an expert in this case. Could
16 you go ahead and give your full name and spell it for
17 the record.
18 A. It is Lawrence Stephen Mayer. Lawrence is
19 with a W, Stephen with P-H, Mayer is M-A-Y-E-R.
20 MR. KNIGHT: And before you go any further, I
21 want to get on the record that I have a colleague who
22 is on the line, Leslie Cooper is another attorney with
23 the ACLU.
24 MS. COOPER: Good morning.
25 BY MR. KNIGHT:

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1 Q. I'd like to talk first about your education,
2 Dr. Mayer. So you have a psychology degree, and you
3 got that in 1967?
4 A. I have an undergraduate degree -- yes, sir,
5 in psychology, and premed, yes, sir.
6 Q. And you went to medical school --
7 A. Yes.
8 Q. -- then, at Ohio State; is that right?
9 A. Yes, sir.
10 Q. Did you receive a degree from there?
11 A. No, sir.
12 Q. Then did you at some pint receive a medical
13 degree?
14 A. Yes, sir.
15 Q. Where was that from?
16 A. London, England, at Guy's Medical School.
17 Q. And was that an MD?
18 A. Well, it is the equivalent of an MD, so it's
19 called an MD, but the actual degree is an MB. It's a
20 Bachelor of Medicine. It's a quite different system.
21 Q. Did you at some point receive an MD?
22 A. I received the English MD. I've received the
23 degree that qualifies you to practice medicine. The MD
24 is an American degree. I did not receive an American
25 MD; that is correct.

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1 Q. So it's the MB that you received, but not an
2 MD?
3 A. There is no MD.
4 Q. Got you.
5 Are you licensed to practice medicine?
6 A. No, sir, I have never practiced medicine.
7 MR. KNIGHT: And why don't I -- why don't we
8 go ahead and mark this as Exhibit 1. I think we're
9 just doing this in order for the deposition.
10 (Exhibit 1 was marked for identification.)
11 (Exhibit 2 was marked for identification.)
12 (Exhibit 3 was marked for identification.)
13 BY MR. KNIGHT:
14 Q. Dr. Mayer, I'm showing you what is marked
15 deposition Exhibit 1. Can you identify that?
16 A. Yes, sir.
17 Q. This is your report with some appendixes to
18 it. So this is a report in this matter, in the Boyden
19 case?
20 A. It appears to be, yes, sir.
21 Q. Well, I would like to turn to, first of all,
22 to your professional vitae, which is appendix B.
23 So is this a complete and accurate
24 professional vitae for you?
25 A. I believe so, yes, sir. Oh, let me see here.

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1 What is this? Yes, sir. I think this is correct.
2 Q. When you received your MB degree in London,
3 was there any clinical experience as a part of that?
4 A. Yes, sir.
5 Q. And for what period of time?
6 A. About a little over a year.
7 Q. A year of clinical experience?
8 A. In London, yes, sir.
9 Q. And that is the only clinical experience you
10 have had, then?
11 A. No, sir. I went to the British health system
12 and spent another year, approximately a year.
13 Q. And was that another degree or what was that?
14 When did you spend this year at the British health
15 service?
16 A. It's equivalent to a residency -- or an
17 internship in this country, so you go and do additional
18 training. When you get an MD degree in this country,
19 you're not licensed to practice medicine, you do an
20 internship, and if you want, a residency -- this is
21 back then. It is quite different now.
22 So I went out as a junior house officer,
23 which is the equivalent of an intern. I went to the
24 British health service.
25 Q. And what kind of clinical experience did you

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1 have during that one year?
2 A. Well, I was interested in a combination of
3 epidemiology and psychiatry. Epidemiology was just
4 getting going as a major division primarily growing out
5 of infectious disease. And at the time, we must be the
6 first, one of the first to believe if we applied these
7 methods to psychiatric illness -- the DSM-3 had just
8 come out -- we applied psychiatric illness, we could
9 cure mental illness worldwide. Pretty idealistic. So
10 I was always interested in that interaction. Then when
11 I found statistics, I really became interested in
12 research.
13 Q. So when you talk about that as clinical
14 experience, were you actually seeing patients?
15 A. Yes, sir.
16 Q. But they were -- so they were patients
17 presenting with mental health issues or what kind of
18 patients?
19 A. Primarily psychiatric patients, because there
20 were four of us in a clinic and nobody else. They were
21 all infectious disease. So I didn't see -- the first
22 year it's like an internship, you see a bit of
23 everything. But, yes, overwhelmingly. I would never
24 hold myself out as an expert in clinical -- clinical
25 medicine. I saw a very limited number of patients, and

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1 they were primarily psychiatric patients.
2 Q. I understand. And were any of those
3 patients, patients, I guess -- what -- let me back up.
4 So what year was this that you did this year
5 of clinical experience at the British -- I'm sorry, the
6 British health service?
7 A. Yes.
8 It was '69 and '70 is the academic year, I
9 believe.
10 Q. And during that time period, did you work
11 with anyone who identified with gender issues or what
12 has come to be known as gender dysphoria? Or do you
13 recall?
14 A. Well, it was a different time. I think that
15 if you mean were there people struggling, if I can use
16 some of the old terms like transvestites, people like
17 that who are concerned about identifying with the
18 opposite sex, yes, there were patients.
19 But this was -- I didn't do in-depth
20 psychoanalysis of people, so I would say my experience
21 was rather limited. I'm a little worried because when
22 you say, like transgender, I don't know if, in the
23 '60s, I knew what that term meant. But there was
24 certainly no focus on that.
25 Q. Do you recall whether -- I mean, do you

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1 recall any specific patient or how many patients you
2 might have seen with gender issues at that time period?
3 A. Well, could gender issues be anyone
4 struggling with being a little boy or a little girl,
5 for example? Or do you mean something more profound?
6 I want to be precise.
7 Q. Right. I think it can be as general as that.
8 Someone struggling with -- but I guess what really I'm
9 asking you about is someone who is coming to you
10 identifying, explaining that, while they have been
11 identified as male, they don't believe they are, in
12 fact, male.
13 A. That's what I -- I think I'm to the narrow
14 sense and the wide sense, that's the narrow sense. I
15 definitely didn't see anything like that that I can
16 remember. It has been many years, but not that I
17 remember.
18 Q. More broadly, in terms of the way you're
19 talking about it, do you recall how many patients you
20 would have seen?
21 A. Well, struggling with their sexual identity
22 is pretty common both for kids and also for people
23 facing kind of mid-age, mid-age crisis. So
24 specifically, you have to go back to time. Remember
25 how primitive our medicines were and all of that. It's

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1 not a large number, but I don't think I can be precise
2 there.
3 Q. Overall it would have been a small number
4 then?
5 A. Yes, sir.
6 Q. Even then?
7 A. Yes, sir.
8 Q. So you don't have a license, then, to provide
9 clinical treatment to a patient at this stage?
10 A. That is correct.
11 Q. Do you have any kind of license to practice
12 medicine?
13 A. I have never practiced medicine. At one time
14 I qualified under the English, the British health
15 service, but we're talking about 50 years ago. I have
16 no license. I've never applied for a license to
17 practice other than my educational license.
18 Q. And so other than that one year, you have
19 never practiced psychiatry then?
20 A. That is right. To be clear, I supervise
21 residents in teaching hospitals, so I have supervision
22 still. But I have no direct clinical practice where I
23 am the attending physician. I just want to be
24 absolutely precise with you.
25 Q. Right. And when you talk about

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1 "supervision," what kind of supervision are we talking
2 about?
3 A. Well, it would usually be on the team
4 rounding, and my role would be the clinical
5 epidemiologist trying to determine how can results in
6 the epidemiological literature be used in analysis of
7 specific patients. So my role there would be to at
8 least understand what is going on, then to reflect on
9 it. I taught a journal club. We would talk about
10 these cases. I just want to point out I do have
11 relatively hands-on relationship with patients, but not
12 as a treating -- not as a treating physician, never as
13 a treating physician.
14 Q. What time period did you have this
15 relationship with -- supervisory relationship?
16 A. Well, I had it at Hopkins -- I'm going to say
17 for the last 25 years. I'll just take a guess. 25
18 years.
19 Q. But you were saying you were rounding with
20 students in seeing patients and addressing what
21 exactly?
22 A. Well, you say rounding patients. We have
23 conference for the patient, we have a mortality
24 conference. I taught at a medical school, and part of
25 that is rounding. These aren't students in your sense,

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1 they are residents, and there is a team -- if you've
2 ever been in a hospital -- and the people would have
3 different people.
4 Oftentimes I would be on that team to
5 represent research, in particular, how does one use
6 whoever doing brain research, scanning research about
7 transgenders, how do they use that in facing this
8 patient. That is clinical epidemiology. Takes the
9 general statistical framework and applies it to an
10 individual patient.
11 Q. And when you were -- were you actually seeing
12 the patient or were you rounding simply with residents
13 who had seen the patients?
14 A. Both. I'd see patients every -- probably
15 every week at least one patient. I wouldn't see -- I'm
16 not doing that anymore, but I saw patients regularly.
17 Q. But you were not providing clinical advice
18 with respect to those patients?
19 A. That's care. If you notice, I'm very careful
20 not to comment on any clinical issue. I will try to
21 represent myself as a research physician, I'm not one.
22 There is a more of a track for that in Europe than
23 there is in this country, but we have more and more
24 "mud-fuds," (phonetic) we call them. That's MD/Ph.D.,
25 coming out. They are academic physicians and not

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1 clinicians.
2 Q. But I --
3 A. Sorry about that.
4 Q. You told me several things, and I just want
5 to make sure that I understand what the bottom line is.
6 You are not providing clinical advice to
7 patients?
8 A. Oh, no, I would not provide any clinical
9 advice, no, sir.
10 By the way, I also did this, if you're
11 interested, in toxicology and cardiology with two other
12 areas, because it is similar. I didn't want you to
13 attach it too close to the psychiatry.
14 Q. Well, that is a good point. When you talk
15 about rounding, what are the areas that you covered?
16 A. Well, rounding would primarily be in
17 psychiatry, and then it would be toxicology, internal
18 medicine, and cardiology.
19 Q. And how much of that was psychiatry? You
20 said you did this for a period of 25 years.
21 A. At Johns Hopkins, it was almost all
22 psychiatry. In Phoenix it would be -- Phoenix would be
23 mostly nonpsychiatry. It would be areas focused on
24 subspecialties in medicine such as toxicology,
25 cardiology.

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1 Q. And the period of time you were at Johns
2 Hopkins was when, exactly?
3 A. I went in '89. I was there until last year.
4 I'm a little weak on dates, forgive me. I'm going to
5 do my best. But I think I was there until 2000, would
6 be '16. That is right. I think that's right, yes.
7 Q. Over the period of time you were rounding at
8 Johns Hopkins, how many of the patients presented with
9 gender dysphoria?
10 A. I don't remember any specifically. I say
11 that because I was part of an Alzheimer's group, a
12 dementia group. So it was primarily people that had
13 neuropsychiatric disorders. There may have been some
14 in the general clinic or presentation, but I don't
15 remember specifically, other than a grand rounds
16 presentation. There was a gender identity program at
17 Hopkins. I do remember a grand rounds presentation.
18 Q. Let me make sure I understand. So you were
19 primarily rounding Johns Hopkins with respect to
20 Alzheimer's?
21 A. I would say the majority of patients I
22 rounded on -- Hopkins is very large in psychiatry.
23 There are hundreds and hundreds of doctors, so it is
24 split up by subspecialty. There is a special group
25 that does gender identity. There is a group that does

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1 memory, Alzheimer's, dementia. I would say the
2 psychological characters of aging, that's the group I
3 worked with, yes, sir.
4 Q. So you worked with an Alzheimer group, not
5 the gender identity group while you were at Johns
6 Hopkins?
7 A. That is correct. I did my gender identity
8 research, but that was in the School of Public Health,
9 which is separate.
10 Q. So you don't recall, then, doing rounding
11 about anyone who presented with gender dysphoria at
12 Johns Hopkins at this point?
13 A. Well, we would have to get into exactly what
14 you mean by gender dysphoric, because it is used all
15 sorts of different ways. But in general, we rounded on
16 in service, in bed, in service patients. I don't
17 remember any with a diagnosis of gender dysphoria.
18 There may have been some. Again, it has been 20 years.
19 You know, I don't have a perfect memory. I don't
20 remember any.
21 Q. And then you talked about that you did some
22 work at the School of Public Health?
23 A. Yes.
24 Q. And over what period of time was that?
25 A. It would be the same. It was the same work.

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1 The work shifted from the School of Public Health to
2 the School of Medicine, so it would have been to '89 to
3 2016.
4 Q. So you were working in both departments
5 during that time period?
6 A. Yes, sir, very closely connected, yes. The
7 Psychiatric research is a Department of Mental Health
8 in the School of Public Health. The psychiatric care
9 is in the School of Medicine.
10 Q. Have you had any education or training
11 related to gender dysphoria or gender discordance?
12 A. Well, you'd have to tell me exactly what you
13 mean by that.
14 Q. Are you familiar with the diagnosis in the
15 DSM for gender dysphoria?
16 A. Yes, sir.
17 Q. So that is what I'm asking about.
18 A. I've not had any clinical updates of any
19 kind, including gender dysphoria.
20 Q. And what do you mean by clinical updates?
21 A. Well, I thought that is what you were talking
22 about, a continuing education program, something where
23 you go and study about these issues specifically for
24 clinicians. If not, I don't know what you mean.
25 Q. Well, I'm talking about any training. And so

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1 if you're saying that would be the relevant training,
2 then that is my question.
3 A. I've had no specific training in dealing with
4 gender dysphoria, no, sir.
5 Q. Okay. And --
6 A. I don't know where that training would have
7 been up until the last few years, but I have not had
8 any since then.
9 Q. And I just want to make sure, my question was
10 broad, and I think you talked about clinical updates,
11 and I'm just talking about anytime since medical
12 school, have you had that kind of training?
13 A. Well, the problem is, I'm a professor, so I
14 go to training every day with the students, so I'm in
15 their training. And so it's a little hard. It's not
16 like a clinician that goes back to a program or
17 something. Since I'm training with the kids every day.
18 But specifically, did I role in a program? No. There
19 was no problem I was enrolled in. But I read five, six
20 hours a day, I probably spend almost that with my
21 students.
22 Q. Other than the two articles that you wrote in
23 the New Atlantis, have you published any research or
24 other articles addressing gender dysphoria?
25 A. No, sir.

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1 Q. Transgender people?
2 MR. KILPATRICK: Objection; vague.
3 THE WITNESS: I'm sorry. I didn't understand
4 the sentence. It was a noun, transgender people.
5 BY MR. KNIGHT:
6 Q. It was part of the previous question. Have
7 you published any research or other articles regarding
8 transgender people?
9 A. No, sir.
10 Q. Have you published any research or other
11 articles addressing gender discordance?
12 A. You will have to be precise, but in the most
13 general term, I have not.
14 Q. Have you given any presentations about gender
15 dysphoria, transgender people, or related issues?
16 A. No, sir. I'm sorry. You said, symposiums,
17 is that what you said?
18 Q. Presentations?
19 A. No, sir.
20 Q. You have a number of scholarly publications
21 listed in your CV. What are those addressing if you
22 can speak generally?
23 A. I'm primarily interested in the use of
24 statistics in epidemiology in analysis of complex
25 medical issues, where the biology is complex. There

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1 are real world implications like policy implications.
2 The data is complex. And I'm primarily interested in
3 the use of models, cross discipline. I've always been
4 interested in the use of how our models transferred
5 from one discipline to another. So it would be across
6 a broad spectrum. The commonness of every paper
7 includes statistics and data.
8 Q. Have those papers focused on specific kinds
9 of medical conditions?
10 A. I have written quite a few papers on
11 dementia. I would say that is the No. 1 condition. To
12 me, as a biostatistician, methodology is like the tail
13 on the dog. So it depends to me who the dog is.
14 They're the ones who really drive the work. A good
15 methodologist is a team player, brings strength to the
16 team.
17 So my topics have often wandered across
18 disciplines, but my interests have stayed very focused.
19 Also the limitations of inference from observational
20 data, very interested in that.
21 Q. Have you written other articles about the
22 efficacy of surgical treatment?
23 A. I have written on ethnic disparities in
24 surgical treatment. And I have done analysis as part
25 of a team of the efficacy. When I ran research for the

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1 Banner Health System, I did a lot of that type of
2 evaluation. How much of it fell into articles that
3 would probably be used? Just as an example in an
4 article, it has never been a primary focus. For
5 example, I did work on the silicone breast implant
6 litigation, so that was evaluation of a whole surgical
7 procedure.
8 Q. Can you point me to that article, please?
9 A. I'm sorry, I thought you said where I
10 prepared a paper or did research. I don't publish on
11 the things I did my expert witnessing on. So I don't
12 believe -- there is a paper on surgical disparities.
13 Q. And really I'm not asking about disparities,
14 I'm asking about efficacy and safety of surgery.
15 A. Well, that comes into it. If you have
16 different procedures used, let's say, on black women
17 and white women, one of the questions is, what is the
18 efficacy? Is there some reason for that to be the
19 case? So efficacy is then. If you mean have I ever
20 evaluated the efficacy of a procedure, I'm not a
21 surgeon. How would I do that?
22 So I have not published anything on efficacy
23 of surgery in that sense.
24 Q. So if you have never treated patients with
25 gender dysphoria, what gives you the expertise to offer

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1 opinions regarding their treatment?
2 A. Say that again.
3 Q. If you have not treated patients with gender
4 dysphoria, what makes you an expert regarding their
5 treatment?
6 A. I'm not an expert regarding the clinical
7 treatment of gender dysphoria. I'm not an expert in
8 that.
9 Q. Well, what is your expertise related to
10 gender dysphoria?
11 A. My expertise is to review the literature and
12 say, what does biology have to say, and to review these
13 different models of the relationship between gender and
14 sex, and try to figure out what the data -- what the
15 best data says is typical of what I do in my own
16 research and in these projects. Half the projects I do
17 aren't for litigation, and this is typically what I do.
18 But if you ask me if Mr. Smith should have transgender
19 surgery, I'm not an expert on that.
20 Q. Do you keep up with the scientific literature
21 regarding gender dysphoria?
22 A. The best I can -- it's immense literature,
23 but to the best I can, I do, yes, sir.
24 Q. When did you first begin to review literature
25 regarding -- in this area regarding gender dysphoria?

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1 A. I think it would be Paul McHugh approached
2 me. I'm going to say -- I'm going to guess it was
3 2014.
4 Q. And why did Mr. McHugh -- or Dr. McHugh
5 approach you?
6 A. Actually, a colleague first approached me, my
7 colleague in psychiatry, the chair in psychiatry at the
8 time, Lyketsos. He approached me and said there was a
9 paper that could be quite controversial that Paul
10 McHugh was producing, and could I help him improve the
11 scientific standards of the paper. He was concerned
12 that the paper could be an embarrassment to Johns
13 Hopkins or the department. And so he asked me to look
14 into it, and I went to a colleague who was the deputy
15 director for Paul McHugh of the McHugh Center, and she
16 asked me if I would actually help him write it. But it
17 was in the 16th draft, I believe, when I came aboard,
18 so he had been doing this for many, many years.
19 Q. So why did you choose to take this on?
20 A. Well, I chose to take it on because Paul
21 McHugh is one of the great psychiatrists of the 20th
22 Century, certainly extreme in some of his views, and
23 some of his view bother me, bother me a great deal.
24 But I thought it was an honor to try to work for the
25 great man, or with the great man. And if I can

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1 increase the scientific rigor of the paper -- and the
2 paper has been well-received in terms of content --
3 that I would get aboard and just try to help him.
4 So the choice of the papers to review, the
5 actual review was mine. I did the extensive review of
6 the papers. So I did the scientific work; he did more
7 the application to clinical work.
8 Q. You said that some of his views concern you
9 or bother you. What views are those?
10 A. Well, I don't want to say what he thinks, but
11 he's made statements that I would consider anti-gay,
12 anti-transgender. And sometimes he has strong
13 opinions, but he could influence people more if he
14 wasn't so extreme. People told me he could use words
15 like gender pretender. Or he's made analogies to
16 anorexia. And I don't think those are very helpful. I
17 also think they can be mean-spirited, quite frankly.
18 Q. So you started reviewing the literature in
19 2016 because you took on this project working with
20 Dr. McHugh, and you're saying you have continued doing
21 so since then?
22 MR. KILPATRICK: I will object. I believe he
23 said 2014.
24 BY MR. KNIGHT:
25 Q. I'm sorry. What was the year that you

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1 started looking into the literature?
2 A. I think it was 2014. The paper, I think, was
3 published in '16, the Mayer/McHugh monograph.
4 Q. Are you familiar with our experts in this
5 case, Dr. Budge and Dr. Schechter?
6 A. I don't know them personally, no, sir.
7 Q. Well, what do you think about them and their
8 expertise?
9 A. Well, take Dr. Schechter. I know more of
10 him. He's supposed to be an excellent plastic surgeon.
11 He does a lot of the -- what I'll call the gender
12 reassignment. I don't want to get lost in terminology.
13 I never try to be offensive to anybody, but gender
14 reassignment, has a good reputation. He's been a very
15 active advocate. He's a clinician, not a scientist.
16 He doesn't know how to do citations properly, drove me
17 crazy. But I think he is probably a very good plastic
18 surgeon. I have no reason to doubt that.
19 Budge is a counseling psychologist, and she
20 makes some amazing claims or pronouncements, but I have
21 less respect for her ability. She comes across as not
22 very knowledgeable about biology and the sciences. And
23 I think she makes some statements that are unfortunate,
24 they don't clarify anything. But both passionate
25 advocates for the patient.

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1 Q. Do you believe experts in the medical field
2 should be advocates for their patients?
3 A. Well, that's a complicated question. To the
4 degree to which they are experts, experts usually are
5 not the attending physician. So it would be
6 independent medical exam and all that, then they should
7 not be advocates for the patient specifically, but many
8 of the patients who are both and treating and
9 presenting -- I mean, physicians who are both treating
10 and presenting experts are advocates for their
11 patients.
12 Q. And shouldn't they be?
13 A. I think that's a very interesting question
14 among legal scholars. Some might say it dilutes their
15 independence as experts, other people might say it
16 makes them more familiar with the specific case.
17 I think it really depends, though, whether
18 you separate it -- general causation from individual
19 causation. In general causation, you know, does this
20 exposure cause this injury is probably not attractive.
21 But an individual causation, was this Ms. Smith damaged
22 by that exposure, then I think it's probably good.
23 It's an interesting bifurcation.
24 Q. You have been an expert witness in some other
25 cases?

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1 A. Yes, sir.
2 Q. Which ones have dealt with gender dysphoria?
3 A. Well, see, I really don't know what you mean
4 by "dealt with gender dysphoria," but I have been an
5 expert -- could that be any case in which gender
6 identity has come up as an issue? Could that be an
7 answer? Because you said in general about gender
8 dysphoria. I don't know if the bathroom case is about
9 gender dysphoria.
10 Q. Well, I know you were an expert hired in the
11 Carcaño case.
12 A. I don't know what that is.
13 Q. That was a case in North Carolina.
14 A. Carcaño. Sorry.
15 Q. This is the case involving a law passed in
16 the state of North Carolina.
17 A. Are we talking about the bathroom bill case?
18 I just want to be precise.
19 Q. I think bathrooms were a part of that case.
20 A. Okay. I remember a case I did. Yeah, I
21 believe you asked me about gender dysphoria. I don't
22 know if that case is about gender dysphoria. I thought
23 it was called the bathroom case.
24 Q. Let me ask more broadly. Have you worked on
25 any cases relating to transgender people or gender

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1 dysphoria?
2 A. Yes, sir.
3 Q. And so we've talked about the Carcaño case,
4 or the case in North Carolina.
5 A. The bathroom case. I'm going to call it the
6 bathroom case, because I don't know that name.
7 Q. Okay. The bathroom case.
8 A. Yes, sir.
9 Q. Any other cases?
10 A. Well, what about the little girl that wants
11 to use the restroom of her assigned gender in Virginia?
12 Isn't that Virginia?
13 Q. Are we talking about the Gavin Grimm case?
14 And Mr. Grimm is a boy.
15 A. Yes, sir. Yes, sir.
16 Q. And were you an expert in that case?
17 A. I'm sorry. I don't know what the definition
18 is of expert. I wrote something in that case, yes,
19 sir.
20 Q. And there you're talking about you wrote --
21 you were a writer of an amicus brief; is that right?
22 A. Yes, sir.
23 Q. Any other cases in which you have worked on,
24 worked or provided testimony related to transgender
25 people or gender dysphoria?

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1 A. I don't remember as I sit here. I think that
2 is it, yes, sir.
3 Q. Why don't you take a look at what I've shown
4 you, and I think you still have in front of you, your
5 report. And there's a list of cases there, appendix A?
6 A. Yes, sir.
7 Q. So there are cases there showing court
8 appearances and depositions.
9 A. Yes, sir.
10 Q. Do any of these cases involve transgender
11 people or gender dysphoria?
12 A. No, sir.
13 Q. So this is another list of cases. There is
14 some overlap, but this is the list of cases from the
15 case in North Carolina that we talked about.
16 So do any of these cases involve transgender
17 people or gender dysphoria?
18 A. When you say "involved transgender people," I
19 don't remember if the people like Robert Anthony Norman
20 might have been transgender, but you mean is it an
21 issue of the case, right?
22 Q. That is what I mean.
23 A. Let me just look quickly. So one is an
24 accident. That's a phony doctor. That's a novocaine.
25 No, no, none of them involve that.

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1 Q. Have you worked on cases involving
2 homosexuality, gay people, or same sex couples, or
3 marriage of same sex couples?
4 A. Yes, sir.
5 Q. What case is that?
6 A. I have listed here appearances in
7 depositions. They represent about half of my
8 consulting, because about half the time I am asked to
9 consult, even on cases where I'm not necessarily a
10 listed expert or I don't even know the specific case,
11 if I know the case, I put it down here. But there were
12 two cases that were quite well-known. One was the --
13 and I'll just describe it to you. It was the case
14 involving whether porn stars should have to wear
15 condoms in adult filmmaking. And this is quite
16 controversial and eventually lead to the proposition,
17 which I believe passed, that porn stars or adult film
18 actors and actresses in Los Angeles County have to wear
19 condoms. And my role in that was testifying for gay
20 people, that they were being singled out unfairly for
21 certain actions, and that the statistics that were
22 provided did not apply to them. This became very
23 controversial because Hopkins itself was on the other
24 side of this case.
25 The second case is a criminal case that I

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1 don't want to talk about. I'd have to go get
2 permission to talk about. But this comes under the
3 sexual tourism. Under the sexual tourism law, people
4 who go abroad for the purpose of having sex that would
5 be illegal in the United States, can be prosecuted for
6 that action, even if that conduct were not illegal in
7 the other country.
8 So what happened was the Department of
9 Justice used the sexual tourism to crack down on gay
10 people that have these sexual tours to Southeast Asia.
11 And I worked on that case for quite a while.
12 Q. Any other cases that specifically involved
13 gays?
14 A. No, certainly I've always been a supporter of
15 gay adoption, strong supporter of gay adoptions, but
16 I've never been in a case of it.
17 Q. Do you consider yourself to be an expert in
18 gender dysphoria?
19 A. You would have to say what you mean. Usually
20 when you talk like that, people will mean the
21 diagnosis, treatment, prognosis, and I'm not an expert
22 in those things, no.
23 Q. Are you an expert in anything related to
24 gender dysphoria?
25 A. I would say by now I'm probably an expert in

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1 the epidemiology of gender dysphoria, having reviewed a
2 tremendous amount of literature on what the science has
3 to say. I would say that is my expertise of anything
4 is what does science really have to say about this
5 issue? What is it that we have to decide outside of
6 science?
7 Q. Would you agree that the scientific community
8 does not yet know what causes someone to have a gender
9 identity that's difference from their sex assigned at
10 birth?
11 A. I don't know what sex assigned at birth
12 means. There's only one sex, and rather than getting
13 lost in nomenclature or terminology, your sex is your
14 sex. So if you want to say that they are struggling
15 with the gender they're assigned at birth, the gender
16 corresponding to their sex, I can understand. But this
17 concept of sex assigned at birth, I'm not sure what
18 anybody is talking about. And that seems to be a
19 keynote problem, focal point.
20 Q. Can you answer my question?
21 A. Could you repeat the question, sir?
22 Q. My question is whether you agree that the
23 scientific community does not yet know what causes
24 someone to have a gender identity that is different
25 from their sex assigned at birth?

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1 A. I don't know what sex assigned at birth
2 means, I'm sorry.
3 Q. Well, let me explain to you that sex assigned
4 at birth is the terminology for the sex that a doctor
5 says someone is when they are born. That is what I
6 mean by sex assigned at birth.
7 A. And when is another sex, sir? I agree that's
8 sex -- that's the only sex. It's the sex from the role
9 in the reproductive system. You are a boy, whether --
10 a doctor could declare you a mongoose. A boy is a boy.
11 Biologically now, speaking, a boy is a boy. We know
12 what that means. And so I have to be, as a scientist,
13 given that, and then go from there.
14 Q. You must understand that you're not -- not
15 everyone agrees with you with respect to this narrow
16 definition of sex; would you agree?
17 A. No, sir. I have found no credible scientist
18 that doesn't believe that sex, overwhelmingly is
19 defined by our chromosomes. Actually, by every cell in
20 our body. Boys have boy cells and girls have girl
21 cells. So the idea that a doctor just picks your sex
22 at birth, what if you're a little boy, and picks you're
23 a little girl?
24 Second of all, it's this idea that you're
25 born with some kind of identity. I don't know what

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1 that even means. How can you be born with an identity?
2 So I'm trying to answer the question, but I have to
3 understand the question to answer it.
4 Q. You're familiar with the WPATH standards of
5 care?
6 A. No, sir.
7 (Reporter clarification.)
8 BY MR. KNIGHT:
9 Q. You understand that these standards are
10 recognized as the standards for treatment by the AMA,
11 the American Medical Association?
12 A. Standards of care for treatment of what? I'm
13 sorry, sir.
14 Q. For treatment of gender dysphoria.
15 A. Well, we have to be a little careful, because
16 when you break those down, some of them are about
17 access to care, some are about treatment, and some are
18 about treatment for gender identity disorder, which, of
19 course, doesn't exist. It is no longer a disorder. So
20 we have to be very careful. Because when I read WPATH,
21 it appears to me that they are giving indications of
22 how to treat transgenders, because they talk a great
23 deal about the transitioning process.
24 So you are treating people for being
25 transgender. If they're saying that -- let's say they

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1 said that surgery was a major treatment for the
2 dysphoric part of being transgender. That may be true,
3 but where is the evidence? I couldn't find any
4 evidence. I searched and searched.
5 Q. I'm not sure that I understand what you just
6 told me. The -- so you would agree with me, then, that
7 the AMA recognizes the WPATH standards as the
8 appropriate standards for treating transgender people
9 who need medical care?
10 A. Well, this is really complicated, for
11 transgender people who need medical care. I actually
12 don't even understand that, because it has never been
13 clear to me whether to be gender dysphoria you have to
14 be transgender. If you are the WPATH, it appears to
15 say in order to be treated, you have to be transgender,
16 in transition, and struggling with dysphoria. You're
17 not functioning well in the world.
18 Why do you have to be transgender in the
19 sense that gender dysphoria you see often among kids
20 that are really struggling with their sex and their
21 feelings of, let's say, not being a little boy when, in
22 fact, they are biologically a little boy. Why, then,
23 do they have to be transgender? But if you say to me
24 it is a effective treatment for gender dysphoria, even
25 if they're just gender nonconforming or gender curious,

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1 then the question is, what is the evidence? Because
2 the AMA offers practical guidance. And the focus, I
3 thought, of their guidance was that transgender
4 patients should be given equal access to care. Doctors
5 needed to learn how to treat transgender patients, and
6 I supported that very much, sir.
7 Q. The AMA has said specifically that "An
8 established body of medical research demonstrates the
9 effectiveness and medical necessity of mental health
10 care, hormone therapy, and sex reassignment surgery as
11 forms of therapeutic treatment for many people
12 diagnosed with gender identity disorder."
13 A. I agree they say that; we don't have gender
14 identity disorder. Because this is very important:
15 part of the treatment for gender identity disorder was
16 to treat people for being transgender. Now, we fought
17 hard. I supported the fight that it, just like gay, it
18 shouldn't be a diagnosis. Being transgender should not
19 be a diagnosis. These are perfectly healthy human
20 beings, and society needs to accept these human beings.
21 So the fact of the matter is, we don't treat
22 gender identity disorder, we treat gender dysphoria.
23 And contrary to what Budge says, the criteria you start
24 with aren't the critical criteria. It's the dysphoria
25 that is. So if you are saying to me, is there -- and

1 you're asking me is there a controlled clinical trial
2 that shows a hormone therapy, butt lifts, facial
3 feminization, or any of these actually reduces the
4 incidence or prevalence of gender dysphoria, I could
5 not find that paper.
6 Q. The diagnoses for the condition of gender
7 identity disorder are very similar to the diagnoses for
8 gender dysphoria, are they are not?
9 A. No. They are absolutely different because it
10 takes out being transgender. We fought hard for this.
11 Transgender is not part of the diagnosis any longer.
12 So gender identity disorder was anybody struggling with
13 their identity. Why do they have a disorder? Why
14 should a woman who identifies -- let's say she's
15 biologically a woman in my terminology -- identifies
16 with being a man, a sincere persistent identification,
17 why shouldn't she be treated with respect. What does
18 it have to do with whether or not she's transgendered
19 or not. The social stigma is a real problem.
20 Q. So you are not understanding that the AMA
21 supports -- or you don't agree? Is that what you are
22 saying? You don't agree that the AMA supports these
23 kinds of medical treatments for persons who are
24 transgender, whether they have gender identity disorder
25 or gender dysphoria?

1 A. Why should a transgender person be treated?
2 What are you treating them for? We fought to get --
3 the same with gay. Gay is a diagnosis we fought for
4 20 years to get rid of that diagnosis. Being
5 transgender is not a condition that needs to be
6 treated. And I see in Budge a contradiction. On one
7 hand is saying, well, this is a normal part of
8 development. On the other hand, they need to
9 transition.
10 Why they are transitioning is to appear
11 differently, if you're talking about surgery, for
12 example, facial feminization, but the fact is appearing
13 different has nothing to do with what they think about
14 themselves. If they sincerely identify with being a
15 member of the opposite biological sex, then what are
16 they guilty of? What are they diagnosed as?
17 Q. They're diagnosed --
18 A. They're viable people.
19 Q. Isn't the gender dysphoria diagnosis a
20 diagnosis that relates to the clinical distress that
21 results from the difference between the -- your, as you
22 call it, your sex, which I would call your sex assigned
23 at birth and your gender identity, your understanding
24 that there is -- your dysphoria about that
25 incongruence? Isn't that what gender dysphoria is?

1 A. Wait a second. Gender dysphoria is your
2 inability to function. In this case, your inability to
3 function. We have to make you functional. We're
4 trying to make you functional. In this case, your lack
5 of being able to function is a distress, but it doesn't
6 have to be a contradiction. You can feel like you're
7 part man, part woman, you're struggling with your
8 gender. Who are you as a human being? That is what we
9 have to cure and help. The fact of the matter is these
10 transgender conditions, the conditions are conditions
11 we look for to see whether this person is struggling
12 with their gender identity. That is exactly right.
13 But the condition that we treat is gender dysphoria.
14 And let me go back to the AMA for a second.
15 I just want to make one comment. There is nothing that
16 the AMA has endorsed more than antidepression drugs,
17 the SSRIs, the selective serotonin reuptake inhibitors.
18 These operate about 5 percent better than placebo.
19 5 percent better. But placebo interacts very, very
20 well.
21 So the question is to me, the AMA has made a
22 lot of mistakes in things it has recommended, but if
23 they are meaning that this is a way to treat the severe
24 disruption of life caused by gender dysphoria, I agree.
25 But we need to have a study of that, a precise,

1 controlled clinical trial. And one of the things I
2 looked at was a base of people who are transgender who
3 don't have gender dysphoria. There can be perfectly
4 well-adjusted people who are transgender, but it should
5 be well-adjusted.
6 Q. So the AMA supports treatment through hormone
7 therapy and surgery for the gender dysphoria, this
8 discordance --
9 A. I've never seen that.
10 Q. Do you understand that?
11 A. No, I've seen them -- they may have endorsed
12 it later. Again, it wouldn't bother me. At one time
13 they endorsed smoking. So it wouldn't bother me
14 because this is a highly political clinical
15 organization. There's absolutely no doubt about that.
16 And whatever clinical guidelines it has, I'm not here
17 to argue about clinical guidelines. But those
18 guidelines have got to be based on scientific studies,
19 and where are the studies? That is all I'm asking.
20 Q. Would you say that your view with respect to
21 gender dysphoria is a minority view?
22 A. I'm sorry. You would have to say explicitly
23 what view it is. I'm not sure what you are referring
24 to as "my view."
25 Q. Your view that transgender people -- that

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1 surgery and hormone therapy is not safe, effective
2 treatment for gender dysphoria?
3 A. I've not been asked that question, have I?
4 Q. That is what I thought you were here
5 testifying about.
6 A. No, I testified it has not been demonstrated
7 to be safe and effective, particularly compared to its
8 competitors. I mean, to me, to do a study of -- give
9 people $50,000 worth of plastic surgery and then ask
10 them if they feel better about themselves is a little
11 bit silly. The outcome has got to be dysphoria. And
12 we've got to look at the treatment versus an active
13 control. I bet anybody you do $50,000 worth of
14 cosmetic surgery on feels better about themselves.
15 Q. Would you agree that gender dysphoria is a
16 serious illness?
17 A. Absolutely. I say that in my report. I'm
18 very concerned about it.
19 Q. And how do you think it should be treated?
20 A. I don't know. But one of the things we
21 should do is we should have studies about what
22 treatments are safe and effective. What are
23 comparative statics of this treatment versus other
24 treatments? And I'm not seeing studies. If you are
25 depressed and you have gender dysphoria, is this an

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1 effective way versus directly treating your depression?
2 I don't know. By the way, there are lots of
3 studies in plastic surgery about breast augmentation
4 and what the effects are in the long run on people's
5 attitude toward themselves. And those are very
6 interesting studies to look at. Those results are
7 quite similar.
8 Q. So you don't know how gender dysphoria should
9 be treated?
10 A. Well, two things. One is, I'm not a
11 clinician. And number two, I can only talk to you
12 about what has been demonstrated in science. If you
13 say, is there a good paper deciding how gender
14 dysphoria ought to be treated, my answer is no. The
15 area is so political, it's a shame, but we aren't doing
16 serious research on how to treat it.
17 Q. You are suggesting that individuals with
18 gender dysphoria should come to accept their natal sex?
19 A. No, sir. I would never suggest that. I
20 think if the person has a long-term consistent -- I
21 think the WPATH long-term consistent persistent
22 insistent deeply held identification with the opposite
23 sex, they should be supported in that identification.
24 Why not?
25 Q. And should they be provided hormone therapy?

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1 A. Well, I don't know. That is a separate
2 question. I would say to you that it has been
3 inadequately studied, and I worry because the advocates
4 will tell you that hormone blocking or even hormone
5 adding, which we wrote about the hormone blocking, are
6 without side effects. There is nothing that doesn't
7 have side effects in medicine. We all accept that. So
8 is it a safe, effective way? We need long-term
9 follow-up studies.
10 I have specific worries about children being
11 put on puberty blockers or being put in to supportive
12 environments as young as 18 months old. I have some
13 concerns about that. But I don't know what the best
14 way to treat it is. And I worry about it. High
15 suicide rate, they suffer tremendous discrimination.
16 Do I think we should have society more accepting? Yes.
17 Yes, why not? Why not?
18 Q. And I'm really asking about adults.
19 A. Yes, sir.
20 Q. And I'm asking about whether you would agree
21 that where clinicians find that effective treatment for
22 this patient is going to be hormone therapy, that that
23 should be provided to them?
24 A. The problem is when you say "provided,"
25 oftentimes issues in American medicine are about who

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1 pays the bill, and I know very little about who pays
2 the bill. Because we talk about cosmetic surgery
3 versus reconstructive surgery, it often comes down to
4 who pays the bill. So with that caveat -- well,
5 actually, could you repeat the question so I get it
6 exactly right.
7 (Record read.)
8 THE WITNESS: I don't see any reason
9 provided. Let's suppose we're talking about somebody
10 that has all the money in the world, they have money to
11 pay for whatever they want, and they came and said, I
12 really identify with being a woman. I think that
13 identification would be enhanced if I had certain
14 physical characteristics.
15 I would probably support that in the
16 abstract. I can't see any reason not to support it.
17 BY MR. KNIGHT:
18 Q. You seem to be not answering my question.
19 A. I'm sorry.
20 Q. I'm asking about an individual whose natal
21 sex was -- is male, but identifies as female, and
22 whether -- and is -- and a physician sees that this
23 person is expressing such levels of distress and
24 dysphoria that the proper treatment for them should be
25 hormone therapy.

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1 Do you agree that that should be provided?
2 A. Well, I would have to see the patient, I'd
3 have to read about the patient. But in general --
4 because I don't want to talk about specific patients --
5 but in general, do such patients exist? I assume they
6 do.
7 Q. And you believe those patients should be
8 provided hormone therapy?
9 A. Well, not necessarily. Suppose there was
10 another treatment that was equally efficacious and much
11 cheaper or much safer. I mean, this reassignment
12 surgery, for example, is dramatic surgery. Now,
13 hormone therapy is not as dramatic, but if they had a
14 long-term consistent persistent identification with
15 members of the opposite sex, and they felt their
16 physical appearance was really causing them great
17 distress, I would say, without knowing the details, I
18 would come down on supporting the treatment, yeah.
19 Q. And you understand that the clinicians and
20 researchers have tried to offer other medications other
21 than hormone therapy unsuccessfully?
22 A. Well, when I read that, though, when I read
23 success -- notice that this literature is primary
24 plastic and reconstructive surgery. If you look even
25 at Dr. Schechter's website, there is great bragging

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1 about how well the surgery goes. Success rates are, if
2 you excuse the expression, the ability to pass, the
3 ability to look like members of the opposite sex. So
4 let me go to the point here: You have a woman who is
5 cisgender, her breasts are sagging or something, she's
6 in her 40s. I support procedures for her.
7 So in general, yes, I support psychiatric
8 interventions. This would be a psychiatric
9 intervention, by the way. It's a psychiatric
10 intervention because we're trying to change the frame
11 of mind, right? But as a psychiatric intervention,
12 could a psychiatrist recommend hormone therapy with an
13 endocrinologist? I think so. I don't know that you
14 could stop it.
15 Q. Do you believe that a transgender person can
16 be talked out of being transgender?
17 A. I think the difficulty there has got to do
18 with at what stage they have long-term consistent
19 persistent deeply held beliefs. If they've been in
20 that for a long time, then I don't think they can be
21 talked out, nor why should they be talked out.
22 On the other hand, if they're struggling with
23 feelings that they're not a little boy, and they're
24 kids or young adults, I think they should be helped
25 with the dysphoria, no matter what that help is. The

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1 enemy is the dysphoria, not the physical appearance.
2 And steps should also be made to have them more
3 accepting of their own self.
4 Q. But you understand that the gender dysphoria
5 is about the physical appearance, the fact that the
6 individual's body does not conform to their
7 understanding of who they are?
8 A. But notice what you said there. They have to
9 have an understanding at birth for this to be true.
10 Their understanding -- you said their gender identity
11 is there at birth. So at birth, they already
12 understand that they don't identify with their
13 biological sex. How is that possible?
14 Second of all, the characteristics that we
15 identify as being male or female are very culturally
16 dependent. What if pregnant mom moves to Timbuktu
17 during her pregnancy? Is the baby born with a
18 different set of expectations?
19 Let me make -- can I make one more comment on
20 that? In general, though, people that want to talk
21 people out of being gay or being transgender seem to do
22 it from a moral crusade, that there is something wrong
23 with these people. I don't know if you notice that, I
24 certainly do.
25 Q. Do you support therapy to help people cease

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1 to act on their same sex attractions?
2 A. Say again?
3 Q. Do you support therapy to help people cease
4 to act on their same sex attractions?
5 A. No, sir.
6 Q. Do you disagree with the DSM's inclusion of
7 gender dysphoria as a diagnosis?
8 A. No, sir.
9 Q. And I believe we've established you do not
10 oppose hormone treatment for adults?
11 A. But on --
12 (Indecipherable simultaneous speaking.)
13 Q. -- gender dysphoria.
14 A. Do I oppose them ever receiving hormone
15 therapy? Is that the question?
16 Q. That is the question.
17 A. I would not oppose it.
18 Q. Do you oppose adults with long-standing
19 gender dysphoria receiving surgery?
20 A. I don't oppose it, but I would say there is
21 not scientific evidence to support it. There is not a
22 single study that shows the incidence of gender
23 dysphoria goes down as a function of plastic surgery or
24 reassignment surgery.
25 Q. I'm sorry, the incidence of gender dysphoria?

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1 A. Yes, sir.
2 Q. What do you mean by the incidence of gender
3 dysphoria?
4 A. The number of cases per year doesn't go down.
5 In other words, gender dysphoria isn't about people
6 feeling better. That's how it's written in the classic
7 reconstruction -- they have a better self-image, better
8 body image.
9 Gender dysphoria is a very serious illness
10 leading to a high risk of suicide, for example. You
11 need to cure that dysphoria. So when they do this
12 surgery, and they talk about how beautiful the woman
13 is -- this is a male-to-female transgender and all
14 that -- we do not have long-term follow-up studies of
15 what percentage of them are still dysphoric.
16 It's the most obvious study to do. You'd
17 randomize people to either have one treatment or
18 another treatment or spend $50,000 on them having a
19 trip to Bermuda.
20 The question is the people who feel better
21 about themselves often do so after they have a windfall
22 or a positive experience. Now, I support more cosmetic
23 surgery, woman and men in general, if people don't feel
24 good about their appearance and their cisgender.
25 They're 45 years old and have a mid-life crisis, I

1 support their use of -- including hormones, including
2 surgery. I think having people have a positive
3 psychological outlook on life is extremely important.
4 And the suicide rate among transgenders is a public
5 health crisis.
6 Q. So you believe that surgery to treat someone
7 with gender dysphoria is exactly the same as surgery to
8 treat a cisgender woman, for example, or a cisgender
9 person?
10 A. Well, it is not exactly the same, but I'm
11 glad you asked that question. I have three triplets.
12 Two are born boys, and one is born a girl by sex. And
13 they all three have very masculine faces. The three
14 little boys have masculine faces. These are fraternal,
15 not identical. The two little boys decide they're
16 transgender -- or discover they're transgender. I
17 don't want to offend anyone.
18 So now we have three little girls, very
19 similar faces, okay? All three are bothered that --
20 they're disabled, they're demoralized by the look of
21 their face. Now, one of them is transgender, but goes
22 s along with it and says, I don't like it. There's a
23 lot of stigma, but I'm not suffering bad enough that I
24 can't go to work, I can do it.
25 The other one says I'm transgender and I'm

1 suffering so bad I can't go to school. I'm clearly
2 dysphoric. And the third one says, I'm a little girl,
3 my sex is a little girl, but as a little girl, I don't
4 like having a masculine face. Do I believe all three
5 of them should have equal access to whatever it is?
6 Absolutely. Why should the one who is dysphoric have
7 different treatment than the other if the issue is how
8 you appear?
9 Q. Are we talking about real people --
10 A. Yes.
11 Q. -- or just something in your head?
12 A. No. We are talking about real people. I've
13 seen several cases now of twins and triplets I've been
14 asked to give input on or even be a witness in which
15 that is exactly the issue. What should something be
16 done -- why should something be different done for the
17 transgender patient that isn't done for the cisgendered
18 patient? I don't understand that. If they're equal,
19 which they are, then why should one be done more than
20 the other? What am I missing?
21 Q. Do you know anyone who is transgender?
22 A. Yes, sir.
23 Q. How many people?
24 A. Oh, probably -- well, that I know for certain
25 are transgender, half a dozen.

1 Q. Have they had medical treatment, hormone
2 therapy?
3 A. I'm not going to say -- they're too small a
4 sample. I'm not going to say anything about it.
5 Q. Are you aware that for some transgender
6 people having medical treatment can be a life or death
7 situation?
8 A. Well, I'm not sure how we would demonstrate
9 that. I have seen patients if I don't get surgery by
10 such and such, I will kill myself. I don't know -- I
11 don't know how you would measure whether it is a life
12 or death situation.
13 Q. Are you aware of the studies of people who
14 have been denied treatment for gender dysphoria who
15 engaged in self-surgery, for example?
16 A. Yes, sir.
17 Q. And wouldn't that indicate the seriousness of
18 the condition, that it's a life or death situation?
19 A. Well, for some patients. I thought you meant
20 as public health, is this a significant problem. The
21 suicide rate or self-harm rate is so high among
22 transgenders, I don't know how you separate it out. So
23 they're denied the surgery and then they go kill
24 themselves. And some have the surgery and kill
25 themselves. The problem is they kill themselves. This

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1 is a crisis. Let's do something about it.
2 Q. But you understand that your work here is
3 being used to prevent treatment that lowers suicide
4 rates?
5 MR. KILPATRICK: Argumentative.
6 THE WITNESS: Do I understand, I'm sorry?
7 BY MR. KNIGHT:
8 Q. Do you understand that your opinions are
9 being used here to -- to prevent getting -- prevent
10 people from getting the treatment that would lower
11 suicide rate for them --
12 MR. KILPATRICK: Objection.
13 MR. KNIGHT: -- or lower the risk of suicide?
14 MR. KILPATRICK: Objection.
15 THE WITNESS: Well, I'm not aware of that. I
16 don't necessarily believe it's true, but I would love
17 to see the study that really shows that, because I
18 think all these numbers are manipulated. These
19 transgender or gender dysphoric people have very high
20 suicide rates, treated or not.
21 You're saying there are people, a large
22 number of people who can show, had they not had
23 treatment, they would have been suicidal. I do not
24 know of that study. I would be interested if you'd
25 send it to me.

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1 BY MR. KNIGHT:
2 Q. Would you agree that medical decisions with
3 respect to the treatment that is provided involves not
4 only looking at research, but also looking at clinical
5 experience?
6 A. Clinical experience of the doctor, you mean?
7 Q. Oh, I'm sorry. All physicians who work with
8 this affected population.
9 A. I'm sorry. I don't understand the question.
10 Q. Isn't it standard that when the -- isn't it
11 typical that when the standards of care for treating a
12 condition such as gender dysphoria are established,
13 that they look at the research as well as clinical
14 experience?
15 A. Well, sometimes they do, but the Cochrane
16 Review that studied OB/GYN procedures found that
17 two-thirds of the things we do, including holding
18 babies up by their feet and spanking their butts are
19 actually harmful. So there is a great deal of folklore
20 in what we do in medicine, and we don't know why we do
21 it. We don't have indications. So I'm very suspicious
22 of the fact there are ramifications.
23 The other example that I worked on were
24 VBACs. A VBAC is a vaginal birth after cesarean
25 delivery. We'd forbid them in the United States. The

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1 AMA said they were dangerous. And yet when we finally
2 did a study of Canadian experiences versus ours, we
3 found out that VBACs were safe. That is the importance
4 of doing research.
5 What I would like is some very conservative
6 people on this issue, some very liberal people on this
7 issue to meet in the middle and let's get together and
8 decide on how to help this population of people. That
9 is my sincere desire.
10 Q. So you don't think that clinical experience
11 is at all important in deciding what kind of medical
12 care should be provided?
13 MR. KILPATRICK: Objection. Mischaracterizes
14 the testimony.
15 THE WITNESS: I think physicians have a
16 union, it's a very strong union, so it's an important
17 input. But can physicians be doing things incorrectly
18 for decades? Bloodletting. Leaches.
19 MR. KNIGHT: I would like to take a break for
20 about five minutes or so.
21 MR. KILPATRICK: Sure.
22 (Recess taken.)
23 MR. KNIGHT: Okay. Back on the record.
24 BY MR. KNIGHT:
25 Q. So, Dr. Mayer, I just want to go back to a

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1 couple things. I asked you about working with
2 students, and I just want to make sure that my question
3 covered everything related to this.
4 Have you, in any of your work over the last
5 25 years, supervised residents who had any involvement
6 with individuals with gender dysphoria, gender identity
7 disorder, transsexualism, any of those specific
8 diagnoses?
9 A. Yes, sir.
10 Q. And when and how many?
11 A. You asked me if I've ever talked to students
12 that they themselves have patients. That happens all
13 the time, so every -- every resident that worked in the
14 gender identity clinic or rotated through that clinic
15 could bring those topics up and we can discuss them.
16 Again, it would be in the context of science and
17 research papers.
18 And then I have a dear friend and colleague
19 who is a psychiatrist and an internist. And she
20 focuses on women in life transition, and has several
21 male-to-female patients they I've helped her with in
22 terms of the emerging understanding of gender -- of
23 gender dysphoria. Those are two very specific patients
24 that come to mind, and that is more direct. So the
25 answer is "yes."

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1 Q. So two patients?
2 A. Yes. They're two specific patients that I
3 know of who are male-to-female transgenders.
4 Q. And when were -- who is the colleague you
5 were talking about?
6 A. I'm not going to say, if that's all right.
7 It has no relevance to this. I mentioned it
8 clinically.
9 Q. I think it does have relevance.
10 A. I'm not going to say. Because it might
11 identify the patients, and I'm not going to do that.
12 Q. I'm not going to ask you the name of the
13 patient. I'm just asking about who the colleague is
14 you're saying you worked with.
15 A. She's my student, so I'm not going to say.
16 Q. When was this?
17 A. Well, to my knowledge she still treats them,
18 but it's certainly been in the last four or five years.
19 Q. And, I'm sorry, you say "treats him." I
20 thought these were women who were transgender?
21 A. I'm sorry. I thought I said "treats them."
22 They are transgender women, yes, sir.
23 Q. And what kind of treatment is she providing
24 for them? Is she treating them as a psychiatrist?
25 A. Yes, sir.

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1 Q. And what kind of treatment is she providing
2 to them? Is she providing them hormone therapy?
3 A. I'm not going to say. I don't know for sure,
4 but I'm not going to say. Because I wasn't involved.
5 I'm involved in understanding the research. For
6 example, one of the questions that came up is, do these
7 women truly believe they are women? That is the very
8 important question of whether they identify with being
9 women or truly believe they are women. What does that
10 mean if they truly believe? What does research show on
11 that topic?
12 So this would be about more general
13 discussions of what the data in epidemiology says, it
14 was never about the clinical treatment of the specific
15 patient. I don't do that.
16 Q. So you did not talk to these students nor
17 this one woman, female student about which kind of
18 treatment should be provided to these women who were
19 transgender?
20 A. No. We talked about the efficacy in general
21 of different treatments for gender dysphoria. I was
22 going to say this is about 2015 and '16 when this
23 research was blossoming. So she was interested in
24 understanding. She's a researcher like I am and she
25 was interested in understanding the implications of

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1 research. And we went over papers. And also she
2 helped me with the Mayer/McHugh -- you know, the
3 subsequent one we did on puberty blockers. You're
4 aware we did that paper too. And she helped me with
5 that paper. She has a master's in neuroimmunology in
6 addition to being trained in psychiatry and internal
7 medicine.
8 Q. Also --
9 A. Let me just add. I apologize.
10 The brain research was just coming out very
11 big, and we also spent a lot of time going over the
12 brain research, scan research.
13 Q. But so you're saying when you talked to these
14 women, it was about the research, not about the
15 specific treatment for those patients?
16 A. Would that be correct, yes, sir.
17 Q. And you said that you have spoken to other
18 students regarding individuals with gender dysphoria,
19 transsexualism, or GID in the past?
20 A. Yes. They rotate through the clinic at Johns
21 Hopkins, and I have them for journal club where we
22 bring in articles and we read them, and then we discuss
23 the articles in light of a given patient. Or they
24 might be presenting a research conference, which means
25 you start with a particular patient and present them.

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1 And I would help them with the research part of that,
2 not the individual patient part.
3 Q. And how many of them did you speak to about
4 this issue: Gender dysphoria, transsexualism, or
5 gender identity disorder, or a related condition?
6 A. Oh, we're talking about over 20 years it
7 would come up. I can't say. I think almost all our
8 residents rotated through those clinics. Do you mean
9 how many of them did the specific conversation come up,
10 I don't remember.
11 Q. I thought that you told me that you were not
12 looking that the research until 2014?
13 A. I wasn't looking at it specifically in terms
14 of trying to write a paper, interested in research. I
15 knew about the research in general, because I knew
16 about the fight over the gender identity disorder in
17 the DSM-4 and DSM-5. But I didn't get seriously
18 involved in this humongous effort until I got involved
19 with Paul McHugh.
20 Q. So do you believe that any psychiatrist or
21 epidemiologist who reads some studies about gender
22 dysphoria or gender identity disorder or transsexualism
23 is an expert in gender dysphoria?
24 A. I would say he's an expert in the
25 epidemiology of gender dysphoria. Just like a plastic

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1 surgeon obviously knows no epidemiology. So the idea
2 is we each have a specialty, so I would consider a
3 person by reviewing the research to be an expert on the
4 scientific foundation. Someone's got to review it, and
5 certainly clinicians don't have time to do it. So,
6 yes, I would say you became an expert on the
7 epidemiology of a topic or the scientific foundation of
8 a topic by reading the scientific literature on that
9 topic.
10 Q. And that reading the studies make you an
11 expert?
12 A. No, no. I spent two years dissecting the
13 studies. I went back to the original data. I spent
14 two years day in and day out trying to find the best
15 studies and figure out what those studies said. It was
16 far greater -- I mean, you could say my whole career
17 has been reviewing and evaluating research papers.
18 That is what I do; I try to extend methodology. No,
19 reading the papers alone wouldn't make you an expert in
20 anything.
21 Q. We talked earlier about hormone therapy and
22 surgery as treatments for people with gender dysphoria.
23 Do you believe, though, that hormone therapy
24 is medically necessary for treating gender dysphoria in
25 adults with long-standing gender dysphoria?

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1 A. Well, I have to know what its relative
2 efficacy is versus other treatments. I don't know,
3 because we don't have the data, we don't have the
4 analysis. Is this an effective treatment? I would
5 like to see people given hormones and people given the
6 reassignment surgery, and follow them up in 20 years or
7 whatever length of time, and see how well they're doing
8 compared to another group.
9 Science is about comparison. Where are the
10 transgender people who then don't undergo hormone
11 therapy to have a comparison group. Or an active
12 control would be spend $50,000 on them by giving them a
13 trip to Bermuda, if you want, and see if that is
14 equally effective.
15 Q. So can you answer my question about whether
16 it is medically necessary?
17 A. I don't know what the question is, sorry.
18 Q. Well, the question, I will ask it again, is
19 hormone therapy medically necessary treatment for
20 adults with long-standing gender dysphoria?
21 A. Now you said "hormone therapy," correct?
22 Q. Correct.
23 A. I've seen no papers that demonstrate that
24 that is an effective and safe treatment.
25 Q. So is your answer "No"?

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1 A. Well, I'm not an expert in what is medically
2 necessary. Medically necessary to me is about a
3 specific patient, looking at Mr. Smith and deciding
4 what is required for Mr. Smith. Could there be cases
5 in which it would be a good thing to do? Yes, I'm sure
6 there are. And are there cases where it's a bad thing
7 to do? I'm sure there are. We just don't know enough,
8 because the people that are supposed to be experts in
9 this are such advocates, they make their money off
10 this, that the fact of the matter is, there's very
11 little push for independent research.
12 It surprises me that the attorneys for ACLU
13 and others are not concerned about what the long-term
14 effects, particularly for young people, are going to
15 be. It concerns me a great deal.
16 Q. So is -- my question, again, I think that you
17 answered that in that you're not an expert with respect
18 to medical necessity, with respect to an individual
19 patient; is that right?
20 A. That is correct.
21 Q. And would you agree with me that hormone
22 therapy can be medically necessary for some patients
23 with gender dysphoria, long-standing gender dysphoria?
24 A. I'd have to see -- remember, we are treating
25 the gender dysphoria. All I'm asking for is a simple

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1 study that shows this treatment is effective. There is
2 no such study. That's all I'm asking for.
3 Q. Now I'm just asking you a simple question.
4 A. Okay.
5 Q. Yes or no, is hormone therapy medically
6 necessary for some patients with gender dysphoria?
7 A. I don't know the answer to that, because I'm
8 not a clinician. I don't know the answer to that.
9 Q. And you're saying you don't know because you
10 don't believe there are studies that show it is safe
11 and effective; is that your answer?
12 A. Let's go back to this. It's as safe and
13 effective as surgery. That is what the studies say.
14 There are no studies -- let me make it clear -- I'm
15 willing to bet Dr. Schechter would show the incidence
16 and prevalence rate of gender dysphoria is
17 significantly decreased by hormone or reassignment
18 surgery compared to other modalities of treatment. So
19 if you mean, if it works as well as a 10 cent pill, is
20 that safe and effective? No.
21 The fact is that all surgery has side
22 effects. The fact is that all medicines have side
23 effects. Is the risk of those side effects warranted?
24 We just don't have the research; we don't have the
25 publications.

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1 We have studies telling people feel better,
2 they like the way they look, they have less burden.
3 None of that is dysphoria. None of it is dysphoria.
4 Better body imagine, but do they actually have a
5 decreased risk of dysphoria, I do not know that. I do
6 not know it. I wish I did.
7 It is also interesting the results are almost
8 always in plastic surgery journals. If they are great
9 psychiatric interventions, why aren't they in
10 psychiatric journals? I've always wondered that: Why
11 aren't psychiatrists the leader in this, since this is
12 psychiatric, it's a psychiatric condition.
13 Q. Is there another kind of treatment other than
14 hormone therapy and surgery that you believe is safe
15 and effective for treating gender dysphoria?
16 A. We do not have a study of the long-term
17 follow-up affecting gender dysphoria. Now, if the
18 dysphoria is depression, there are treatments for
19 depression. We have a great experience with people
20 dissatisfied with their body appearance, and we do
21 plastic surgery on them. We have a great deal of
22 experience on that, what it does to their image and all
23 that. And we have evidence on medicine, like
24 depression.
25 The question is, what is their dysphoria?

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1 Dysphoria is a general term. Is it anxiety? Is it
2 depression? Is it social withdrawal, social isolation?
3 And then you go after treating those characteristics.
4 Is that as effective? I don't know; we don't have the
5 papers.
6 Q. I will ask the question again.
7 Is there another kind of treatment that is
8 safe and effective for treating gender dysphoria other
9 than hormone therapy and surgery?
10 A. I never accepted that it was safe and
11 effective. How in the world can you say -- that's a
12 rude way to ask a question, in my opinion, sir. I
13 never said it was safe and effective.
14 Q. My question was, is there something else
15 other than hormone therapy and surgery that is safe and
16 effective to treat gender dysphoria?
17 A. It is not safe and effective. There is no
18 evidence for it.
19 Q. I didn't say it was safe and effective.
20 A. Yes, that's in the construction of the
21 sentence.
22 Q. My question is --
23 A. Let's go to the board and write out the
24 meaning of the sentence. I'd be glad to because the
25 sentence implies that it is a safe and effective

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1 treatment. I specifically said a dozen times there is
2 no evidence for it.
3 Q. Is there another treatment?
4 A. You mean is there any treatment.
5 Q. Is there any treatment for gender dysphoria
6 that you believe is safe and effective?
7 A. I don't have the evidence that there is any
8 treatment that has been proven to be safe and
9 effective.
10 Q. And are you aware of other -- so what do you
11 think should be done for people with gender dysphoria?
12 A. I think we should treat them for gender
13 dysphoria the best we can. That might be supportive
14 therapy. It might be programs to reduce stigma. It
15 might be changing their physical appearance to make
16 them feel better about themselves, but I don't
17 understand the difference of why a transgender female
18 would be entitled to some surgery because she doesn't
19 like her appearance, and a cisgendered female would not
20 be entitled to it. Explain to me what the difference
21 is.
22 Q. So you think that people with gender
23 dysphoria should be -- one of the treatments should be
24 to try to make them comfortable with their natal
25 gender; is that what you are saying?

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1 A. No, sir. Why -- I don't know what you mean
2 by natal gender. Maybe I misunderstood. What does
3 natal gender mean? I'm sorry. I don't know what that
4 term is. You mean their sex? I'm sorry.
5 Q. Natal sex? Is that what you are saying the
6 treatment should be --
7 A. Okay.
8 Q. -- to help someone to be comfortable with
9 their natal sex?
10 A. I'm sorry, I still don't -- let's talk about
11 a male-to-female transgender. Would the treatment be
12 to help her feel comfortable as what now? She's a
13 male-to-female transgender, I'm trying to understand.
14 Q. As a man.
15 A. As a man? She's a male to female -- no, as a
16 woman. As a woman, not as a man.
17 Q. But you just said that -- I understood you to
18 be saying that one of the treatments that should be
19 provided is to make that person comfortable with the
20 gender -- with their sex.
21 A. Well, I don't -- I'm surprised you believe
22 that. I don't believe that.
23 Q. I thought that is what you just said.
24 A. Well, if I did, I misspoke. I apologize. I
25 don't believe that at all. Why would you do that?

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1 These people are seriously -- they're transgender.
2 They identify with the other sex. Why wouldn't you
3 support them in that identification?
4 Q. So you are saying you should support them in
5 identifying in -- with their gender identity? So a
6 transgender woman should be supported in identifying as
7 a transgender woman; is that correct?
8 A. I think she should be supported as
9 identifying as a woman. Is that what you mean by a
10 transgender woman, as a woman? She is a woman, right?
11 I thought that's why we were here.
12 Q. Are your former colleagues at Johns Hopkins
13 aware that you are participating in this case?
14 A. I don't know.
15 Q. Are they aware of your -- I assume that they
16 are aware of your writing this publication in the New
17 Atlantis?
18 A. Yes, sir.
19 Q. And have you spoken to them about it?
20 A. Some of my colleagues, yes, sir. It has been
21 several years.
22 Q. And what did they say?
23 A. Different colleagues said different things.
24 Almost uniformly they liked the paper for its
25 scientific content, and they didn't like the paper in

1 the sense that it was picked up by people who have
2 rather extreme views.
3 Q. Well, I assume that you have seen the letter
4 that was written by clinicians at Johns Hopkins
5 disavowing the report on gender and sexuality, that --
6 the New Atlantis publication?
7 A. They're not clinicians, but other than that
8 they were my colleagues at Bloomberg School of Public
9 Health, including the president of the university's
10 wife. I'm familiar with that. There was one, and then
11 there was another article condemning. But most of it,
12 as I say before, I condemn it for the strange
13 bedfellows as opposed to content. But there are
14 certainly people very happy with it and there are
15 certainly people unhappy with it.
16 Q. But you are aware that Johns Hopkins is
17 providing surgical treatment for gender dysphoria?
18 A. Yes, sir.
19 Q. And that, when they did so, they did so
20 because they believe that the treatment was safe and
21 effective?
22 A. Some people there do. Certainly the surgery
23 department does. And the psychiatry was actually
24 against the -- having the clinic. But let me say
25 something again about safe and effective. Safe and

1 effective in surgery means safe and effective as
2 surgery. You can't mean it's safe and effective
3 treatment of dysphoria if you don't have any evidence.
4 And it's interesting to note that almost all the papers
5 published are in surgery journals. Why aren't they in
6 psychiatric journals if you're doing this in order to
7 help people with a psychiatric condition?
8 Q. Are you aware that the American Psychiatric
9 Association recognizes that social transition hormone
10 therapy and sex reassignment surgery is appropriate and
11 medically necessary care for some people with gender
12 dysphoria?
13 A. Yes, sir.
14 Q. And you disagree with the APA on this?
15 A. No, sir. I'd say there is insufficient
16 evidence to make conclusions, but I have no reason
17 to -- if you are saying there are some people who
18 probably benefit by some treatment, I have no doubt
19 that that is going to be the case.
20 Q. But you don't believe that insurance coverage
21 should be provided for it?
22 A. I don't know anything about -- I'm not an
23 expert on insurance coverage. I said at the start,
24 because in other countries you either need a procedure
25 or you don't. This distinction between elective

1 surgery and required surgery has much more to do with
2 who is paying than it does with the medical needs.
3 I would encourage more plastic surgery for
4 people in their 40s or 50s who are uncomfortable with
5 their appearance. Now, who should pay for it is a
6 separate question.
7 Q. So do you believe the State of Wisconsin
8 should be providing coverage for surgery and hormone
9 therapy for patients with gender dysphoria for state
10 employees with gender dysphoria?
11 MR. KILPATRICK: Objection to the extent it
12 calls for a legal conclusion.
13 THE WITNESS: Yeah, I don't even -- I don't
14 know anything about the state of -- I haven't been
15 asked anything related to what you're saying. I don't
16 know anything about the state of Wisconsin.
17 BY MR. KNIGHT:
18 Q. Well, do you know what this case is about?
19 A. I read a complaint in the case. It's an
20 open-ended question. I know a bit about it, what I've
21 read. Have I read a lot of reports in detail? No,
22 sir.
23 Q. Well, you understand this is a case involving
24 a ban on providing coverage for gender dysphoria and
25 surgery -- I'm sorry. For hormone therapy and surgery

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1 for state employees with gender dysphoria?
2 A. Did I understand that is the case?
3 Q. Yes.
4 A. Can you repeat it again, the case is what?
5 Q. This is a case involving a state exclusion on
6 coverage for hormone therapy and surgery for state
7 employees with gender dysphoria.
8 MR. KILPATRICK: Objection to the extent it
9 mischaracterizes the description of the case.
10 BY MR. KNIGHT:
11 Q. Did you understand that?
12 A. I understood there are patients who are
13 seeking medical care. That is all I understood. The
14 rest of the legal part and the financial part, I don't
15 know anything about.
16 Q. Okay, but what I'm understanding is that you
17 agree that -- with the American Psychiatric Association
18 that social transition, hormone therapy, and sex
19 reassignment surgery is appropriate and medically
20 necessary for some people with gender dysphoria,
21 correct?
22 A. For some people, I think that is probably
23 their best judgment. Remember, they have to make the
24 decision under uncertainty. We don't know what the
25 long-term outcome would be. I'm very concerned about

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1 altering the genitalia, for example, of young men, what
2 the implication is going to be 20 or 30 years -- 20 or
3 30 years later. I wish we did know, but we have to do
4 an experiment under naturalistic conditions. That is
5 what we are really doing is an experiment. Do we have
6 enough experience with them compared to other
7 procedures to know that it's safe and effective as a
8 psychiatric treatment? We don't, we just don't. I
9 wish we did.
10 Q. You seem to want to tell me about treatment
11 for young people, but you understand this is a case
12 about treatment of adults?
13 MR. KILPATRICK: Objection to the extent it
14 mischaracterizes the lawsuit.
15 THE WITNESS: I'm sorry. Do I know it's a
16 case about adults?
17 BY MR. KNIGHT:
18 Q. This is a case about an exclusion of coverage
19 for adults.
20 MR. KILPATRICK: Same objection.
21 THE WITNESS: You're asking me if sitting
22 here I know that? I don't know that. I don't know
23 explicitly -- I've not read about what it is that is
24 objectionable to people. Where would I have read that?
25 But it's a long way to go that some people

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1 might benefit from a treatment, and, therefore we
2 should try that because this is a desperate population
3 versus that everyone should get that treatment. I
4 don't quite understand it.
5 BY MR. KNIGHT:
6 Q. So are you aware that the American Medical
7 Association supports gender transition including
8 hormone therapy and surgeries as treatment for gender
9 dysphoria?
10 A. I've seen a lot of documents about access. I
11 don't remember that particular -- exactly what you
12 said. I remember a statement about gender identity
13 disorder, but it would not surprise me.
14 Q. Well, assuming that it's true, do you agree
15 with that statement?
16 A. What is the statement again? Sorry.
17 Q. That the AMA should support gender
18 transition, including hormone therapy and surgeries as
19 treatment for gender dysphoria.
20 A. By the way, I don't know what gender
21 transition means. You're born with that gender. It
22 seems that -- and people are talking out of both sides
23 of their mouth. They say you're born with a gender,
24 but then you need gender transition. If you're born
25 with that gender, why do you need a transition? What

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1 am I missing?
2 Because they keep talking about gender
3 transition being necessary. The other thing that's
4 interesting is that a gender transition seems to be
5 culturally defined. What it means to transition to be
6 more male or more female is a cultural definition. So
7 I really don't know what they're saying, all this need
8 for transition. They can be -- to me, they can weigh
9 280 pounds and be very masculine and claim they are a
10 woman. They need to have a long-term identification,
11 not any particular body configuration.
12 Q. Do you support the AMA's -- assuming what I
13 said was true that the AMA supports transition,
14 including -- or let's put it this way: Assuming that
15 what I said is true that the AMA supports hormone
16 therapy and surgeries as treatment for gender
17 dysphoria, would you agree that that is the correct
18 position?
19 A. I agree the AMA supports it. I can't
20 second-guess the APA. I don't know that much about
21 what their position is. I would have to read the whole
22 document, but if they are saying that's been
23 demonstrated that it's a significant factor in reducing
24 dysphoria, I would have a great deal of difficulty with
25 that statement.

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1 Q. Dr. Mayer, have you seen this letter from
2 Dr. Rothman, Dr. Klag supporting -- are you familiar
3 with these individuals at Johns Hopkins?
4 A. I don't know Patricia Davidson. I know the
5 others, yes, sir.
6 Q. And this document on the second page, the
7 last paragraph starts with "We have committed to and
8 will soon begin providing gender-affirming surgeries,
9 another important element of our overall care program."
10 Do you see where I'm reading?
11 A. Yes.
12 Q. And it indicates that they have done this
13 "Reflecting careful consideration over the past year of
14 best practices and appropriate provision of care for
15 transgender individuals."
16 Do you see that?
17 A. Um-hmm.
18 Q. And so I read this to say that they have made
19 a medical decision that this is a right thing to be
20 doing, to be providing surgical treatment for
21 transgender individuals who need it.
22 Is that your understanding?
23 A. The problem is when they say "provision of
24 care for transgender individuals," I get confused,
25 because transgender individuals don't need any care.

1 It's no longer a diagnosis or an illness. If that said
2 for gender dysphoric individuals -- I don't know what
3 people keep talking about the provision of care. I
4 think they should have equal access to care. So people
5 should know how to treat a transgender woman.
6 Should they have special provisions of care
7 because they're transgender? Not unless it's a
8 disorder in itself. So if you said we should have the
9 best practice and appropriate provision care of gender
10 dysphoric individuals, I agree, and we should also
11 provide the best care for transgender individuals.
12 That doesn't mean that there's evidence that the best
13 care would be performing surgery. There's certainly a
14 lot of money to be made in them, we know that. But we
15 really don't know what the long-term consequences are.
16 Wish we did.
17 Q. Are these colleagues that you know and
18 respect?
19 A. That might be a little strong. I mean,
20 they're colleagues. They're not great scientists. I
21 know Paul Rothman. I know he's a dean-type person.
22 Michael Klag is an internist. They're not giants, but
23 they're good physicians. I don't disagree with the
24 document, by the way.
25 Q. Are you aware that the Endocrine Society

1 supports hormone therapy as treatment for gender
2 dysphoria?
3 A. I'm aware that there are some long involved
4 publications about that. But it doesn't surprise me.
5 The Endocrine Society is in the business of giving
6 hormones to people, that they support giving hormones
7 to people. Is there a long-term study which shows that
8 they're successful in treating gender dysphoria? There
9 is not.
10 Q. Do you disagree with the Endocrine Society?
11 A. I don't have any reason to agree or disagree.
12 Q. Do you understand that every major medical
13 association recognizes the medical necessity of hormone
14 therapy and surgery for individuals with gender
15 dysphoria?
16 A. I've never seen that recommendation actually
17 just for individuals with gender dysphoria. But I do
18 know there are a lot of organizations that feel that
19 way and publish those guidelines. That is fine. I
20 have no argument about that other than they're not
21 based on science.
22 Q. What kind of medical treatment should be
23 provided for someone with a condition where the -- in
24 your view the studies are insufficient to show a
25 treatment that would be safe and effective?

1 A. I think that's a very interesting question.
2 I don't have an answer. As a scientist, I can tell you
3 there is not enough information. Is there enough, I
4 guess, in the interim to make a decision one way or the
5 other? Well, I think you can do some good for people
6 or you can do some damage for people, and I don't know
7 how to develop the two. And the idea that everyone who
8 goes through these procedures is going to be happy ten
9 years down the road is not true. The question is what
10 percent will be unhappy or what percent, at least, will
11 still be dysphoric.
12 Q. I'm asking in general, aren't there other
13 conditions where we provide treatment where there is
14 not a great deal of research supporting the particular
15 kind of treatment?
16 A. Yes, sir. Probably half the treatments we do
17 are not supported by strong scientific research. That
18 doesn't mean we don't strive to do more, particularly
19 in areas so politically charged as this.
20 If I believed hormone therapy and affirmative
21 therapy were the answer to gender dysphoria, I would
22 say so. I would absolutely endorse them.
23 Q. What are other treatments that are provided
24 for which we don't have sufficient research in your
25 opinion?

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1 A. There are thousands of them. There is
2 aspirin. There's cholesterol-lowering medication.
3 There are all sorts of drugs we use where there are
4 mixed results, and we have to resolve that the benefits
5 are -- are worth the risks.
6 Q. Well, let's talk about, for example, high
7 cholesterol. Do you agree that high cholesterol is a
8 medical issue that should be treated?
9 A. Well, it's really -- and high cholesterol is
10 a bad example, because high cholesterol is really a
11 marker of something going on. But, yes, it is an
12 indication of a condition that needs to be treated.
13 Q. And if the research -- and you're saying,
14 though, that the research about cholesterol medications
15 is insufficient in your mind?
16 A. Well, I'm saying it evolved over time. The
17 important point -- I thought you were saying were there
18 treatments we did where we didn't know for sure. We
19 could show that the treatments for cholesterol lowered
20 the body's level of cholesterol. What we couldn't show
21 for a long time is whether that meant the risk would be
22 reduced to the same risk as someone that had that level
23 naturally occurring, therefore, we didn't know whether
24 it would really lead to decreased heart attacks,
25 decreased strokes.

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1 That took many years of teasing out the data,
2 very sophisticated data where we now have been able to
3 show recently a very positive effect to lowering the
4 cholesterol. So there are many, many medicines in the
5 early stages where we might know more complete now, but
6 we certainty didn't know then. The SSRIs are another
7 example.
8 Q. What --
9 A. Just one more thing. Have to include hormone
10 therapy for hormone replacement therapy for menopausal
11 woman.
12 Q. And what about hormone replacement for
13 menopausal women?
14 A. That the indications were that there were
15 high risks of breast cancer. It was good, it was bad,
16 it's gone back and forth, and back and forth. I'm not
17 an expert. When we carefully did clinical trials, we
18 found that the recommendations, like the VBAC
19 recommendations were absolutely false, what the
20 recommendations were.
21 Q. And do you believe that until you have
22 definitive research, you should not provide any care
23 for people with these issues, these medical issues?
24 A. Well, the issue I see is a psychiatric issue.
25 You keep switching it to a medical issue. I don't know

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1 if you mean the two as separate from each other. The
2 issue is not their physical appearance. The issue is
3 their dysphoria. And so what should we do in the
4 meantime about this dysphoria? That's why we have task
5 forces to get together and decide what's the best thing
6 to do. And we should be doing ongoing studies.
7 Q. I am asking about the use of aspirin, for
8 example. Where there are some indications that aspirin
9 is a helpful treatment, for example -- well, let's talk
10 about -- I'm sorry.
11 Let's talk about the cholesterol medication
12 where there is some indications that cholesterol
13 medications are likely to help someone, but we don't
14 have definitive research studies. What should we do?
15 Should we provide them the medication or not?
16 A. I think we -- that's an excellent question.
17 I think we provide them with the medication and ensure
18 that there are ongoing studies to increase our
19 knowledge. I would be less concerned if there were
20 ongoing studies. But, yes, we have to make a judgment
21 in the meantime, and that is a judgment -- the people
22 in medical research and only the judgment of clinician
23 what to do with his or her patients.
24 Q. But I guess I'm a little unclear. Is that
25 your -- is that also true for surgical treatment for

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1 gender dysphoria, that we should not provide it until
2 we have definitive research to show that it is safe and
3 effective? Is that what you are saying?
4 A. No, I never said we should not -- we should
5 not provide it. There might be situations in which it
6 should be provided. I'm suggesting to you it is a very
7 expensive procedure, and I see issues of equity. I see
8 issues of secondary versus primary characteristics. I
9 see issues of changing the body versus changing the
10 psyche in some sense. If these issues were being
11 worked on. Let's say Schechter, Dr. Schechter came to
12 me with a psychiatrist. He and Paul McHugh said, We
13 have a patient here. We believe for this patient that
14 reassignment surgery is absolutely critical to resolve
15 their dysphoria. I would have no reason to argue with
16 them. Why would I argue with them?
17 Q. So -- and I believe you said this before. So
18 surgery can be a medically necessary treatment for some
19 individuals?
20 A. Well, I don't know that for a fact, but I
21 would guess it could be. You could find patients which
22 are just like -- there are certainly transgenders that
23 don't suffer any dysphoria. That's why I don't
24 understand this. This says we have to support
25 transgender people in transition. Well, if they are

1 not ill, there is no disease, why do we have to support
2 them? But could there be people for which that
3 treatment is successful and indicated, yes, of course.
4 Q. So there can be people for whom surgery is a
5 beneficial and medically necessary treatment for gender
6 dysphoria?
7 A. Well, I don't know that for sure, but I
8 wouldn't slam the door on it if people came to me that
9 are knowledgeable and clinical and said, We believe for
10 this patient this is required. It wouldn't be someone
11 with a Ph.D. in counseling psychology, for example.
12 But I would understand their recommendation. I would
13 respect it.
14 I also don't understand what surgery they
15 would be entitled to. Because suppose mom moved to a
16 society where femininity is measured by small hands.
17 Now a male-to-female transgender, is she going to be
18 entitled to surgery to reduce the size of their hands?
19 When does it stop? How does it go? I guess that's
20 really the question. How do you split the baby?
21 Q. Are you aware of any patient with gender
22 dysphoria who has asked for surgery on their hands?
23 A. I don't know what gender dysphoric
24 patients -- I do know there are societies that could
25 value small hands. There are societies that value

1 great big butts. There are societies that value all
2 sorts of different definitions of femininity and
3 beauty. That's what I don't understand. How can
4 someone be born with this idea of femininity or beauty
5 or masculinity when you're not born with anything.
6 It's a clean slate.
7 Q. So I would like to look at your report again,
8 which is Exhibit 1.
9 A. Okay.
10 Q. On page 3, paragraph 6, you say that medical
11 and surgical treatments have not been demonstrated to
12 be safe.
13 Do you see where I'm reading?
14 MR. KILPATRICK: I'm sorry. What page?
15 BY MR. KNIGHT:
16 Q. Page 3. You say that medical and surgical
17 treatments have not been demonstrated to be safe and
18 effective for gender dysphoria?
19 A. Correct.
20 Q. What do you mean by safe?
21 A. Well, safe to mean that the risk associated
22 with the treatment for gender dysphoria is worth it.
23 So let's suppose you had surgery on positive outcomes
24 for most people, and some people you have negative
25 outcomes. Well, is the risk worth it? So safe always

1 means, is the risk of that procedure worth it.
2 Effective means both medically effective and
3 financially effective. Is it an effective way -- and
4 we never used to consider that, and now we have to
5 consider are there alternatives to treat the person
6 that would be less expensive. But there has been no
7 demonstration that they're safe and effective. There's
8 argument, but there is no demonstration.
9 And the studies would be so simple it is just
10 inexcusable. I have no idea why they aren't there. I
11 would donate my time to help people do the study.
12 Q. So on page 7 you say that these treatments
13 are not optimal. And then on page 8, paragraph 22, you
14 talk about optimality -- or 22 and 23.
15 So what do you mean by "optimal"?
16 A. Well, optimal means that the procedure
17 employed in the treatment of condition effectively
18 address the underlying feature of the condition. So
19 articles that say you feel better about your appearance
20 or you look better, you're more likely to pass aren't
21 optimal in the sense -- maybe optimal is not the best
22 word -- but they are not optimal in the sense they
23 don't go directly after the dysphoria, the underlying
24 features of the condition being depression, anxiety,
25 alienation, withdrawal.

1 In most of the studies that were primarily in
2 the surgery? Particularly the plastic and cosmetic
3 surgery, talk about how good they looked. That these
4 male-to-female transgenders can pass as females. And
5 that's not what the condition is about. This is either
6 a serious condition that needs to be treated or it is
7 an excuse that gives cosmetic surgery to people who
8 have a persistent identification with the opposite sex.
9 I don't know which it is.
10 Q. So you are not suggesting that for a
11 treatment to be optimal, it should be focused on trying
12 to talk someone out of their gender dysphoria?
13 A. Well, you should try to talk someone out of
14 their gender dysphoria, of course. To be less
15 dysphoric, if I could sit with you and talk to you, why
16 wouldn't I do that?
17 Q. So you should try to tell an individual --
18 you're saying I should try to talk to a woman who is
19 transgender and is clinically distressed, and I should
20 try to talk her out of her distress? Is that what
21 you're saying?
22 A. Of course. That is what psychiatry is about,
23 to try to help her with her distress. What is
24 bothering her. What is she depressed about. And this
25 is the heart of psychiatry. Medications I could give

1 her. Is she manic depressive? What is going on with
2 her? Why is she here? And if she says she is here
3 because she's transgender, I say that is not enough.
4 It is not an illness. Embrace your transgenderism.
5 You can't have it both ways. These people treat it as
6 though it's a devastating illness, and then they say,
7 but this is normal development.
8 Q. So what is -- what if the individual explains
9 that their dysphoria is about the incongruence in their
10 body?
11 A. Why --
12 Q. What is the optimal treatment for that?
13 A. Well, that's very interesting, because I'd
14 have to go back to something Paul McHugh said, and that
15 is for anorexic. We don't put them on a diet. We try
16 to give them better body image. We try to give them
17 better body image. We try to help people feel better
18 about themselves. Dysphoria is full of a feeling of
19 helplessness, a feeling of hopeless, a feeling of
20 despair. Of course you try to help them with all
21 those. That is what psychiatry is.
22 Q. So you're saying that gender dysphoria is
23 just like body dysmorphia disorder?
24 A. No. I don't believe that. It has some
25 characteristics, though. And that is it's a

1 psychiatric disorder. Where you wouldn't change their
2 body to try to change that disorder. You try to change
3 their attitude to themselves. You try to give them a
4 healthy attitude about themselves. Isn't that what
5 it's about? You try to stop the demoralization.
6 Q. And how would talk therapy address or stop
7 someone whose dysphoria is about the incongruence in
8 their body?
9 A. Well, when you go to these clinics, they have
10 young people in there. They're not old enough for
11 hormone therapy, they're not old enough for surgery.
12 They talk to them about being accepting. They talk to
13 them about a supportive environment, how important it
14 is to be around people who accept them, people who
15 understand them. It is not just talk therapy. First
16 of all, talk therapy is very powerful therapy. But the
17 fact is, you want to make them feel better. You want
18 to make them better able to function in their daily
19 life.
20 Q. And if we're talking about an adult patient
21 who says that I am a woman, and I look -- my body looks
22 male because, for example, I don't have breasts. I
23 don't have a vagina. Then what do you do? You try to
24 talk them into being comfortable with these incongruent
25 body structures? Is that what you are saying?

1 A. If I could, of course I would. What do you
2 mean incongruent? This is a female. You just said it.
3 She is a female, she identifies being a female, and
4 this is her body. There were no social stigma.
5 Q. I'm talking about a woman who is transsexual,
6 whose natal sex is male.
7 A. The only sex. I don't know natal sex.
8 Q. And she is dysphoric about the fact that her
9 body does not match her femaleness.
10 A. Is she in the wrong body?
11 Q. That is -- my question, if you can answer it,
12 what do you do with a woman whose body does not line up
13 with her understanding that she is a woman?
14 A. Her existence doesn't line up. Every cell of
15 her body is a male cell. Every reproductive cell is a
16 male cell. In fact, you said something in there and
17 Schechter says something, that 85 percent of these
18 women believe they're truly women. What does that mean
19 to believe you're truly women? Do you believe there is
20 some nature you have that comes before sex and gender,
21 and that made you something else? Of course they
22 should be accepting of their own body. They are
23 female. They identify with being female, and they have
24 a male body.
25 Q. So you're saying we should just help someone

1 who is facing distress about their body --
2 A. Right.
3 Q. -- because it doesn't match who they are?
4 A. Who they think they are, yes.
5 Q. That we should simply try to make them
6 comfortable with their body?
7 A. Well, I think you're demeaning it. I think
8 making them comfortable with their body versus $50,000
9 worth of surgery makes a lot of sense. What in the
10 world -- why are they uncomfortable? They identify
11 with being a female, and this is the body they have.
12 They are transgendered, why do they need to look like
13 something else. I don't understand it.
14 Yes, I would try to make them feel
15 comfortable. I might give them medication for anxiety,
16 for depression. And maybe I would give them hormone
17 therapy. I don't know enough about the clinical side
18 to make any pronouncements.
19 Q. Let's take a woman, as an example, who has
20 had cancer, breast cancer, and has, as a result of
21 that, had her breast removed. Would you agree that
22 breast reconstruction surgery after cancer is medically
23 necessary treatment for that woman?
24 A. Well, again, medical necessity goes back, in
25 our country, to billing. And I don't know enough about

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1 billing, I'm not interested in billing to know that.
2 But do you mean -- and I was involved in the Schechter
3 case when this -- the police officer was hit in his
4 Crown Vic and blew up and burned his face off. At what
5 point are these procedures, if you will,
6 reconstructive, and at what point are these cosmetic?
7 And I think it's a false distinction. I think if
8 surgery can help people feel better about themselves,
9 they ought to be entitled to that surgery.
10 Q. So is it medically necessary?
11 A. I don't know what that term means. That term
12 usually is referring to who pays for it. Medical
13 necessity means your insurance will pay. Tell me what
14 you mean --
15 Q. Do you think --
16 A. -- by medically necessary.
17 Q. I'm sorry.
18 Do you think insurance should pay for surgery
19 to treat a woman who has cancer, breast reconstruction
20 surgery?
21 A. Wait. The fact that she had cancer and
22 breast reconstruction isn't her problem. The fact is
23 she's probably depressed about it. So you treat that
24 depression. If you believe that that surgery will
25 significantly reduce that depression, and there's

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1 evidence of that, which there is in this case, then,
2 yes, I think it should be given to her. Now, who
3 should pay? I really don't know about those issues.
4 But, yes, I'm for much broader use of
5 cosmetic and plastic surgery. Why shouldn't people
6 feel good about themselves?
7 Q. So treatment, breast reconstruction surgery
8 for a woman post-cancer that will address her
9 depression related to that, that is something that
10 should be provided and covered; is that what you're
11 saying?
12 A. I don't know about coverage, but I think
13 society should seriously consider. Burn victims. Why
14 don't we leave burn victims looking like they are? And
15 the answer is because we know they are going to have a
16 very difficult time, and we can show that if we give
17 them reconstruction surgery, they do better. So why
18 wouldn't they do better? It might be easy to show, by
19 the way, that transgenders with gender dysphoria who
20 are given surgery have a lower risk of dysphoria, and
21 they have a higher rate of cure. No one has done that
22 study. Reminds me a lot of the silicone breast implant
23 studies where people argued about silicone breast
24 implants and whether they are safe, and no one had done
25 the study. All I want is to do a study.

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1 Q. How do you do a study for -- a double-blind
2 study for surgery?
3 A. It is very difficult to do double-blind
4 studies. You can approximate by doing single-blinding.
5 For example, you can bring transgenders in that are
6 dysphoric, and you could say -- you have to have an
7 active control, not a passive control. We're going to
8 give you $50,000 worth of surgery, or we're going to
9 give you $50,000, and we're going to flip between them.
10 I think a lot of people would be willing to be in that
11 trial. You either get $50,000 worth of cosmetic
12 surgery, or we give you $50,000. The coin is flipped,
13 and now we compare the two groups in terms of gender
14 dysphoria. One group gets surgery, the other group
15 doesn't. They're both gender dysphoric, and we would
16 have the answer.
17 Q. But that's not a double-blind study, is it?
18 A. That is correct. No, there are ethical
19 considerations in doing a double-blind study.
20 Q. And aren't there ethical considerations about
21 giving people who need surgery money to go on a trip?
22 A. Not at all. If they chose that, that is the
23 point. If we knew the surgery worked, then there would
24 be ethical considerations. If we don't know it works,
25 that is why we are doing the study. So it's very

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1 important, we have to have prior equipoise. We have to
2 prior -- indifferent between whether it works or it
3 doesn't. And I have no evidence to be not indifferent,
4 so I'd be glad to do the study. It would be wonderful
5 to show that plastic surgery --
6 Q. Do you have any reason to disagree with the
7 experts in this field who believe it would it unethical
8 to do the study that you're talking about?
9 A. Nobody believes that study would be -- nobody
10 could -- and I ran research for the largest corporation
11 west of the Mississippi, the largest hospital system in
12 the world. Over seven RNBs. Nobody would think it is
13 unethical to do a study a patient gets their choice
14 between treatment or not, unless we knew for sure the
15 treatment worked. We do these studies all the time in
16 surgery, all the time.
17 So the idea we'll declare a procedure works,
18 but it's too complicated to do a study, and then we'll
19 just put a bunch of myth in the journals about how good
20 people look and never even address their dysphoria is
21 really just tragic. And the AMA has been wrong so many
22 times. Remember, the AMA believed that being gay was a
23 disorder. The AMA believed that the answer to domestic
24 violence was never to leave your husband. The AMA
25 supported smoking. The AMA is a trade union. They've

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1 made all sorts of mistakes. I can't tell you if
2 they're wrong. I can tell you what science supports
3 and doesn't support.
4 Q. Do you know the studies that show that
5 pharmacotherapy is ineffective in treating gender
6 dysphoria?
7 A. I have not seen any specific studies that are
8 well-controlled or well-designed. There are some
9 studies that show antidepressants don't improve
10 people's outlook and all of that. So, yes, there are
11 some studies that crudely get at this issue. I've not
12 seen one that actually uses gender dysphoria, but maybe
13 there is.
14 Q. And those studies indicate that
15 pharmacotherapy is ineffective at treating gender
16 dysphoria?
17 A. Is ineffective?
18 Q. Is ineffective in treating gender dysphoria.
19 A. In general, for the most part, it shows
20 that -- well, again, we have to go back to the gender
21 dysphoria. We show that for people who are depressed
22 who are gender dysphoric, that treatment does not
23 change that depression, even by the minimal standards
24 it changes depression for other people, yes. And that
25 is not surprising.

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1 Q. So as I understand it in your report, what I
2 see here is that you are citing three different
3 documents to support your opinions. The first is this
4 sexuality and gender publication. The second is this
5 amicus brief in the Gavin Grimm case. And then I
6 believe you also cite on page 8, the Centers for
7 Medicare and Medicaid Services decision memo.
8 A. Right.
9 Q. Is there anything else that would -- that you
10 believe supports your opinions here?
11 A. Everything in my citations does. I have
12 lists and pages and pages of citations I reviewed. All
13 the papers, I mean it depends on what conclusion you
14 mean. That sex is biological? Any book in biology
15 will tell you that. So I'm not sure. I'm not sure
16 what opinion I'm presenting.
17 Q. Opinions that you've stated in your report,
18 that's the opinions we are talking about.
19 A. Most of the opinions come from first
20 principle. They don't come from research, because
21 there isn't any good research on the treatment of
22 gender dysphoria. I'm not sure -- I mean statements
23 like gender dysphoria is a serious medical condition is
24 overwhelmingly supported in the literature. You want
25 me to go through and give you citations? That's

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1 interesting because your expert can't give me complete
2 citations. I didn't even want to write anything down
3 that was controversial.
4 Q. So you said, other than those three things,
5 that there are -- and let me be clear. What I'm
6 talking about is your opinion that -- with respect to
7 the efficacy and safety and optimality of hormone
8 therapy and surgery in treating gender dysphoria. That
9 is what I'm asking you.
10 A. There were no references on that. There was
11 an extensive search I did of the literature, probably a
12 thousand papers. I probably reviewed the biography of
13 500 of them in the abstract, and probably read 200 of
14 them over the course of four years now trying to find
15 studies on gender dysphoria.
16 Q. So you are saying there are no studies about
17 efficacy and safety of treatment for gender dysphoria?
18 A. I wouldn't say there are no studies. I'd say
19 there are no decent studies. There's not a simple
20 controlled study in which gender dysphoria is actually
21 measured.
22 And by the way, I must just say, the studies
23 that show that people are happy with their surgery are
24 funny, because I send you to the book Charlatan by
25 Pope, I believe. Charlatan was a man named John

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1 Brinkley. And John Brinkley is famous in the Southwest
2 because he invented border radio. But he, in fact,
3 because famous as a surgeon because he transplanted
4 goat gonads into the testicle sacks of men in order
5 that they would have rejuvenated sexual prowess. And
6 the interesting thing is, of course, it doesn't work.
7 You can't have a third gonad help you. But the men
8 were overwhelmingly positive toward the surgery. They
9 all claimed they had a better sex life.
10 So we know the theory of some costs that
11 economists give us is that people are happy after
12 they've had $50,000 worth of procedure. Does it help
13 them function more effectively in society, let's say in
14 five years? There are no studies. There are no
15 studies. At least I could not find them.
16 Q. Would you agree with me that transgender
17 people exist in a number of countries and probably
18 throughout the world?
19 A. Go ahead. Say that again?
20 Q. Would you agree that transgender people exist
21 throughout the world?
22 A. Well, I don't have a lot of experience, but I
23 assume they would. Why wouldn't they?
24 Q. Well, you understand that WPATH is an
25 organization made up of researchers and clinicians

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1 throughout the world?
2 A. I find WPATH to be made up of advocates for
3 transgender communities. I don't find many of them --
4 there are a few exceptions -- to be very serious
5 scientists. If they were serious scientists, they
6 would have done this study a long time ago.
7 It would also be interesting to do a
8 follow-up of people who decline to have sex
9 reassignment surgery or facial feminization versus ones
10 that accept it. It is not a randomized study. It
11 would still be interesting to see where they are in
12 five years with respect to dysphoria.
13 MR. KILPATRICK: Jim, it is after noon, and
14 I'm wondering if we can break for lunch soon.
15 MR. KNIGHT: Okay. We can take -- can we go
16 a little bit longer?
17 MR. KILPATRICK: Sure. How much longer?
18 Minutes?
19 MR. KNIGHT: I mean, maybe if we go another
20 half hour?
21 MR. KILPATRICK: Can you get through that?
22 THE WITNESS: Sure.
23 (Exhibit 4 was marked for identification.)
24 BY MR. KNIGHT:
25 Q. Dr. Mayer, I'm showing you what is marked as

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1 Exhibit 4. This is the amicus brief in the Gavin Grimm
2 case.
3 You have seen this before?
4 A. Yes, sir.
5 Q. So directing you to page 5.
6 In the second paragraph you say, "In this
7 brief, amici leave aside all questions about how best
8 to treat gender dysphoria in adults."
9 Do you see where I'm reading?
10 A. Yes, sir.
11 Q. So this doesn't -- this brief does not
12 address the efficacy of surgery or hormone therapy in
13 an adult, right?
14 A. That is correct.
15 Q. And yet you're relying on it and claiming
16 that pages 15 through 21 of it support your opinions
17 regarding the lack of evidence that hormone therapy and
18 surgery are effective at treating gender dysphoria.
19 A. Correct.
20 Q. Why is that?
21 A. Because this is a conclusive. This
22 particular thing is about children, because I was asked
23 to write about children, but the fact is the same
24 analysis applies. Obviously, there are more important
25 issues with children because of putting them in gender

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1 affirming environments when they're young, talking
2 about two year olds, and know they're of the opposite
3 sex and things like that. So they're complicated
4 issues, but the conclusions we'd make are the same --
5 they're the same for adults as for children. This was
6 about children. It wasn't about this young high school
7 kid, I believe.
8 Q. Again, this section, section 15, talks about
9 gender affirming polices harm rather than help gender
10 dysphoric children.
11 So again, the section itself is titled
12 something dealing with children.
13 A. Okay.
14 Q. Is that right?
15 A. I'm sorry? Say it again.
16 Q. Is it right that this section is talking
17 about policies with respect to gender dysphoric
18 children?
19 A. Yes. Yes. Policies that could harm gender
20 dysphoric children might not harm gender dysphoric
21 adults. Is that what you mean?
22 Q. On page 18, you cite to a paper by Michelle
23 Cretella.
24 A. Um-hmm.
25 Q. Do you know Michelle Cretella?

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1 A. No, I don't.
2 Q. You've never met her?
3 A. No, sir.
4 Q. But you understand she's the president of a
5 group called American College of Physicians?
6 A. Pediatricians?
7 Q. Or Pediatricians. I'm sorry.
8 A. Yes, sir.
9 Q. Are you a member of the American College of
10 Pediatricians?
11 A. No, sir.
12 Q. Are you a supporter?
13 A. No, sir.
14 Q. You understand this group was recently
15 founded?
16 A. I don't know much about the group.
17 Q. Did you understand or do you know that it was
18 founded as a protest against the American Academy of
19 Pediatrics' decision to support adoption for gay
20 couples?
21 MR. KILPATRICK: Objection; lacks foundation.
22 You can answer.
23 THE WITNESS: No, sir.
24 BY MR. KNIGHT:
25 Q. You didn't know that?

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1 A. No.
2 Q. Do you have any reason to dispute what I'm
3 telling you about it?
4 A. No, sir.
5 Q. And did you know that it has approximately
6 500 members?
7 A. No, sir.
8 Q. You know, though, I assume, that this group
9 is different from the American Academy of Pediatricians
10 that has -- I'm sorry, I think it's the American
11 Academy of Pediatrics?
12 A. Yes.
13 Q. That has about 65,000 members?
14 A. Yes, sir. Well, I'm sorry. I don't know how
15 many members it has. I know it is much larger, yes,
16 sir.
17 Q. So you support -- I'm sorry. You cite her to
18 support a claim that allowing a person who is
19 transgender to live consistent with their gender
20 identity will change their brain through
21 neuroplasticity.
22 Do you remember that?
23 A. Yes, sir.
24 Q. How is that supposed to happen?
25 A. Well, we know the brain is very plastic. The

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1 idea there is how people live their lives has an effect
2 on their brain. I don't think there is any -- I'm not
3 sure what's debatable about that.
4 Q. Well, do you have any research that would
5 support your position that a transgender person's brain
6 is going to change through neuroplasticity?
7 A. I guess you're going to have to give me the
8 exact citation, because I don't know exactly --
9 remember, three of us wrote this. We didn't all agree
10 with everything on this, but if you are saying our
11 brain is plastic, yes. It's part of the transgender
12 support or argument that brains are plastic. So I
13 don't know exactly what we're talking about or
14 objecting to.
15 Q. Do you agree with everything that is in this
16 amicus brief?
17 A. No, sir. I didn't disagree with anything
18 severely, but these were a combination of three of our
19 ideas. And my focus, again, is very much on science
20 and whether everything said in science is accurate. I
21 did not know about the origin of the American --
22 whatever you said. American College.
23 Q. The American College of Pediatricians, it
24 says on the top of that page.
25 Does that concern you?

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1 A. Yes, sir. Very much so.
2 Q. Would you have cited her to support this
3 position had you known that she was the president of
4 that group?
5 A. Well, that is an interesting question,
6 because the degree I agree with it, I would support it
7 anywhere. She is a good scientist. But my respect for
8 the group wouldn't be as high. I didn't cite a group;
9 I cited her. And she's written quite a bit. She's
10 obviously a very bright woman, but she seems to be
11 quite opinionated. I had not heard that opinion, but I
12 more or less avoided her. The group is a bit
13 conservative for my taste.
14 Q. Sorry. Why don't you give me a minute.
15 What parts of this brief did you not agree
16 with?
17 A. Well, as I said, I didn't disagree, but a lot
18 of the brief is not my area of expertise. So you are
19 talking about a guy -- I think Hruz did this with us.
20 He is the chair of pediatric endocrinology at
21 University of Washington St. Louis. So I respect him,
22 and particularly as to how fetal testosterone affects
23 the brain and all that. I can't cover everything. And
24 Paul McHugh is one of the outstanding psychiatrists of
25 the century, actually. And so I accepted him. I'd

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1 have to go through every line and try to figure out --
2 most of it is just ones I don't have any opinion on,
3 because if I really objected to it, I would not have
4 put them in.
5 But did I know who Cretella -- was that her
6 name? I did not know who she was with this reference.
7 Q. So directing to page 16.
8 A. Of what? Sorry, sir.
9 Q. Of the document you were looking at before.
10 A. Page 16?
11 Q. Footnote 10. So you talk about the
12 Giuseppina Rametti article, which looks at brain
13 imaging or does brain imaging. And the last sentence
14 says, "The results of that study may be explained by
15 neuroplasticity."
16 A. Female-to-male transsexual was more similar
17 to that of heterosexual males than females to male.
18 One study showed the white matter microstructure of
19 specific brain areas of the female to male transsexual
20 was more similar to that of heterosexual males than
21 that of heterosexual females.
22 Okay. I find all of this brain research,
23 other than suggestive of our hypotheses, to be
24 spurious, because we know the brain changes the
25 function of life experience. We can now measure that

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1 with scanners. But this idea of whether the cisgender
2 brain, the transgender brain are similar or different,
3 I find all that research highly suspect, and I did
4 review that research specifically for this project.
5 Q. These researchers were looking at the white
6 matter in transgender patients before they took hormone
7 therapy, right?
8 A. That's correct.
9 Q. So how does neuroplasticity explain the
10 results they found?
11 A. Well, I don't think it did find. I found
12 that the fusion tensor imaging study, much on
13 methodology, and not much on result. My mentor at
14 Princeton used to say $100 worth of analysis of a
15 dime's worth of data doesn't produce a penny's worth of
16 output.
17 I found the analysis not very convincing, but
18 at least sexual -- at least suggestive of this idea
19 that the brain -- that the brain can change.
20 Other than that, I would let Hruz comment on
21 that, because it is not something that I added.
22 Professor Hruz did. Dr. Hruz did.
23 Q. So you don't have a position over whether
24 neuroplasticity could explain the results that this
25 researcher found?

1 A. I would say I support the idea that most of
2 these studies could be affected by neuroplasticity.
3 The idea that brains are elastic and plastic, and that
4 is a fundamental concept in the new brain research we
5 do. But do I believe they do explain these results?
6 No. They are just suggestive. And this whole area of
7 who the transgender looks like is very, very suspicious
8 for me. Remember, these are -- never mind. I
9 shouldn't say that.
10 Q. Well, you understand that these researchers
11 concluded that their results provided evidence for an
12 inherent difference in the brain structure of
13 female-to-male transsexuals?
14 A. Yes, sir.
15 Q. And do you disagree with that conclusion?
16 A. Yes, sir.
17 Q. Why?
18 A. Well, I disagree, because if you go to the
19 basic methodology, what these people do is poke around
20 the brains until they find areas where whatever side
21 they're on -- whether they want transgender brains to
22 look like, cisgender brains or the opposite sex brains.
23 And they go around until they find patterns, and they
24 explain those patterns.
25 Well, the first rule of statistics deals with

1 multiple comparison, multiple statistical tests, and
2 I'm never convinced that the results they find on an
3 artifact in the methodology, that they're really there.
4 So all of the brain research, arguing about this brain
5 looking like that brain, first of all, we don't know
6 how to get from brain to behavior, so it's almost a
7 waste of time.
8 Second of all, the difference at the mean
9 does not predict the interest at the extreme. And
10 we're only interested in extreme. So I don't believe
11 they have any reliability to any -- or significant
12 reliability to any of them.
13 Let me go to the statement, though, above it.
14 "Neuroplasticity means that a child who is encouraged
15 to impersonate the opposite sex may be less likely to
16 reverse course later in life. For instance, if a boy
17 repeatedly behaves as a girl, his brain is likely to
18 develop in such a way that eventual alignment with his
19 biological sex is less likely to occur." I think it's
20 a hypotheses.
21 Q. On pages 11 and 12, you cite Dr. Kenneth
22 Zucker.
23 Would you agree with me that the articles
24 that you cite here are about the treatment of children
25 only?

1 A. Yes, sir.
2 Q. And do you know that Dr. Zucker has made it
3 clear that he agrees that surgery and homotherapy are
4 effective treatment for adults?
5 A. Yes, sir.
6 Q. In fact, in 2016, he published an article
7 called "Gender Dysphoria in Adults," in which he says
8 that "Recent investigations have largely confirmed the
9 opinion that hormone therapy is an effective and
10 reasonably safe treatment in adults with gender
11 dysphoria."
12 A. Yes, sir.
13 Q. What do you think of Dr. Zucker?
14 A. Well, he's been in a lot of controversy, some
15 of which I don't understand, I think revolved around
16 conversion therapy or something. Some of his work
17 seems very reasonable. Other work gets highly
18 criticized. So he's not really in my area to make an
19 opinion, but I hope he's right. Now, if he said there
20 are studies that demonstrate that definitively, I would
21 take issue with it. But he's certainly a leader in the
22 field, and if he says it works, that's a great deal of
23 evidence in my opinion.
24 Q. So you recognize him as an expert in the
25 field of treatment of gender dysphoria?

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1 A. Yes, sir.
2 Q. Well, he also says that "Empirical evidence
3 from adulthood suggests that gender dysphoria is best
4 treated through hormonal and surgical interventions,
5 particularly in carefully evaluated patients."
6 Do you understand that?
7 A. That's his opinion. That's his functional
8 experience. He has much greater experience, but there
9 is no clinical trial which shows that's true.
10 Q. But you disagree with Dr. Zucker?
11 A. No, I disagree that what he says has been
12 demonstrated by any sound scientific research. He says
13 it is safe and effective. You can only be safe and
14 effective relative to your effect. If it doesn't have
15 any effect, what does it mean to be safe? Are these
16 treatments really safe for people? I don't know that.
17 Are they effective? I don't know that.
18 Q. If he says -- but you understand he says it
19 is best treated through hormonal and surgical
20 interventions. That's his statement.
21 A. Fine. And Zucker's a clinician. He's very
22 experienced in this thing, and I respect his opinion.
23 He's got a lot more experience than I do. Do I respect
24 him in understanding scientific evidence and what is
25 demonstrated or not by clinical studies? No, I

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1 don't -- I don't know. I don't have any reason to
2 suspect him, but if he believes that evidence is
3 accumulated to make that decision, then that's his
4 belief. It would just take one study to show that, in
5 fact, it works.
6 Q. Do you believe that you have greater
7 expertise in the field of gender dysphoria than
8 Dr. Zucker?
9 A. We have different types of expertise. I
10 think I'm a better scientist than Dr. Zucker. I spend
11 all my day doing science. I don't see patients. I
12 don't go on talk shows. I don't do all these other
13 things.
14 Q. Do you know whether --
15 A. When it comes to the epidemiology of gender
16 identity, I think I've worked as hard as anybody.
17 Q. Do you know whether Dr. Zucker has done any
18 scientific research?
19 A. Oh, yeah. He's done quite a few studies,
20 scientific studies.
21 Q. But you don't think he's a scientist?
22 A. I think he's a scientist. He's a lot of
23 different things. So I think he's a committed
24 scientist. Do I think he'd be held out as a great
25 academic physician? No. I mean, is he a Paul McHugh?

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1 No.
2 Q. Were you paid for your work on this amicus
3 brief?
4 A. No, sir.
5 Q. Did you receive any funding for work related
6 to the brief?
7 A. Not to best of my knowledge. I'd have to go
8 back and see if there was some minimal amount of
9 payment. As I sit here, I don't believe I was. I
10 don't know who would have paid me.
11 Q. Were you encouraged to work on the brief by
12 anyone?
13 A. Yes, sir.
14 Q. Who?
15 A. Mr. Bradley. Gerald Bradley is his name.
16 Gerard Bradley of Notre Dame Law School.
17 Q. Who did you talk to about the brief other
18 than Mr. Bradley?
19 A. Paul Hruz and Paul McHugh. Dr. McHugh and
20 Dr. Hruz.
21 Q. Anyone else?
22 A. No, sir.
23 Q. Anyone review drafts other than the people
24 you just mentioned?
25 A. Not to the best of my memory.

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1 Q. Were there any nonfinancial contributions
2 from anyone for the work on the brief?
3 A. What would that be? I don't know what you're
4 talking about.
5 Q. Somebody assist by providing some research or
6 something for you?
7 A. No.
8 Q. Any other ways, nonfinancial ways that you
9 can think of that someone assisted?
10 A. I want to be a good scientist and a good
11 citizen and help out, understand the issues. I felt it
12 was a very complicated case.
13 MR. KNIGHT: I think we should take a break
14 now, if you're wanting to take a break now.
15 MR. KILPATRICK: Okay. 45 minutes, is that
16 enough time?
17 MR. KNIGHT: Let's go off the record.
18 (Recess taken.)
19 MR. KNIGHT: Back on the record.
20 Doctor, do you understand you are still under
21 oath?
22 THE WITNESS: Yes, I do.
23 BY MR. KNIGHT:
24 Q. I wanted to ask about your testimony earlier
25 about counseling a woman who is transgender to accept

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1 her femaleness, but to also accept her body, even
2 though it -- her body doesn't conform with her female
3 gender identity. Did I -- is that what you said
4 before, if I understand correctly?
5 A. I'm not sure what you mean by "conform,"
6 because she has a female gender identity, so she is a
7 female. Why does her body need to look any particular
8 way. She is what she is. She's a transgendered
9 female. So I don't understand, other than social
10 acceptance or self-image, why shouldn't society accept
11 these people as who they are? Maybe I'm missing
12 something.
13 Q. Well, I'm just trying to make sure -- I have
14 some other questions to ask, but I want to make sure
15 I'm representing what you said before, that you believe
16 that one kind of treatment that should be provided is
17 counseling this transgender woman to be accepting of
18 her body, even though she has the body that would be
19 typically associated with a man?
20 A. Right. So she has a body of a man. We can
21 either make her and society accept that, or we can try
22 to have them more comfortable so they can pass,
23 basically, as being biologically a woman. And that --
24 that's fine too.
25 To me, the treatment has to go after the

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1 dysphoria. What is the dysphoria? Do I think that
2 would work with most women? No. I mean most people,
3 no. I think it is very resilient overall, this
4 dysphoria.
5 Q. And you're talking about two different
6 things. So which is the thing do you think that would
7 not work for most people, which kind of treatment?
8 Counseling?
9 A. I don't think there is any evidence that any
10 treatment really works. I'm sorry. I don't know of
11 any controlled study that shows that transgenders who
12 are dysphoric have a lower rate of dysphoria given any
13 treatment. Any treatment. But since you are at a
14 psychiatrist, talk is there. It's certainly less than
15 $50,000, of course you try to reduce there. Of course
16 you try to do anything to make them more comfortable,
17 reduce their anxiety, reduce their depression. In an
18 ideal world, they should be comfortable with their
19 body. Why not?
20 Q. Is there any research that supports the
21 efficacy of counseling someone to accept -- counseling
22 a transgender women to accept her male body?
23 A. No, it's not her male body, it's her female
24 body. She's a female, it's her body.
25 Q. Her body that she perceives and society

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1 perceives as male?
2 A. It is male.
3 Q. Is there any reason?
4 A. But it's her body, she is a female. Go
5 ahead.
6 Q. Is there any research that supports your
7 notion of having someone be counseled or counseling
8 someone to accept their female gender identity and also
9 accept their male body?
10 A. That is a good question. I don't know the
11 answer. There is a lot of research on children --
12 children's relevant here -- where they put them in an
13 affirming supportive environment and they do get
14 positive results with regard to their self-image and
15 all that. So, yes, we have some indication of being in
16 a positive affirmative environment that affirms who
17 they are has positive results. Do I think it would
18 work on a 45-year-old woman? I doubt it, but I don't
19 know.
20 Q. Is there any research that would support that
21 kind of therapy for a 45-year-old woman?
22 A. Well, a 45-year-old with dysphoria has
23 distress, she has depression, she had that. Yes,
24 there's treatment to show that those treatments work
25 with regard to depression, for example, but are they

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1 carefully designed clinical trials, no. I don't know
2 of any that were done. I tried to find them. I was
3 surprised how little was done in psychiatric research.
4 Q. You are saying that there are no studies
5 supporting the efficacy of talk therapy to treat gender
6 dysphoria in a 45-year-old woman?
7 A. Transgender woman, though, right?
8 Q. Yes.
9 A. I don't know of any. There are studies that
10 suggest it. Did I find any rigorous scientific
11 studies? No. There may be some, but I didn't find
12 them.
13 Q. There are studies that suggest that talk
14 therapy is going to work for a 45-year-old transgender
15 woman to have her accept her body when she is gender
16 dysphoric with respect to her body?
17 A. Well, it depends on how severe her gender
18 dysphoria is. It's not about her perception of her
19 body. It's about her inability to function day-to-day.
20 Do we know that going to psychiatrics makes it more
21 able for people to function day-to-day? Yes, we know
22 that. Do we know it specifically for transgender? No,
23 but why in the world would their depression be
24 different -- treatment be different than any other
25 depression? There's something going on they're

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1 depressed about. The key is try to help them be less
2 depressed.
3 So do we know that psychiatrists have an
4 effect? Yes. It's very marginal, but we know they
5 have an effect with people with depression in general.
6 Is there a study in particular with transgenders? No,
7 because it would have to be advocates of transgenders,
8 these clinics that have enough patients to do these
9 studies, and they don't do the studies. I don't know
10 why they don't do the studies.
11 Q. I'm still not sure -- are you saying there is
12 a study or there isn't a study?
13 A. There are studies about treating depression.
14 I've seen references in transgender. Are there any
15 that would stand up to scientific scrutiny? I didn't
16 find any. It's a good question. I looked, but I
17 didn't find any.
18 Q. You mentioned earlier the study that you
19 thought should be done, and I want to see if I
20 understand that study. I believe that you said this
21 would be a study that would offer people with gender
22 dysphoria two options: They would have surgery or they
23 would go on a trip to Europe?
24 A. Well, an active control -- an active control
25 means you give them time and attention. I might have

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1 been facetious about a trip, but if you brought them in
2 for the equivalent time -- we want to know it is not
3 the time and the amount of money spent on them making
4 the difference. We want to know there is something
5 really in this treatment.
6 So you could have an active control of many
7 kinds, but an active control means you do something to
8 them. You give them maybe supportive psychiatric
9 therapy and measure the outcome. But the outcome can't
10 be how pleasant it is, how much they like their body.
11 It's got to be, are they functional? Are they
12 functional?
13 Q. So what would that study look like? I still
14 don't understand.
15 A. Well, I haven't tried to design the study.
16 There could be many different designs. But you could
17 certainly bring in transgender people and give them an
18 option of transgender surgery or talk therapy or
19 antidepressants and measure the percent that are
20 dysphoric in six months' time.
21 Q. And you think some people would choose talk
22 therapy who are severely gender dysphoric?
23 A. I think there are people who do choose
24 talk -- I didn't say severely. You keep tossing these
25 little adjectives and adverbs in, and you said

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1 "severely," and that is a matter for the clinician to
2 decide. But there are, there are people who don't want
3 to do genital surgery? Of course. It's a huge
4 undertaking, a huge process. And some of them will
5 go-- let them pick what they want, and have them go
6 through talk therapy. It's not a randomized trial, but
7 it would be a trial.
8 I'm going to have to step out a second. I'm
9 just not feeling well. I'm going to use the restroom.
10 Sorry.
11 (Recess taken.)
12 BY MR. KNIGHT:
13 Q. Can we try again?
14 A. Yes, sir.
15 Q. I'm trying to understand about the study, and
16 at one point you said we need a control group, and you
17 offered the control group might be a trip?
18 A. An active control, yes, sir.
19 Q. I'm sorry?
20 A. I didn't mean to interrupt you. An active
21 control versus a passive control.
22 Q. And what do you mean by "active control"?
23 A. An active control means we do something of
24 equivalent time and attention. So let's suppose we
25 bring in young people. I can use about the age that

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1 start hormone therapy, because they usually start in
2 their teens. And we start some on hormone therapy, and
3 we give the others just a very supportive environment
4 but no hormone therapy. And then we measure the
5 percent that have gender dysphoria.
6 Q. And you think that -- I want to talk about
7 adults, but you think that there are some adults with
8 what the clinicians would characterize as serious
9 dysphoria.
10 Do you understand what I mean by serious
11 dysphoria?
12 A. Yes, sir, I have a definition. You may have
13 a different one, but I have a definition.
14 Q. What is your definition for serious
15 dysphoria?
16 A. People who are seriously mentally ill. They
17 can be suicidal. They can be self-harming. I mean,
18 it's a very serious -- I put on the -- I mean, without
19 any parallel to the clinical, on a parallel with
20 anorexia, which we joke about, but it's probably one of
21 the most significant mental illnesses you can have.
22 So these people are dysphoric, and that's
23 their problem. And we're addressing their dysphoria by
24 changing their physical appearance. That might work,
25 but I'm surprised. I couldn't even get data on the

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1 percentage of transgenders that decline hormone
2 therapy, that decline surgery.
3 I also couldn't get any data on how many
4 transgenders are not dysphoric. Because I tell you my
5 experience with these clinics, and I read their
6 literature and stuff. If you come in and you are
7 transgender, they very much support that you're
8 dysphoric and try to get in treatment. They call it
9 "treatment to transition." And I don't want to see
10 treatment to transition. There is nothing people have
11 to transition. I want to see society be accepting of
12 these people as they are.
13 But if it causes them serious dysphoria, if
14 they're suicidal, of course that has to be treated one
15 way or the other. But I don't know what the best way
16 to treat them is. We have too little data.
17 Q. So you believe that if we change society,
18 there would not be any gender dysphoric people?
19 A. Well, the advocates believe that. They say
20 the problem is transgenders are fine except for the --
21 what do they call it? Social stigma. The social
22 stigma hypothesis and could reduce it greatly. Do I
23 think -- there are societies, primitive societies in
24 particular, where people are full spectrum, male to
25 female and all sort of things in between, they seem to

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1 function perfectly fine. Why not accept these people?
2 They're our brothers and sisters.
3 Q. I am not asking you about the advocates. I'm
4 asking you, do you believe that if we change society,
5 there would be no need for treatment of gender
6 dysphoric people?
7 A. No. I believe it would seriously reduce the
8 amount of gender dysphoria, but I don't think it -- I
9 mean, it would be nice if it were true, that there
10 would be no need for treatment, but I would be a little
11 surprised at that. I'd be very surprised.
12 Q. So the study involving active therapy would
13 involve a -- I just want to ask it. So the study you
14 are designing, you believe that a seriously gender
15 dysphoric adult would, given a choice between talk
16 therapy and hormone therapy or surgery, would choose
17 talk therapy?
18 A. Well, look at your own statistics of the
19 people like Schechter. They say 50 percent of the
20 people would eventually choose -- I don't remember the
21 exact statistic -- choose surgery, and some percent
22 would choose hormone therapy. That means there's a
23 huge percent that don't choose either. Yes, I think
24 they should be accepted. Why not?
25 Q. I didn't ask about Dr. Schechter. I asked

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1 you about your opinion.
2 A. Of what now?
3 Q. Do you believe that for a seriously gender
4 dysphoria adult, that some of those individuals would
5 choose talk therapy rather than hormone therapy or
6 surgery?
7 A. There is no choice, because when you have
8 hormone therapy and surgery you get talk therapy.
9 People talk to you consistently in an affirmative
10 environment. That is what these gender clinics are
11 about. You get surgery but no therapy?
12 Q. I'm asking you about your controlled study.
13 And I believe you said the controlled study would
14 involve seriously dysphoric adults given --
15 A. I never said that. I never said seriously
16 dysphoric. I never used the word seriously.
17 Q. All right. I'm asking you about a controlled
18 study.
19 A. Okay.
20 Q. Let's say we have a controlled study in which
21 we offer these seriously dysphoric adults a choice
22 between talk therapy, hormone therapy only, and hormone
23 therapy and surgery.
24 Is that the kind of study you're talking
25 about?

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1 A. Well, I'm not an expert in the field to
2 design the study, but that's the general idea. Some
3 study -- statistics isn't about whether something works
4 or not. It's about how it works compared to something
5 else. I need a comparison group. What is my
6 comparison group?
7 But there is self-selection. I've seen the
8 Hopkins statistics. A large percent don't select any
9 hormone therapy or surgery. Let's look at them versus
10 the other and see how they deal with it. The important
11 point is to reduce the distress.
12 Q. Are you saying you are not an expert in
13 designing a study to treat with respect to gender
14 dysphoria?
15 A. I'd say there are two kinds of expert.
16 There's an expert on study design, I am. And then
17 there's an expert on the clinical side of gender
18 dysphoria, which I'm not. But it has to be together.
19 Q. I'm asking you about the study. The study,
20 what is the study that you believe would be sufficient
21 to show that hormone therapy and surgery are effective
22 treatment in contrast with talk therapy?
23 A. That's a great question. There are books
24 written about clinical trials in psychiatry. If you
25 read any of those books, it will tell you exactly how

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1 to set those studies up. What the control group -- I'd
2 have to estimate the means, the difference in the
3 means, the standard deviations to figure out what the
4 sample size is, what the idea control is. That's part
5 of the art of studying design. But you'd need an
6 expert in the clinical part, and I'm not an expert in
7 the clinical part.
8 Q. So you are saying without an expert in the
9 clinical treatment of gender dysphoria, you would not
10 be able to design the study to decide whether or not
11 hormone therapy or surgery is more effective than talk
12 therapy?
13 A. It's beautifully said. I envision a table.
14 Schechter is there. Bailey who is an advocate is
15 there. You are there. Someone on design is there. A
16 clinical psychiatrist. And we decide to resolve this
17 by having a definitive multi-site clinical study. I
18 would be -- I would just -- I would donate my time.
19 Q. Can you answer my question?
20 A. Sure.
21 Q. Are you telling me that without a clinician
22 in the treatment, who is an expert in treating gender
23 dysphoria, you yourself are not qualified to create a
24 study of the sort that you think should happen?
25 A. I can design a study. I can't run a study.

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1 I'm not a clinician. I don't know what you are saying.
2 Clinicians run studies. How could I run a study?
3 Q. I'm asking you, how could you design -- can
4 you, are you qualified to design a study of the sort we
5 have been talking about --
6 A. I have designed hundreds of studies.
7 Q. -- which would compare the efficacy of
8 hormone therapy and surgery to talk therapy?
9 A. You're almost like you're asking Schechter if
10 he can do surgery. You're talking about my whole life.
11 This is what I've done for 45 years. Yes, I could
12 design that study. Do I need clinical people to run
13 that study? Yes.
14 Q. And what would that study look like?
15 A. I don't know, because I have to see more of
16 the data. The first thing I'd want to do is get
17 preliminary data from these sites, which won't share
18 their data on that. I would like to see preliminary
19 data on the percent of dysphoric, the different
20 modalities that are used, and then we cold come up with
21 a design that everybody would embrace.
22 And just like with women's hormone therapy;
23 just like whether or not -- I worked on giving SSRIs to
24 pregnant women, Paxil in particular; just like I worked
25 on the various nasal sprays, you would get a definitive

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1 answer to whether or not this is safe and effective.
2 Yes, would that be wonderful.
3 Q. But you could not do this by yourself,
4 because you would need to work with clinicians; is that
5 what you are saying? You could not design this
6 control -- this perfect study that you think does not
7 exist?
8 A. You generate a hypothesis. You have some
9 conjuncture. You generate hypotheses, you design the
10 study, you run the study and analyze the study and make
11 inferences. I can do every step of that but run the
12 study. I don't run the study. And do I think you have
13 to be an expert? Yes. You'd have to be a
14 psychiatrist, an endocrinologist, and probably a
15 surgeon to be in there to understand it.
16 Q. And would you have to be any psychiatrist, or
17 a psychiatric who is an expert in treating people with
18 gender dysphoria?
19 A. That's a good question. I don't know -- I
20 mean, I'd want it to be someone that's a sceptic. If
21 they're in the bandwagon where every transgender needs
22 $50,000 worth of surgery, I probably wouldn't want
23 them. I'd want some independent thinkers.
24 The reason I say that is clinicians are
25 usually advocates. I've never met a plastic surgeon

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1 that was not an advocate for plastic surgery. But if
2 they're a good academic, sure, why not? Why don't we
3 resolve this question once and for all, and get people
4 to care.
5 Q. So what is it about the study? It's a --
6 what is the study that we -- I'm still not
7 understanding. What is the study we need? You're
8 saying it's -- at one point you said I can't design a
9 study because I don't have the data from studies that
10 are already done?
11 Did I understand that correctly?
12 A. I need preliminary data. I don't know the
13 level of dysphoria of people going into a gender
14 identity clinic. I have no data that is published
15 other than on people who are advocates that claim, you
16 know, everything is the great panacea or people like
17 Paul McHugh's clinic who wouldn't look at evidence no
18 matter what. I want to be in the middle. I want to
19 look at what the study would be.
20 Q. I'm sorry. I'm sorry. I didn't understand
21 what you said about Paul McHugh?
22 A. Well, Paul McHugh would have extreme
23 opinions, some -- I like Paul. I don't mean to pick on
24 Paul -- have extreme views. Some people have the view
25 that transgender is against the will of God, you know.

1 I don't know where they're coming from.
2 Q. Which is Paul McHugh's view?
3 A. Well, I don't know. He's made some extreme
4 statements about tran- -- I mean, I read a statement
5 about gender pretenders or something like that, an
6 analogy to -- to body dysmorphic disorder. And kind
7 of -- I believe he might even have said that
8 transgenders are mentally ill. Don't quote me on that,
9 but I believe he has. I find that very bothersome.
10 Very bothersome.
11 Q. The --
12 A. I'm kind of betwixt and between on some of
13 these issues I don't understand more deeply.
14 (Exhibit 5 was marked for identification.)
15 BY MR. KNIGHT:
16 Q. I'm showing you what has been marked as
17 Exhibit 5. Can you identify this document?
18 A. It appears to be the report that I published
19 with Dr. McHugh in the New Atlantis on sexuality and
20 gender findings for the biological, psychological, and
21 social sciences.
22 Q. And you would agree this is not a
23 peer-reviewed journal this is published in?
24 A. It is not a peer-reviewed journal, correct,
25 sir.

1 Q. And aren't peer review journals the gold
2 standard in that terms of deciding what kind of -- in
3 science in general?
4 A. Yes, sir.
5 Q. And this is copublished by the Ethics and
6 Public Policy Center.
7 Do you understand that?
8 A. No, sir, but I'll take your word for it.
9 Q. Do you have any affiliations with that group?
10 A. Who is it?
11 Q. The Ethics and Public Policy Center.
12 A. Never heard of it.
13 Q. Do you understand that the EPPC is dedicated
14 to applying the Judeo-Christian moral tradition to
15 critical issues of public policy?
16 A. I've never heard of it, so I can't tell what
17 their policy is.
18 Q. You weren't aware of that when you wrote this
19 article?
20 A. I've never heard of the group. You just said
21 it's their motto or something? I don't know the group.
22 You asked me if I was aware of the motto of a group I
23 never heard of. I don't mind been tarred by a broad
24 brush because of the people that support this kind of
25 activity, but I did my best at honest scholarship.

1 Q. I believe you said elsewhere that this paper
2 did not draw any policy or practice conclusions; is
3 that right? Do you recall that?
4 A. That this monograph -- we're talking about
5 the big monograph --
6 Q. Right.
7 A. Well, it depends on how you would interpret
8 policy inclusions. I tried not to make it
9 prescriptive -- or proscriptive. Very proud of this
10 report, I might add, just because I worked so hard on
11 it.
12 Q. And as I understand it, this article
13 addresses three different topics. First, it talks
14 about sexual orientation, and challenges the position
15 that sexual orientation is fixed; is that right?
16 A. That you're born with it. Yes, that you're
17 born with and it's fixed, yes, sir.
18 Q. In fact, it argues that sexual orientation
19 can be quite fluid; is that right?
20 A. Yes, sir.
21 Q. And it also takes the position that
22 nonheterosexual and transgender persons are at higher
23 risk of mental health problems.
24 A. That's from the advocates own literature.
25 Even Schechter has written about that. At some place

1 he said they have a lifetime suicide rate of
2 80 percent.
3 Q. I wasn't asking about the advocates, I was
4 asking about you. Is that the position that this took?
5 A. I'm not an advocate. I'm not an advocate.
6 Q. So you didn't take the position that
7 nonheterosexual and transgender persons are at higher
8 risk of mental health problems?
9 A. No, they are. We know that to be a fact.
10 I'm saying both sides, everyone has written about that
11 fact. That is why we are here, because it's urgent.
12 It's urgent that we do something for these poor people.
13 Q. And then it finally talks about transgender
14 persons and it challenges the position that gender
15 identity is fixed; is that right?
16 A. That you're born with a gender identity. I'm
17 not sure what you mean by "fixed." Gender identity is
18 fixed. Children grow up and they're curious about
19 their gender identity, so they often identify with
20 being a little girl, and later with a little boy. They
21 play with different genders. So I don't know what you
22 mean by fixed. Gender identity, the struggle for
23 gender identity is a fluid struggle when children are
24 growing up.
25 Q. And, again, I'm talking about adults --

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1 A. Because a developmental course run starts --
2 I don't mean to interrupt you, but it starts when
3 they're children. You have to talk about the
4 development. Forget about adults. Adults got there by
5 being children.
6 Q. And so you're saying that -- are you
7 suggesting that a transgender woman is a woman because
8 of her child raising?
9 A. A transgender woman is a woman in gender
10 because she has a long-term consistent, insistent,
11 persistent deeply held view that she identifies with
12 the opposite sex. That is the definition.
13 Q. And do you believe that her identity is fixed
14 or changeable and flexible?
15 A. Well, I think as you grow older, it's less
16 and less flexible. Do I see a large number of
17 transgenders converting back to their -- the gender
18 identity consistent with their sex? No, I would be
19 surprised at that. I'm sure there are some. And
20 actually, there's some cases been written about, but I
21 wouldn't assume. We're doing too much by the exception
22 and not enough by the bulk of the rule. I would say it
23 is very rare.
24 Q. The other thing this article talks about is
25 challenging the position that surgery and hormones are

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1 effective at treating gender dysphoria; is that right?
2 A. Yes, sir.
3 Q. And I believe that the article, the part of
4 this which you cited in your report here, is at pages
5 106 to 113 of this paper; is that right?
6 A. I don't know what you are asking me.
7 Q. I'm asking whether that's the portion that
8 talks about -- well, is that the portion that you
9 relied on for -- to support your positions in this
10 case?
11 A. This is my own work. I relied on everything
12 in my own work. You only ask me whether I relied on
13 someone else's work. I relied on all of this. This is
14 all in my brain.
15 Q. Well, let's look at Exhibit 1 again.
16 A. Okay.
17 Q. And on page 7 of Exhibit 1.
18 A. Okay.
19 Q. You reference specifically pages 106 to 113
20 of your sexually and gender publication?
21 A. Um-hmm.
22 Q. So that's why I'm asking you whether that is
23 the portion that you are citing as supportive of your
24 opinions in this case.
25 A. Yes.

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1 Q. You agree that that's right?
2 A. Yes sir.
3 Q. So looking at page 106, the first section
4 here talks about interventions in children.
5 A. Yes, sir.
6 Q. Are you relying on that to support your
7 positions about treatment of adults?
8 A. Well, let me see. Before I did dementia
9 work, I worked on child development. That was my first
10 thing at Johns Hopkins, whether early interventions
11 could make a difference. So I see human beings, not in
12 a clinical setting of child, adolescent, adult, but
13 it's a continual process of development. And I'm
14 interested in that process of development. So it's
15 hard for me to make a distinction between children and
16 adults, because all adults were children at one time.
17 But if you're saying is this research focused
18 more on children, absolutely. I'm much more concerned
19 about children. The whole reason I did this paper was
20 to write about children, quite frankly.
21 Q. On page 108 you start -- the section then
22 starts talking about therapeutic interventions in
23 adults.
24 A. Um-hmm.
25 Q. And there, at least as far as I can see, you

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1 are pointing to three studies, a -- sorry -- a 1979
2 study by Meyer and Reter?
3 A. Um-hmm.
4 Q. A second study by Cecilia Dhejne, I guess.
5 A. Um-hmm.
6 Q. And then a Kuhn study on -- from 2009, which
7 was cited on page 111.
8 So those are the three studies I see cited in
9 this section. Am I missing something in terms of
10 studies that you are relying on?
11 A. Well, there was the Murad and colleagues,
12 their systematic review.
13 Q. Okay, literature review.
14 A. Yes. I reviewed 1000 papers, which you can
15 have. I mean, the bibliography is out, you can see.
16 But these were not intended to be exhaustive, they were
17 intended to be suggestive.
18 Q. And then you also relied on a journal article
19 in The Guardian?
20 A. Yes, sir.
21 Q. Now, why would you rely on an article in a
22 newspaper to support your views?
23 A. Let me say something. I'm an academic, so
24 when I cite things, I'm not regurgitating what other
25 people said. These are my opinions, and to support my

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1 opinions or elaborate my opinions, I often cite
2 something that I find of interest. I'm not citing any
3 of these as being the end-all and be-all of my opinion.
4 It's to give an example of what other people
5 are out there doing. So I think it's perfectly fine --
6 I notice in the early part of this I cited the work of
7 feminists and things like that. We're all over the
8 map. Also, it's a popular text and all that. That's
9 what you do. If you mean did my conclusions fall from
10 a Guardian newspaper, of course they didn't.
11 Q. So the Meyer/Reter article you admit is a
12 study of only 35 people and has important limitations?
13 A. Absolutely.
14 Q. And the Dhejne article also, you agree, does
15 not address the effectiveness of sex reassignment as
16 treatment for transsexualism?
17 A. That is correct.
18 Q. And you believe that -- and, in fact, that
19 study says -- I believe that maybe you said, and
20 certainly the study says that things might have been
21 even worse without sex reassignment.
22 A. Yes, sir.
23 Q. Similar to the Kuhn study compares patients
24 who completed gender surgery with cisgender women, and
25 says nothing about the effectiveness of gender

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1 confirmation surgery, right?
2 A. Right.
3 Q. Because it doesn't compare patients with
4 gender dysphoria to -- patients who got treatment to
5 those who didn't get treatment; is that right?
6 A. Yes, sir.
7 Q. And you understand that the Murad article
8 concludes that gender reassignment with the use of
9 hormone therapies was associated or were associated
10 with improvements in gender dysphoria, psychological
11 functioning, and co-morbidities, lower suicide rates,
12 higher sexual satisfaction, and overall improvement in
13 quality of life.
14 You understand that is true?
15 A. Um-hmm. In fact, I say on the top of 110,
16 "Compared to their condition before surgery,
17 individuals who have undergone surgery appear to show
18 improvement in the well-being, though the results have
19 a fairly low level of statistical significance. But
20 individuals who had no surgery went on to display a
21 significant improvement follow-up."
22 But there were statistical difference between
23 the groups. Even if there were, we're splitting hairs
24 at the 05 level. If this stuff is great and really
25 cures dysphoria, then the signal to noise ratio should

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1 be terrific and we'd be able to demonstrate that.
2 Where is the definitive demonstration for all
3 the money we spend on hormone therapy, and particularly
4 on surgery, where's the definitive study that shows it
5 works.
6 Q. And how much money do you think we are
7 spending on hormone therapy and surgery?
8 A. Well, I've seen estimates that complete
9 surgeries can be in the 50- to $100,000 range.
10 When you say "we", you personally, or who do
11 you mean?
12 Q. Well, I'm talking about costs on a general
13 level?
14 A. Well, I'm not an expert in cost, but we know
15 that plastic surgery is extremely expensive. I've seen
16 estimates that, going all the way with whatever that
17 means, can be 50- to $100,000. Well, suppose there are
18 10,000 transgender people wanting that surgery.
19 Obviously, could be huge expense. And we do have
20 estimates of how much you spent on plastic surgery,
21 Joe.
22 Q. And we also have estimates about what a small
23 population this is, don't we?
24 A. Absolutely.
25 Q. So the overall cost, ultimately, is quite

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1 small.
2 A. Well, but the problem with the overall cost
3 is you still have to argument on equity, and I would
4 assume the ACLU would be a real bear on equity. The
5 why are we giving this treatment to a transgender
6 person. But to her sister, we're not giving any
7 treatment when they virtually look identical. What
8 does being transgender have to do with being
9 unsatisfied with your appearance?
10 Brother and sister almost identical and he
11 becomes a transgender girl. She is a girl and she's
12 not entitled to surgery, but he's entitled to surgery
13 because he's a girl. Doesn't make any sense to me. I
14 would argue they're both entitled to surgery, I guess.
15 Q. And you are saying that -- that -- so you are
16 saying that even though an individual has clinically
17 significant distress because of the dysphoria about
18 their incongruence, that that is exactly the same as a
19 nontransgender person who expresses some feelings of
20 distress with respect to their body; is that what you
21 are saying?
22 A. No, I'm not saying that, but that is
23 interesting you said that. Could you interview these
24 people -- take a cisgender woman and a transgender
25 woman, interview them, and get the exact same responses

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1 about how they feel about their looks. Of course, you
2 could. Is one more deserving than the other? Well,
3 let's go to the idea of -- are we agreed -- what's it
4 called? Confirming? Are we confirming, were they
5 something at birth other than what their biology was?
6 Well, what is it that they are at birth that we are
7 reconstructing or reconfirming? I don't understand it.
8 I'm not criticizing. I just can't get my head around
9 it.
10 Q. So, again, are you saying that an individual
11 with gender dysphoria who has serious dysphoria about
12 the -- their body, focused on their body, is the same
13 as a nontransgender person who says that they have
14 distress with respect to their body?
15 A. I don't know if they're the same. But if
16 what -- distressed is a general word. If you mean
17 depressed, can I find 45-year-old women who are
18 depressed about their looks just as much as 45-year-old
19 transgender women? Absolutely. What does being
20 transgender have to do with this distress? I'm just
21 missing it.
22 Q. So you're saying that, in an adult, that you
23 believe that there is a -- that it's the same to -- if
24 we have two women, one who is gender dysphoric about
25 her body, and a cisgender woman who has, let's say,

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1 diagnosable depression with respect to her body.
2 You're saying they're both the same?
3 A. No. I don't know what you mean by "the
4 same." No two patients are the same. When you say
5 "distress," distress is not a diagnosis. Dysphoria is
6 a whole spectrum. What does she have? Is she
7 depressed, for example? Is the depression similar to
8 depression of cisgender women? I don't know. We
9 haven't even studied that. I would love to know --
10 it's a real good question.
11 Is the depression of a transgender woman more
12 resistant to treatment like antidepressant than the
13 depression associated with a cisgender woman who is
14 unhappy with her looks. I think it's a beautiful
15 research question. I don't know of anyone that has
16 done the research. It's a beautiful question.
17 Q. So again, are you suggesting that an
18 individual with gender dysphoria who has distress about
19 their body is the same as an individual without gender
20 dysphoria but clinical depression in terms of their
21 need for surgical treatment?
22 MR. KILPATRICK: Objection; asked and
23 answered.
24 THE WITNESS: You keep asking the same
25 question.

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1 MR. KNIGHT: You haven't answered my
2 question. I'm just trying to get an answer to my
3 question.
4 BY MR. KNIGHT:
5 Q. You didn't answer my question.
6 A. I did answer your question.
7 Q. You didn't answer my question?
8 A. I said they're not the same. No two patients
9 are the same. I don't know what you mean, by are they
10 the same. It seems like we get this surgery we're very
11 precise about surgery, but when we get to the mind and
12 psychiatry, we are often vague about distress and this
13 sort of thing. If she's transgender and bipolar, does
14 she act like a bipolar? Yes. Why wouldn't you expect
15 her to. I don't get it. But I do get tired of
16 answering the same question over and over again. I
17 have to admit, it's very rare. I'm usually both
18 precise and concise, and I'll try to be better.
19 Q. So the other document you cite as support for
20 your opinions in Exhibit 1, is this 2016 decision memo,
21 the Centers for Medicare and Medicaid Services.
22 A. Yes, sir.
23 Q. But you understand that that memo stated that
24 gender reassignment surgery may be reasonable and
25 necessary service for certain beneficiaries with gender

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1 dysphoria?
2 A. Yes, sir.
3 Q. And it indicated that it was not --
4 A. Can I clarify that one thing? I think it was
5 Dr. -- I'm sorry. I'm bad with names. Schechter --
6 not Schechter. Schechter comments that this memo that
7 I read was part of a longer discussion, you know what I
8 mean? And I just saw this memo, and I saw that
9 basically what I thought it was saying is that there
10 shouldn't be a blanket rule, but that, for some people,
11 this was a good choice. Isn't that what it says? I
12 think that's what it says.
13 Q. Well, it says it's reasonable and necessary.
14 A. Yes.
15 Q. And you agree that that's what it says?
16 A. Yes, sir, for some people I imagine it would
17 be, yes, sir.
18 Q. And you are aware that in 2014, a
19 adjudicative board from the Department of Health and
20 Human Services concluded that surgical care to treat
21 gender dysphoria is safe, effective, and not
22 experimental, and, thus, at such time, struck down the
23 exclusion for such care?
24 A. I don't know about that. What I do know is
25 when I saw this document, I saw Schechter refer to

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1 other documents. So I went to the documents, and there
2 was a lot of stuff I don't understand, but what I was
3 trying to use this for is to say it's an open issue,
4 but certainly there are some cases in which it is
5 called for. If I knew it was part of a longer process,
6 I wouldn't have cited it unless I had access to the
7 longer process. And then I wouldn't have cited it
8 because it's too complicated and too political.
9 THE WITNESS: I have to step out again. I'm
10 sorry. Be right back.
11 (Recess taken.)
12 (Exhibit 6 was marked for identification.)
13 BY MR. KNIGHT:
14 Q. Have you seen -- Dr. Mayer, have you seen
15 this document before?
16 A. It does not look familiar to me, no, sir.
17 Q. Well, this is the Department of Health and
18 Human Services, Departmental Appeals Board, Decision
19 With Respect to Transsexual Surgery. And I would
20 direct you to page 20.
21 A. Okay. Page 20, yes, sir.
22 Q. So at the end of that first paragraph --
23 A. First new paragraph or original -- oh, that
24 is the original paragraph. Go ahead.
25 Q. The decision says that there -- "that

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1 indicates a consensus among researchers and mainstream
2 medical organizations that transsexual surgery is an
3 effective, safe, and medically necessary treatment for
4 transsexualism."
5 Do you see where I'm reading?
6 A. No, sir. I'm trying. It says it explains
7 general acceptance -- page 20, right?
8 Q. Page 20. And it starts "regardless of
9 whether the new evidence here meets."
10 A. Okay. "Set forth in the guidance says
11 clearly, does not assert -- means the second option --
12 well, the problem with this, of course, and this
13 bothers me a great deal. Why there is any treatment
14 for transsexualism. How can you remove transsexualism
15 as a disorder and then talk about treatment for it? I
16 just don't understand. I never will. Maybe you can
17 explain it, why a transgender person needs treatment.
18 Why aren't they healthy as a transgender person? Why
19 isn't society doing everything to support them in their
20 choice?
21 Q. So you believe transgender people don't need
22 treatment?
23 A. I believe it's not -- you can't treat a
24 nondisorder. What's the disorder that they have?
25 Q. Gender dysphoria.

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1 A. Then they get treated for gender dysphoria.
2 Does every transgender have gender dysphoria? Because
3 that's bothering me if you say yes. Because I can tell
4 you I've met some very well-adjusted transgenders. The
5 two women that my student has as patients are both
6 physicians, and they're both well-adjusted. What do
7 they need treatment for? It's a little insincere to
8 work so hard to get it off -- just like being gay --
9 get it off the list of diagnoses, and then to spend our
10 time treating it. Why are we treating someone if it's
11 not an illness?
12 Q. The two woman you are talking about in terms
13 of -- this is the student you were talking about
14 earlier?
15 A. Yes, sir.
16 Q. And are the people she's treating being
17 treated through surgery or hormone therapy?
18 A. I said, I've not kept up with it so I don't
19 know. I should have gone back and checked, but I don't
20 know. By the way, there are two students, just so you
21 know. I didn't want to mention the other, because the
22 other's married to a transsexual. I don't want to go
23 into that -- and I'm sorry. Transgender. Her husband
24 has become transgender, and she's living with her
25 husband. She's living with her former husband in a

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1 relationship, but --
2 Oh, I'm sorry. I'm sorry. You asked me
3 about the two patients. He's undergone complete
4 surgery, I know for sure. I don't know about the two
5 patients.
6 Q. But I believe you said earlier that you did
7 not provide supervision or advice about the treatment
8 for those, for your students' patients; is that right?
9 A. I would never -- you've got to be careful.
10 When you say "treatment," I can talk about the general
11 efficacy, but you're talking about specifics. I didn't
12 give any recommendation. I would never. I never open
13 my mouth at these clinical rounds.
14 Q. In terms of which treatment should be -- or
15 whether treatment should be provided. You don't enter
16 into those discussions?
17 A. I don't believe I'm qualified. I think part
18 of being a good expert -- maybe you talk to Professor
19 Budge -- is knowing what you're qualified to do.
20 Q. I don't understand. What is it you're saying
21 about Dr. Budge?
22 A. Well, Dr. Budge talks about things being
23 medically necessary and not. In most states, to opine
24 on what's medically necessary or not, you have to be a
25 physician. She's a counseling psychologist.

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1 Q. Based on what?
2 A. In California, it's based on the law. To
3 give a medical opinion in California, you must be a
4 licensed physician or an allied medical professional.
5 She's a counseling psychologist, so she can give
6 psychological opinions. Can she tell me a patient can
7 benefit physically from surgery? I wouldn't be
8 arrogant enough to, and I'm a physician.
9 Q. So you're saying she's arrogant because she
10 is making -- or has opinions about the kind of
11 treatment that would be appropriate to treat the
12 condition of gender dysphoria for these individuals?
13 A. Well, first of all, I said things she's said
14 would be arrogant or if I said it, it would be
15 arrogant. I don't know anything about her. I don't
16 want to say that. But does she go far afield from her
17 expertise as a counseling psychologist, I would say so.
18 You can go right through it. Her theory of sex and
19 gender, these things.
20 I mean, I give her a break because she's a
21 social scientist, but these are off the wall. The idea
22 that you're born with a gender. That somehow your sex
23 is based on your gender. These statements are so
24 ridiculous, I don't even know what the statements mean.
25 How is your sex based on your gender?

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1 Q. So you're saying the only people who can
2 decide -- who can work with a gender dysphoric
3 individual to decide what is necessary treatment for
4 them would be a physician? Is that what you're saying?
5 A. I would say the only person to decide for a
6 specific patient ought to at least be a physician if
7 not several physicians, yes.
8 A clinical physician, now, I'm talking about.
9 Who in the world now should decide -- I mean, where do
10 we have -- if you have tonsillitis, does a psychologist
11 tell you to get your tonsils out? I hope not.
12 By the way, tonsillitis is another example.
13 AMA took out millions of tonsils in this country when
14 no tonsils virtually were taken out in Europe. And we
15 did it so we wouldn't have recurrent sore throats. And
16 we quit taking tonsils out, there was no increase in
17 sore throats. Nobody has their tonsils out. When I
18 was a boy, 100 percent had their tonsils out. Isn't
19 that amazing?
20 You have your tonsils. I know you do.
21 You're too young to have them out. He doesn't have his
22 tonsils.
23 The best definition of sex is based on
24 gender. Gender somehow predates sex. I don't want to
25 be too critical, because I don't even know what the

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1 statements mean to be critical of. Maybe it's from
2 dianetics or something.
3 Q. So I want to be clear, you are not making or
4 offering opinions with respect to Dr. Budge's diagnosis
5 of Ms. Boyden and Ms. Andrews with gender dysphoria; is
6 that right?
7 A. I would have criticism because she came in
8 this already loaded and it was clear she's not an
9 unbiased observer. I would if someone did that kind of
10 an independent medical exam. Is she a treating -- I
11 got mixed up, because if she's a treating person
12 advocate, then she's not an independent expert. I
13 couldn't figure it out. If she's an independent
14 expert, first of all, I think she interviewed him for
15 90 minutes. That's certainly inadequate to determine
16 whether anybody has major depressive disorder or any of
17 these other disorders.
18 And so did she already feel that her
19 conclusions were justified? I don't know. It was
20 clear to me that she was not an independent medical
21 examiner, that's for sure.
22 Q. You weren't asked to look at her opinions
23 with respect to Ms. Boyden and Ms. Andrews, were you?
24 A. Yes, sir.
25 Q. You were asked to look at that?

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1 A. I don't know what you mean by "asked." They
2 were in the report I read, yes, sir.
3 Q. And so you believe that she is wrong in
4 diagnosing these two individuals with gender dysphoria?
5 A. I can't tell you that, because I can't
6 diagnose and know what the correct diagnosis is. But
7 the kid selling pencils in the corner could be right.
8 I'm suggesting she has minimal credentials to be saying
9 any of these things. Her understanding of biology is
10 so poor it reflects badly on all of her statements.
11 She's as weak an expert as I have seen in 40 years.
12 I'm sorry to say that, but I'm surprised you used her.
13 Q. Do you have any basis for disputing her with
14 respect to the gender dysphoria of Ms. Boyden and
15 Ms. Andrews?
16 A. I don't dispute. I said she doesn't have the
17 qualifications to be rendering a medical opinion. I
18 don't have any statement about what opinions she gave.
19 Whether she was right or wrong, I'm not a clinician.
20 You keep going back to this. I'm know a clinician.
21 Q. And because you're not a clinician, you don't
22 have any opinions about whether or not hormone therapy
23 or surgical treatment is the appropriate treatment for
24 them; is that right?
25 A. Well, let's go again. If we go to general

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1 causation of what the data says, I can tell you, the
2 individual causation about this specific patient. I
3 have nothing to say about that patient. Now, they can
4 be the two most deserving -- I think they're both
5 women. They can be the two most deserving women in the
6 world.
7 By the way, I'm not even saying -- I'm going
8 to make this clear, go on the record. I'm not even
9 saying it is inappropriate for these women. I'm not
10 saying it is inappropriate for these women.
11 Q. You are saying it shouldn't be -- there
12 should not be insurance coverage for it, is that what
13 you are saying?
14 A. No. I would never say that. I don't know
15 enough about insurance coverage. In the best of all
16 worlds, I believe these woman would be given treatment,
17 and I believe that a woman who feels she's losing her
18 husband because her face looks like a man should be
19 given treatment too.
20 I believe in improving the quality of life
21 through treatment, including surgery. But I want
22 evidence that it actually increases the quality of
23 life. In a way it does remind me of body dysmorphic.
24 In any suggestion of change in eating patterns among
25 anorexics is just so -- I mean, body confirmation is so

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1 crazy, because what you have to do is get to the
2 distress. Can you imagine how distressed these people
3 are?
4 Q. Do you have any other version of your vitae
5 other than the one you provided us?
6 A. I've updated over the years, and I've changed
7 my -- I've stayed for another year, and I formally
8 removed myself from teaching in 2017, I tried to redo
9 it. So I have earlier versions. Do you mean do I keep
10 a second version for something? Is that -- I'm sorry I
11 don't know the question. I have old versions. Is that
12 what you mean?
13 Q. I'm asking if you have a separate version
14 that you use for other purposes?
15 A. No, sir. Should I? I don't know.
16 Q. Do you have any religious beliefs about being
17 transgender or transition?
18 A. I'm sorry. I don't know what you are saying.
19 Religious beliefs.
20 Q. Do you have any religious beliefs about --
21 that relate to the medical treatment for transgender
22 people?
23 A. Would that be like a moral -- I'm not sure
24 what religious belief -- is that a moral or ethical
25 belief? You mean like a moral belief?

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1 Q. Correct.
2 A. It's immoral?
3 Q. That it's immoral to provide this kind of
4 treatment, or that it violates your religious beliefs.
5 A. Not at all. To the contrary. I admire what
6 these people are doing. They are alleviating
7 suffering.
8 Q. I'm sorry. You admire what people who treat
9 gender discrimination are doing?
10 A. Yes. Yes. They are trying their best. I
11 believe they are honest at what they are doing, and are
12 trying their best with a very difficult problem. And I
13 do think when you are too close to the problem, you
14 often lose sight of the broader thing. We still hold
15 babies up by the feet and spank their little butts.
16 Terrible for the baby. Terrible for the baby.
17 And, by the way, in case you're not old
18 enough, women were told to stay in bed the last three
19 months of their pregnancy and two months after they
20 delivered. Horrible advice. Oh, and you were told to
21 gain weight during pregnancy. You had to gain at least
22 20 pounds for a healthy pregnancy, none of that is
23 true. So I don't follow the AMA. Hopefully I lead the
24 people making those decisions.
25 Q. I'm sorry, hopefully you lead the people

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1 making those decisions?
2 A. Yeah. People making clinical decisions. I
3 said, half of my consulting is not in cases. Half of
4 my consulting is with other physicians and others in
5 terms of interpreting research results. So people that
6 do research, as you know, are on the cutting edge of
7 medical treatment. But we're not treaters.
8 Q. So you talked earlier about -- and I believe
9 you said in your report -- as I understood it, you were
10 comparing surgery to treat gender dysphoria with
11 surgery to treat anorexia.
12 Did I understand that correctly?
13 A. I'm sorry, you said compare them?
14 Q. Yes.
15 A. Well, no, there are some similarities in the
16 way that we -- in the suggestions for treating them,
17 but they're completely different. No, they are not
18 related at all, the disorders. I think it is people
19 like Paul McHugh have made that claim. I don't
20 think -- I don't know what it is based on. I don't
21 think it's very helpful.
22 Q. And what about body dysmorphia disorder do
23 you understand that body dysmorphia disorder is very
24 different from gender dysphoria?
25 A. You know it's -- I don't know what the metric

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1 is. They're very different and very similar, and they
2 present different, they have different risks. I guess
3 you would have to tell me what you see is the
4 commonality. I don't see any commonality between them.
5 I think there is a use of that to be dismissive. Do
6 you want to hear what that is? I don't subscribe to
7 it, but I think you can be dismissive.
8 Q. I'm sorry. Use of what? Of the comparison?
9 A. Of the analogy, yes, sir.
10 Q. And what use is that?
11 A. Well, the use is that in body dysmorphic
12 disorder, people have a misperception of their body. I
13 might add, parenthetically, you think it's only for
14 women. I had a guy come in, he had body dysmorphic
15 disorder because he was a 90-pound weakling, and
16 weighed 250 pounds. And he thought it was exactly the
17 reverse of that.
18 But the idea -- the commonality is we don't
19 alter their body to change their misperceptions. We
20 try to change their misperceptions. So you could be
21 dismissive of gender dysphoria by saying it's just a
22 misperception of their body, and we have to correct
23 that misperception. I think that's --
24 Q. You think that's wrong? You disagree with
25 that?

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1 A. I disagree with it absolutely. They're both
2 very serious conditions, very serious conditions. But
3 the idea of an anorexic, trying to get her to gain
4 weight or lose it or whatever. These people are
5 suffering, suffering.
6 Q. Well, but I guess I'm having some difficulty
7 understanding where -- why you find those different.
8 Because at times you seem to suggest that surgical
9 treatment should not be provided for gender dysphoria
10 patients.
11 A. I've never said that.
12 Q. You're not saying that?
13 A. Absolutely not. I have no basis to say that.
14 I have no -- I think it's wrong, and there is no more
15 evidence for that than there is evidence that it is a
16 good thing to use.
17 There are too many people involved in it for
18 it to be, what, quackery? I don't buy that for a
19 second. What are these people just predators on these
20 poor transgender people? It's ridiculous.
21 Q. You cite, I believe, in the Gavin Grimm
22 Amicus brief, a report from the Hayes Directory.
23 A. Yes, sir.
24 Q. What is the Hayes Directory?
25 A. That was a document with some sort of summary

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1 on when certain treatments should be used with the
2 transgender population. I've read it. I've never seen
3 it before. There must have been a vague reference put
4 in there by Paul Hruz. He's the one that had it. I've
5 read it, but I actually don't know what the role is of
6 it. It was his citation, I can tell you that.
7 Q. So you're not supportive of this -- the use
8 of this particular document?
9 A. I don't remember exactly how -- I don't
10 remember exactly how it is used. I just like a plastic
11 surgeon that couldn't afford to buy a copy. I had to
12 buy one and send it to him.
13 Q. I don't understand. You're talking about
14 Dr. Schechter? You're saying that Dr. Schechter should
15 have bought it himself because he's a plastic surgeon?
16 A. Well, it's about plastic surgery. I had to
17 go out and buy it because he didn't have access. I did
18 not ask him to give me any of his references. And he
19 didn't even give me complete references. That is the
20 only thing I'm irritated by, is that some of his
21 references were incomplete and some were wrong.
22 It is common courtesy in the academic world
23 to give people complete references. Actually, usually,
24 when you have footnotes, there's a separate attached
25 reference list, which I thought there would be. Since

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1 he sent me 222 pages of material, I thought it would
2 include a reference list properly done.
3 Q. Are you aware that there are a number of
4 private insurance companies that have found that
5 surgical treatment should be covered for transgender
6 individuals?
7 MR. KILPATRICK: Objection; lacks foundation.
8 You can answer.
9 THE WITNESS: I'm sorry. Am I aware that --
10 could you repeat the question?
11 BY MR. KNIGHT:
12 Q. That a number of private insurance companies
13 have found that policies supporting coverage for
14 transgender people to have surgery, are -- should be --
15 I'm sorry.
16 A. No, I'm sorry. I can't follow. Are you
17 basically saying they pay for it?
18 Q. Yes.
19 A. Okay. No, I'm not surprised, but I wasn't --
20 don't know much about insurance.
21 It, again, goes back to your question. We
22 were talking about people who have severe dysphoria.
23 Do they just try other treatment? I don't know. Or do
24 they just blanketly offer it to anybody. I don't know
25 the answer. I don't know anything about it.

1 Q. So you are aware of the letter that was --
2 that 600 academics and clinicians signed on to
3 challenging the New Atlantis paper?
4 A. I don't know the number, but there was a
5 petition signed, published, yes, sir.
6 Q. And that -- that particular letter states
7 that the report's conclusions should not be viewed as a
8 source of scientific or medical justification to
9 support any legislation, judicial action, policymaking,
10 or clinical decision-making affecting the lives of LGBT
11 people or their families. Were you aware of that?
12 A. Aware of the sentence? I'm sorry. Was I
13 aware of that sentence?
14 Q. Yes.
15 A. I don't remember specifically, but I remember
16 the document, yes, sir.
17 Q. Do you recall that it said that: "We affirm
18 that the sexuality and gender report does not represent
19 prevailing expert consensus opinion about sexual
20 orientation or gender identity-related research or
21 clinical care"?
22 A. Yes, sir.
23 Q. Do you disagree with that?
24 A. Well, I wouldn't have written the article if
25 I agreed with it. Of course I disagree. If you look

1 at their credentials, they're mostly young assistant
2 professors in the social sciences or literature or
3 women's studies. There are one or two names that I do
4 respect, but the ones I do, I respect their opinion.
5 The majority of them are angry about the place we
6 published it.
7 There were very few attacks on the substance
8 of the document, mostly attacks on: A, the strange
9 bedfellows; and, B, was on ignoring certain papers. I
10 had to cut somewhere.
11 Q. So who are the clinicians and/or the
12 researchers who signed on to this letter whose opinions
13 you approve of.
14 A. Well, I approve all their opinions. I didn't
15 think most of them are scientists, but most important,
16 science isn't about opinions. Science is about facts.
17 And I know we live in an opinion-driven world, but the
18 fact is there is no study. And rather than beating me
19 up about the head for the fact there is no study, and
20 other experts disagree, I can go through the H Pylori
21 where the consensuses were wrong.
22 I hope their consensus is right. I hope all
23 transgender people are happy transgender, they're
24 well-adjusted, whatever treatment they get, and we
25 reduce the mental illness and the suicide. So I have

1 no desire to prove them wrong, but I was surprised at
2 the personal nature of the attacks versus citing what I
3 said that was wrong.
4 No one has pointed out the mistakes that I
5 made, and if you read -- it's extensive literature
6 review and the basic propositions are so simple. There
7 are no little boys born as little girls and little
8 girls born as -- I don't even know what it means. But
9 people were certainly mad.
10 Just as an aside, is it the 14th? Yesterday
11 in Australia somebody claimed to have found the process
12 that makes little boys and little girls. That's an
13 amazing discovery in science, just unbelievable. That
14 could be a real key to this thing, really. Every
15 embryo would be a little girl unless there is a
16 particular protein that intervenes. Whether it's true
17 or not, it is fantastic research.
18 Q. What are the best studies you think in terms
19 of showing the efficacy -- that get the closest to what
20 you think a study should be --
21 A. Well, unfortunately --
22 Q. -- in terms of showing the efficacy -- I'm
23 sorry. Let me just finish.
24 A. Yes.
25 Q. -- in terms of showing the efficacy of

1 surgery to treat gender dysphoria?
2 A. Unfortunately, nobody has asked me or paid
3 me. I've done most of this work on my own, my own
4 money to look at that issue. I'd love to review all
5 the studies out on the efficacy of surgery. I
6 collected a bunch of them. That is part of the
7 references I sent you, but it's so complicated in the
8 surgical part, that there are no studies that I would
9 endorse as really being definitive one way or the
10 other. I'd say we know very little. But I do believe
11 in the physician's creed: Above all do no harm.
12 And cutting a little boy's penis off just
13 seems to me a potential for disaster. Should he
14 want -- and they say only a small fraction change their
15 mind, but should he want to identify -- and by the way,
16 I find that strange, because I find children go back
17 and forth quite often, but it's probably not true for
18 adults.
19 Q. So are you saying you believe the standard of
20 care for children with gender dysphoria is to provide
21 genital surgery to them?
22 A. No, sir. Are there advocates for very early
23 gender -- yes, sir, there are advocates for very early
24 hormone blocking, and the earlier the gender surgery
25 done the better. There is paper after paper that

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1 states that. I believe Schechter wrote a paper that
2 says that.
3 Q. What paper is that?
4 A. Well, I don't remember. I have to go -- he's
5 written quite a bit. But the idea is, the earlier the
6 adjustment procedure, having the surgery, the younger
7 the patient is. I'm not talking about teens now, I'm
8 talking about 20s, 30s, 40s. It would seem to me more
9 likely to get a benefit out of a younger person than an
10 older person.
11 Q. So when you're talking about a little boy,
12 you're talking about a 20-year-old individual?
13 A. Who's the little boy?
14 Q. You said that you were objecting to having
15 surgery on a little boy. And I'm trying to
16 understand --
17 A. I apologize. I object to putting a little
18 boy in a gender-affirming environment where he knows
19 nothing else but that being raised as a little girl,
20 let's say. Let's say he's a biological boy, raised as
21 a little girl. Then he's on this developmental path,
22 puberty blocking, hormone addition, and then surgery,
23 that when he wakes up in 20 years after being on this
24 path -- but certainly the surgery doesn't occur in
25 adolescence. We're not that barbaric yet.

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1 MR. KILPATRICK: Do you mind if we go off the
2 record?
3 MR. KNIGHT: You want to take a break? Sure.
4 (Recess taken.)
5 BY MR. KNIGHT:
6 Q. In your report when you talk about safety,
7 were you talking -- were you opining about complication
8 rates in surgery for treatment of gender dysphoria?
9 A. No, sir.
10 Q. You were talking about safety in a more
11 general way, or you were talking about -- let me make
12 sure. You were not addressing complication rates
13 compared with respect to surgery; is that right,
14 comparative complication rates?
15 A. No, that is right.
16 Q. You were talking about surgery as opposed to
17 another form of treatment?
18 A. Well, the end point is dysphoria, yes, sir.
19 Q. Would you agree with Dr. Schechter that
20 surgery can be effective treatment for some individuals
21 with gender dysphoria?
22 A. I don't know that for sure, because I don't
23 have the experience. But I would be surprised if there
24 are no individuals for which it is good. I mean, could
25 there be an individual out there that's dysphoric and

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1 you could show they had plastic surgery and they have a
2 more positive outlook on life and they're less burdened
3 in their daily work, yes. I would not be surprised at
4 all.
5 Q. So your criticism or your opinions are
6 limited to the notion that the surgery -- or I'm sorry,
7 that the research does not show that this surgical
8 treatment is effective; is that -- am I understanding
9 correctly?
10 A. Well, it doesn't show it is safe and
11 effective, and effective also means cost effective
12 compared to other treatment. Make it simple. When you
13 talk about kidney transplant and whether it's a
14 successful transplant -- and I've worked on this
15 problem. You can take one of two measures. One is,
16 how well does the kidney work? And you get 99 percent
17 effective now. We have very high rates of successful
18 surgery.
19 The other measure is, how good is the quality
20 of life after a year? And I'm sorry to say the results
21 of surgery are much better than the results when you
22 measure quality of life. The fact is, the majority of
23 people with transplants don't die of the transplant,
24 they die of other diseases that occur in part because
25 their immune system is weakened.

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1 So the issue of how much did surgery, even
2 the most basic transplant, contribute to the increase
3 in quality of life, is what is critical. That is the
4 piece. That is the piece I'm missing that I would like
5 to see. But could there be -- are there likely to be
6 patients for which it has a positive impact equal of
7 life? Sure.
8 Q. And are you suggesting that kidney
9 transplants should not be provided for patients because
10 you don't think there's enough research to support it?
11 A. Well, no, there is quite a bit of research
12 now on quality of life. In the early days -- when did
13 it start, in the '80s? Starzl did it at Pittsburgh.
14 There wasn't enough research. But now we have
15 research, but we also know there are a lot of patients
16 we don't transplant that we used to transplant.
17 I was involved in a case whether or not a man
18 on death row should be provided a liver transplant.
19 And these are very complicated issues when it comes to
20 quality of life. But, yes, I would love to see a study
21 that shows that surgery improves quality of life for
22 transgender patients, and particularly with respect to
23 the risk of dysphoria.
24 Q. But my question was about transplants, and
25 maybe I'll ask kidney transplants. And I will ask it

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1 slightly differently than I did before.
2 Are you saying that in the early days when
3 the research was not there to show that a surgery
4 transplant was effective -- safe and effective
5 treatment for someone with kidney failure that that
6 should not have been provided?
7 A. Well, now we're getting confused. Because in
8 the kidney transplant your kidney is failing, you have
9 end-stage renal disease. The goal of the surgery is to
10 have a translated kidney. So that is a medical
11 procedure.
12 In this case, it's an indirect case, because
13 it is a surgical procedure, but the outcome, which is
14 what is critical in a clinical study, is the risk of
15 dysphoria, and do we have evidence that it reduces the
16 risk of dysphoria?
17 So it is a very good point you are making.
18 When people got the kidney transplant, if we could show
19 they now have an effective kidney, that's all -- that's
20 what we asked for in the early days. It took a long
21 time to show improvement of quality of life. Maybe
22 that's what we do here. Maybe that's what we do here.
23 I don't know. I don't know.
24 Q. Isn't that what the studies show here with
25 respect to gender dysphoria, that surgery improves

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1 quality of life for individuals with gender dysphoria?
2 A. Actually, the studies are silly. They show
3 that you spent $50,000, people have a better body
4 image. You spend $50,000 on me, I'll have a better
5 body image too.
6 I go back. Dysphoria is a serious mental
7 illness. Does anyone show that the incidence, the
8 prevalence, or the risk of dysphoric behavior is
9 reduced, the answer is no, and that is what brothers
10 me.
11 Q. Well, we looked earlier at one of the studies
12 you had cited. Let me just find my reference to that.
13 So the Murad story that you cited in the New
14 Atlantis paper?
15 A. Where are you, sir.
16 Q. Where in the New Atlantis did you cite it?
17 A. Yes, sir. Oh, I thought that is what you
18 were reading from.
19 Q. I'm not. I was going to ask -- so I'm
20 reading from the study itself. The Murad study
21 concludes that gender reassignment with the use of
22 hormone therapies -- I'm sorry. With the use of
23 hormone therapies were associated with the improvements
24 in gender dysphoria. I thought you were saying --
25 trying to tell me that there were no studies showing

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1 that hormone therapy improves people's experience with
2 gender dysphoria?
3 A. I didn't say that. I said there is not
4 sufficient evidence at a group level that it's an
5 effective treatment, meaning the percentage of
6 people -- I don't remember the Murad study right off
7 the top of my head, but I'm 99 percent sure it did not
8 talk about the incidence of gender dysphoria or show
9 the decreases. I will go back to check the study to be
10 sure.
11 (Exhibit 7 was marked for identification.)
12 MR. KILPATRICK: I'm sorry, Jim, did we ever
13 mark the New Atlantis? Yes? What number was that? 5.
14 Okay, thank you.
15 BY MR. KNIGHT:
16 Q. I just want to direct you to couple of the
17 studies that she mentions here.
18 So the De Cuypere study -- I'm looking at her
19 reference list on page 38.
20 Are you familiar with that study?
21 A. Yes, sir.
22 Q. And does that show the efficacy -- does that
23 study show the efficacy of surgery as treatment for
24 gender dysphoria?
25 A. I don't remember specifically. I mean, I

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1 knew of the study. There are so many studies here, I
2 would have to go back and take a look at it. I do
3 remember that they have some statements about cause and
4 effect, whether it is actually the percent that
5 dysphoria -- I don't think it is, but I want to make
6 sure.
7 Q. So I guess what I am trying to get at is, in
8 general, what is it you think is wrong with these --
9 all these studies that have been done to show that
10 surgery and hormone therapy are effective treatment for
11 gender dysphoria?
12 A. First of all, the investigators clearly are
13 not equipoise. They're not equal between the
14 hypothesis that works and that doesn't. The people
15 that published this can be on one side or the other,
16 but it's clear, in my opinion, their analysis follows,
17 at least in part, from their prior beliefs about it.
18 Second of all --
19 Q. I'm sorry. How do you -- why do you come to
20 that conclusion?
21 A. Because they'll have statements -- for
22 example, I mean, she has a statement that transitioning
23 is medically necessary. I believe she has the
24 statement that transition is medically necessary. What
25 do you mean to transition? What is it that gets

1 transitioned? That's an opinion piece. What does it
2 mean to even transition? You are a transgender woman.
3 Does "transition" mean to transition your appearance?
4 Then that's an empirical question. The most important
5 question is the idea that you feel good about yourself.
6 Like the goat gonads. Once you have a third
7 gonad into your testicle sack, you feel empowered
8 sexually. Is not surprising at all. It's called the
9 theory of sum cost to economists.
10 So they don't actually measure the gender
11 dysphoria, they don't actually break it down into the
12 incident rate, and they don't show, which is clinical
13 trials 101, a significant difference between people who
14 get the treatment and people who don't in terms of risk
15 of being gender dysphoric. So as they improve body
16 image, feel better about themselves, more positive
17 outlook in life, those are fine. You know, they may be
18 fine for surgery. They aren't fine in psychiatry.
19 The question is, are these people having
20 serious life adjustment problems, and are those
21 problems alleviated by the surgery? That is all I want
22 to say on that.
23 Q. But you don't think there is any study that
24 shows that?
25 A. I could not find a study that shows that; not

1 even close.
2 Q. But you said that these researchers -- and
3 I'm asking about all of these researchers -- who find
4 that their research shows that the treatment is
5 effective, you are saying that the problem is that they
6 are not on equipoise?
7 A. Correct.
8 Q. And what does that mean?
9 A. Equipoise, meaning they have no prior
10 hypothesis about whether it works or not. Because if
11 you believe it works, then you should not be giving
12 people an alternative treatment. You're supposed to be
13 neutral. This is science. There isn't advocacy.
14 We're not selling medication. This is science. You
15 should be equipoise between the two hypotheses that it
16 works or it doesn't.
17 But I didn't mean to say there's bias on one
18 side. There is bias on the other side. People who
19 opposed this. No matter what, they oppose it. And
20 that may be fine too, but that's not what science is
21 about. Science is about testing empirical
22 propositions. And I want to test that this works for
23 these people. That is all I want.
24 Q. And you are saying all of these researchers
25 are -- have a -- I guess I'm trying to understand.

1 You're saying they all have a position about whether
2 it's effective prior to doing the research?
3 A. Yes. Just read the Hopkins thing. They're
4 advocates one way or the other way. I mean, the way I
5 was treated at Hopkins by people, including the dean,
6 is if I -- I'm going to finish this. If I had not been
7 a very senior person, it would have ended my career.
8 I would tell any young person who wants to be
9 an independent medical researcher, don't work on this
10 topic, because this topic will destroy your career.
11 Because when a topic becomes so political, we have
12 people on one side, people on the other, then all we do
13 is talk past each other. We use all sorts of
14 inflammatory language.
15 And the question ought to be, what really
16 works for these people? And I hope surgery really
17 works for them, but, boy, I will tell you with all the
18 patients they've had and all they've done, not to be
19 able to demonstrate any stronger than this makes me
20 really worried. When they have very strong studies
21 showing breast augmentation, tummy tucks, face lifts,
22 and all that give people a much more positive image of
23 themselves.
24 I don't see the same with the transgender.
25 And one of the reasons I don't is these are very

1 troubled people. Are they less -- significantly less
2 troubled afterwards? I hope so, but I don't see the
3 results.
4 And by the way, when the results are not
5 positive, like the suicide rates stay high, they say,
6 well, that is social stigma. Budge just got a whole
7 bunch of stuff on social stigma. Some of the arguments
8 that the reason they don't do as well is because of
9 social stigma. Social stigma is there. But the
10 question is, how do you function in the world you have
11 around you? I'd like these treatments to work, very
12 much.
13 Q. Would you agree that many of these studies
14 show a reduced suicide rate among people who have had
15 the treatment as opposed to those who have not?
16 A. Well, I have seen studies that claim that.
17 But I want to say that being in a supportive
18 environment and doing these other things seems to have
19 an effect on significantly decreasing the suicide rate.
20 We're talking about a suicide rate, by my memory, that
21 is 15, 20 times as high as the suicide rate. So if you
22 take that down by a few percentage, then that would be
23 positive evidence that it makes a difference.
24 Is that cost effective versus other
25 treatment? Is the control group correctly done? Would

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1 it be true if you just gave them an active control of
2 time and attention? I don't know, because particularly
3 in psychiatry, placebos are so powerful. Placebos are
4 so powerful. The fact that you're having a surgery and
5 people are fussing over you and they're trying to help
6 you, does that produce the positive result? I don't
7 know. I want to know. I want to know. I just truly
8 don't know.
9 Q. So the researcher that would be able to do
10 this would be, from what you're telling me, would have
11 to be someone who is completely removed from treatment
12 with respect to people with gender dysphoria.
13 Is that what you are saying?
14 A. They could be treating. They'd have to be
15 open minded. I doubt they could be part of a gender
16 mill, which I'll encourage some of these patients. And
17 I go to their lectures. They've never met a child who
18 comes in that wasn't having some sort of sexual --
19 they're transgender. Two years old, three years old,
20 they're transgender. And they put them in an
21 environment that propagandizes them. Particularly the
22 parents.
23 The parents I'm really concerned. I have
24 seen -- I believe he has triplets, let me say this.
25 Parents of two boys, and mom tells me when they came

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1 out, it was clear that one of the twins was a male and
2 the other was a female.
3 I said, At what age? At three days. I knew
4 that was a female at three days. Yes, I've seen these
5 patients. Three days. She wants a girl and she's
6 going to have a little girl. There's nothing wrong
7 with this. The point is, do these treatments work?
8 All I want to know is what works.
9 Q. So you're saying every clinician treating
10 gender dysphoria tells everyone who walks in that they
11 have gender dysphoria?
12 Is that what you are saying?
13 A. I've explained to you that people that come
14 into the gender clinic that show the condition, A, seem
15 to be told they have gender dysphoria and are
16 immediately put in a supportive environment. If there
17 are others that that does not happen for, in other
18 words, we say, you're struggling with your gender
19 identity and that's fine. We don't think you need any
20 treatment. You are not dysphoric. Where is the
21 publication on those patients?
22 I'm telling you I see a one-to-one
23 correspondence in the literature between being
24 transgender and being gender dysphoric. So we got rid
25 of the label of gender identity disorder, because we

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1 don't want the stigma of being a disease, but on the
2 other hand, if you have this condition, you do have
3 this condition, and we'll treat this condition.
4 Q. So you are saying all the literature treats
5 every transgender person as someone with gender
6 dysphoria?
7 A. Not every literature. I believe these gender
8 mills run by surgeons that make their money off
9 transgender surgery. I'm not saying consciously. I
10 think they have an unconscious bias to believe every
11 patient that comes in has gender dysphoria. Most of
12 them would not know gender dysphoria if it bit them in
13 the ass. They didn't become plastic surgeons to worry
14 about people feelings. They became plastic surgeons to
15 do surgery.
16 I teach surgeons. I know who becomes a
17 surgeon, particularly orthopedic and plastic surgery.
18 So do they think they're doing well? Yes. But can
19 they demonstrate it? No. All I want them to do is
20 demonstrate it. That's all I want.
21 Q. Do you understand that surgery is not
22 provided by -- to a transgender individual without a
23 clinician who is trained as a mental health
24 practitioner to treat gender dysphoria?
25 A. And I'm telling you right here and now it's a

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1 joke. They have a master's level clinical psychologist
2 at Johns Hopkins that -- talking to great big surgeons.
3 And I'd be very interested in seeing their data on how
4 many people they don't have gender dysphoria.
5 Because these people are struggling, and they
6 see they're struggling. That's not enough. That's not
7 enough. Do they have major depressive disorder? Can
8 they not get of out of bed this morning? What is their
9 dysfunction? Then let's go after that dysfunction. If
10 that requires hormone, if that requires surgery, that's
11 fine, but let's get the evidence that it works. That
12 is all I'm asking. Is it that great? That's all I
13 want.
14 MR. KNIGHT: Let's take about a five-minute
15 break.
16 MR. KILPATRICK: Okay.
17 (Recess taken.)
18 BY MR. KNIGHT:
19 Q. When we broke, Dr. Mayer, I think you were
20 talking about the research, and I think you were
21 telling me that researchers -- let me just -- I think
22 you were talking about clinicians and that clinicians
23 provide or make a gender dysphoria diagnosis for
24 everyone who walks into the gender dysphoria clinic.
25 Did I misunderstand what you were saying?

1 A. I don't know if it's everyone that walks in.
2 I tried to get evidence on how many transgenders they
3 do not believe are dysphoric, and I have not been able
4 to get that. I've not been able. You'd think someone
5 would publish it somewhere unless people believe that
6 if you're transgender you're automatically gender
7 dysphoria, which really just gives gender identity
8 disorder a new name.
9 Q. Well, do you have any basis for this -- your
10 position that everyone is being diagnosed with gender
11 dysphoria?
12 A. No, I don't believe everybody's being
13 diagnosed. I think the bulk is. Or where is the
14 group -- where are the statistics on the group that are
15 not being identified. Let me say it better: I have no
16 access to any data on people that are found to be
17 transgender and not found to be gender dysphoria. I
18 would like to know what happens to them. How well are
19 they adjusted? How will they go on in life? If we're
20 serious about this condition, we have to look at the
21 people who are transgender.
22 And I do believe some of the advocates
23 believe every transgender has gender dysphoria, because
24 it's the struggle they have with the gender that is
25 opposite their sex. And that is not fair, because we

1 worked too hard to get rid of that diagnosis.
2 Q. But, again, I'm asking, do you have any basis
3 for saying that everyone who --
4 A. I didn't say it, so I can't have a basis for
5 it.
6 Q. Okay, well --
7 A. You've repeated it three times. Please don't
8 repeat it a fourth, because I didn't say it. If you
9 want to ask me if I said something, please repeat
10 something I said or have her read it back. Thank you.
11 I didn't say it. I didn't say anything about
12 every transgender being dysphoric.
13 Q. I believe what you said was most gender
14 persons with gender dysphoria.
15 A. I don't even know that. I know I have not
16 been able to get any data, and nobody is publishing on
17 the -- you find me a publication on well-adjusted
18 transgenders. I have tried to find it. Could there be
19 a community somewhere in Greenland of perfectly
20 well-adjusted transgenders? Why not? Why in the world
21 would they need any surgery? Why would they need any
22 treatment?
23 The idea was, get the illness off the back of
24 the transgender and say, Look, you're perfectly fine as
25 people. I truly believe that in my heart, but if

1 you're struggling so badly that you can't function,
2 then we have to do something about that struggle. It's
3 debilitating you. Might that be hormone therapy?
4 Might that be surgery? Might that be talk therapy?
5 Might it be a combination? Yes.
6 I want the answers to those questions, but,
7 yes, I have asked for information and data, including
8 from advocates, including from Bailey who is a
9 well-known sociologist in this, on where are the
10 transgender people who are well-adjusted? And I don't
11 see any papers about it. Is there an equivalence? And
12 I don't see any reports on them.
13 Q. So when you were talking about the -- what
14 you were pointing to in terms of the basis is the
15 absence of studies.
16 Is that what I'm understanding?
17 A. Absolutely. I'm here to say that there's an
18 absence, not only of studies, but there's an absence of
19 evidence. We need evidence.
20 Q. What other evidence would there be other than
21 studies and clinical experience?
22 A. There would be open -- let me say, there is
23 one gender clinic in UK, they're very open about the
24 data. They're open about how many people come in.
25 They're open about how many go on to different

1 procedures. They're very open with the data. Our
2 centers are not open with the data. I've written to
3 the centers. I've gotten no response.
4 I just want a breakdown. I'm asking them for
5 a breakdown of their patients. What else can I do?
6 Nobody pays me to do any of this stuff.
7 It seems to me if you go back to do no harm,
8 you have to have evidence that treatment is effective
9 and safe as a treatment for gender dysphoria. That
10 means the incidence or prevalence of gender dysphoria
11 is decreased by application of this treatment. I don't
12 see evidence to that.
13 Q. I believe you said earlier that the
14 researchers in this area are not at equipoise.
15 (Reporter clarification.)
16 BY MR. KNIGHT:
17 Q. And what is your basis for that statement?
18 A. Well, because it is such a political area,
19 the only people who write in this are people who do so
20 at tremendous professional risk from both sides.
21 Whenever an area becomes this political, like gun
22 control or anything, abortion, you try to be an
23 independent researcher at your own risk. I never would
24 have done this 10 years ago. I never would have
25 written with Paul McHugh 10 years ago. I knew what the

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1 blowback would be.
2 And, by the way, he is the former chair for
3 25 years, the most senior psychiatrist, and Hopkins, in
4 fact, tried to fire him. Tried to get rid of a tenured
5 professor because of his position on these issues.
6 So we have advocates one way that say it's
7 immoral, it's against their religion. We have the
8 advocates the other way who say, these people are
9 suffering, we have to give them A, B, C, and D, and
10 reduce that suffering. And I'm in the middle. I'm
11 sure there are other people too. I just want to find
12 the evidence.
13 Why not have a board, an independent board,
14 you send these patients to made up of people who have
15 no dog in the fight, and they review the reports of why
16 you believe this patient deserves or needs this surgery
17 and let that board decide? We do that in a lot of
18 cases, including burn surgery.
19 Q. I don't understand. What kind of board are
20 you talking about?
21 A. A hospital can have a board or an insurance
22 can have a board like an appeal board. You come in and
23 you state your case. So, for example, they won't give
24 you -- I just worked on one. They wouldn't give
25 someone testosterone because they thought he was using

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1 it for sexual enhancement. The board simply looked at
2 his T level. His testosterone was three standard
3 deviation, and they decided to do it.
4 So if you have a specific patient where you
5 believe that this could be of benefit, and you have
6 evidence to that, then why not approve it for that
7 patient?
8 Somehow you seem negative against that. I'm
9 not sure why you'd be -- I can't imagine why you would
10 be negative.
11 Q. Well, I think that's exactly what we are
12 talking about in this case, which is that decisions
13 about whether these treatments should be provided
14 should be decided on an individualized basis.
15 A. Yes, but I don't believe it should be decided
16 by anyone who makes a dime out of that case. I feel
17 that very strongly. He or she should be allowed to
18 testify -- the reason academic physicians are so
19 important is because we don't have a clinical practice.
20 My reputation in 45 -- I've been a tenured professor
21 for 45 years -- rests on my opinion, my prestige, my
22 honesty, my ethics. People trust me. I believe that.
23 They trust me not to have a dog in any of these fights.
24 Have people like that. I've worked for Jehovah's
25 Witnesses whether to give their child a transfusion.

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1 When you say that's what this case is about,
2 I don't know what this case is about. No one told me
3 what the case is. Maybe I should have known what the
4 case is about. I don't know what the case is about. I
5 was asked to look at one report and comment on whether
6 or not there is sufficient evidence to show that these
7 are safe and effective for treatment of gender
8 dysphoria.
9 Q. So you really don't understand that this is a
10 case about denying coverage for treatment for people
11 who are transgender, is that what you're telling me?
12 A. First of all, they can't be treated for being
13 transgender, because transgender is not a disorder, so
14 that can't be the issue of the case. If you mean
15 they're being denied treatment for gender dysphoria --
16 Q. That is what I mean.
17 A. Well, I've read it in the complaint. I've
18 read it in Budge, but compared to most cases I'm on,
19 I've read virtually nothing about these two women.
20 Budge -- and I'm sorry I don't want to tell you, but
21 Budge doesn't rate very high in my impression of
22 medical expertise. So the fact of the matter is, I
23 don't know much about these -- about these two women,
24 and I certainly don't know what decisions are made on
25 their behalf. I'm not sure how it would affect my

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1 opinion.
2 Q. I've tried to understand the issues with
3 respect to the research that is out there, and I'm
4 still -- you've said that these investigators -- one
5 thing you've told me is that you believe these
6 investigators who have done the research in this area
7 are not in equipoise.
8 What are the other problems with the surveys?
9 A. The fact is, the area is so political that --
10 you know that. The academic leads their advocates one
11 way, advocates the other way, and they're fighting
12 about some greater grand principle of -- I don't
13 exactly know. Is it a religious principle or something
14 like that? I want to take care of patients, so it's a
15 problem when something gets this political, it's hard
16 to find people who are independent.
17 So you have a treating physician. And we
18 used to call this -- by the way, I think the term is
19 gone -- but compassionate care. And as director of
20 research, I often passed on compassionate care. That
21 is where you have a treatment that's still in research,
22 and you apply -- the rules are different now. But you
23 apply to use on a patient for which it is not
24 indicated, it goes to a board, and the board decides
25 whether it should be used on that patient. That board

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1 has got to be independent. My guess is there are
2 patients for which it would be used. And my guess is
3 there are patients for which they'll say there is no
4 adjustment in life severe enough that they'll need to
5 have this treatment.
6 Q. I guess I'm trying to -- if you were saying
7 that this issue is so politicized that -- you seem to
8 be suggesting that research in this area is not
9 possible.
10 Is that what you're saying?
11 A. I worry -- I worry about it. I do worry
12 about that. I hope it's not true, but I worry about
13 this country is so polarized and so many different
14 views. I mean, take it that there are people who not
15 only hate the ACLU, but when they find out I'm a member
16 of the ACLU, they want to kill me and shoot me. How
17 can you be part of that organization? I don't
18 understand, I really don't understand it.
19 Why are we so opinionated that it drives our
20 facts? There are people out there suffering. What
21 works for these people? How do we demonstrate? I
22 would be better at the equipoise if I could see a spark
23 of curiosity in people like this doctor. Is he curious
24 about whether it works? No, he's convinced it works.
25 It works in every case. It's wonderful it works.

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1 Nonsense.
2 Q. And that is your opinion about all of the
3 researchers --
4 A. No, it's not. I don't know all of the
5 researchers. I can talk -- I like to make general
6 characterizations as a statistician. You're very
7 concrete and like to get the -- kind of like an
8 engineer. Specifically I don't know all the people
9 doing research, but I can tell you being beat about the
10 head and neck by people sending in 500 people and
11 writing a letter to the president of the university,
12 and requesting the dean fire me. You'd never survive
13 that as a young professor. Never.
14 So would I -- if someone came to me, like me,
15 and I'm thinking my wife died, left a trust fund of
16 endowing a physician at Hopkins or Harvard to study
17 this issue, it would be very hard to fill that
18 position, even with support, because it is so
19 political.
20 And part of that is people view it as a civil
21 rights issue, and that is very important. Because once
22 you view it as a civil rights issue, you appear to be
23 on a side that is against people's rights.
24 MR. KNIGHT: I think I'm done.
25 MR. KILPATRICK: I don't have any questions.

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1 MR. KNIGHT: Okay. Thank you, sir.
2 (The videotaped deposition of
3 LAWRENCE S. MAYER concluded at 3:51 p.m.)
4
5
6
7
8
9
10
11
12 I, LAWRENCE S. MAYER, do hereby declare under the
13 penalty of perjury that I have read the foregoing
14 transcript; that I have made any corrections as appear
15 noted, in ink, initialed by me, or attached hereto;
16 that my testimony as contained herein, as corrected, is
17 true and correct.
18 EXECUTED this _____ day of ________________,
19 20____, at ________________________, ________________.
20 (City) (State)
21
22
23 ____________________________
LAWRENCE S. MAYER
24
25

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1 I, the undersigned, a Certified Shorthand
2 Reporter of the State of California, do hereby certify:
3 That the foregoing proceedings were taken
4 before me at the time and place herein set forth; that
5 any witnesses in the foregoing proceedings, prior to
6 testifying, were duly sworn; that a verbatim record of
7 the proceedings was made by me using machine shorthand
8 which was thereafter transcribed under my direction;
9 that the foregoing transcript is a true record of the
10 testimony given.
11 Further, that if the foregoing pertains to
12 the original transcript of a deposition in a Federal
13 Case, before completion of the proceedings, review of
14 the transcript [X] was [ ] was not requested.
15 I further certify I am neither financially
16 interested in the action nor a relative or employee of
17 any attorney of party to this action.
18 IN WITNESS WHEREOF, I have this date
19 subscribed my name.
20 Dated: JUNE 21, 2018
21
22
23 ____________________________
24 PATRICIA Y. SCHULER
25 CSR NO. 11949

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Lawrence S. Mayer
22
Subscribed and sworn to before me
23
this ____ day of ___________, 20__.
24
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25 Notary Public

A

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