Boyden vs State of Wisconsin Dept of Employee Trust Fund

17-CV-264

Deposition of: Loren Schechter, M.D.

Taken on: August 23, 2018

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IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WISCONSIN

ALINA BOYDEN and SHANNON ANDREWS,	)	
Plaintiffs,	)	
vs	)	No. 17-CV-0264
STATE OF WISCONSIN DEPARTMENT OF EMPLOYEE TRUST FUNDS, et al.,	)	
Defendants.	)	

The deposition of LOREN SCHECHTER, M.D., called by the Defendants for examination, pursuant to notice and pursuant to the Federal Rules of Civil Procedure for the United States District Courts pertaining to the taking of depositions, taken before Nina Dudziak, Certified Shorthand Reporter and Notary Public, at 6201 North Broadway, Chicago, Illinois, commencing at 9:30 a.m. on the 23rd day of August, 2018.

APPEARANCES:

ROGER BALDWIN FOUNDATION OF AMERICAN CIVIL LIBERTIES UNION OF ILLINOIS
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On behalf of the Plaintiffs;

STATE OF WISCONSIN
DEPARTMENT OF JUSTICE
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On behalf of the Defendants.

* * * * * *

I N D E X

E X H I B I T S

(Witness sworn.)

WHEREUPON:

LOREN SCHECHTER, M.D.,

called as a witness herein, having been first duly sworn, was examined and testified as follows:

EXAMINATION

BY MR. KILPATRICK:

Q. Good morning. Could you please state and spell your name for the record, please.

A. Loren, L-O-R-E-N, last name Schechter, S-C-H-E-C-H-T-E-R.

Q. Dr. Schechter, my name is Steven Kilpatrick. I am an assistant attorney general with the Wisconsin Department of Justice representing the defendants in the Boyden versus Department of Employee Trust Funds case. I'm going to be taking your deposition today.

Have you ever been deposed before?

A. I have.

Q. Okay. Great. I will quickly review the rules that I have. I ask that you speak clearly so that the court reporter can understand you. When I'm asking a question, wait until I'm done asking the question so we don't talk over each other. Answer yes or no verbally rather than head nods. And if you do need a break, feel

free to ask and we can break, but if I do pose a question, I ask that you answer the question before asking for a break. Do you understand?

A. Yes. Thanks.

Q. Great.

Is there any reason why you cannot truthfully answer any questions posed by me today?

A. Not to my knowledge.

Q. Great.

Dr. Schechter, you are the same Dr. Schechter retained by the plaintiffs in the Boyden litigation, correct?

A. Yes.

Q. Great.

Other than medical malpractice cases, have you ever been retained as an expert witness?

A. I have.

Q. What cases?

A. On behalf of the ACLU for a case in South Dakota.

Q. What case is that?

A. I'm blanking on the name, the name of the plaintiff. I was just deposed two weeks ago perhaps.

Q. Do you know whether it was a federal case or a

state court case?
A. Federal.
Q. Federal case.
And what was the case about?
A. Case regarding coverage for gender-related surgeries.
I was also retained in another case involving Wisconsin, also a federal case, involving coverage related to gender-related surgeries.
Q. Is that the Flack case?
A. The attorney I had worked with is Wordenski.
Q. I'm the attorney on that as well. Sorry.
A. I have -- There may be other treating physician cases where I have been deposed or involved as well.
Q. But I'm more concerned about being an expert witness. Those cases in South Dakota and the other in Wisconsin are the only expert witness cases -- cases in which you have been an expert witness that you have been involved in other than medical malpractice?
A. No. There was -- There have been other medical-related cases not involving medical malpractice where I have been involved in. I was also deposed in 2006 in the Kosilek, K-O-S-I-L-E-K, case. Again,

involving coverage related to -- I think 2006. May have been 2007. I don't remember.
Q. What court was that in, if you recall?
A. I believe the case was out of Massachusetts. I was deposed by phone locally.
Q. In the Kosilek case, excuse me, were you retained by the plaintiffs?
A. I was retained presumably by the law firm representing the plaintiff, yes.
Q. And the same goes for the suit brought by the ACLU in South Dakota?
A. Yes.
Q. The suit in South Dakota, are you aware whether the issue regarding gender-confirmation surgery deals with an employee state coverage exclusion?
A. I'm aware that it deals with an exclusion. I don't know specifically the nature of employment.
Q. And if you recall, what was the issue in the Kosilek case in Massachusetts?
A. It was pertaining to coverage for, I believe, vaginoplasty for the plaintiff who was incarcerated.
Q. If you recall, in the Kosilek case, what was your opinion?
A. I believe that the procedure, if I'm

remembering correctly, was medically necessary.
Q. That brings up a great topic. Medical necessity, you're aware that medical necessity is a term that is used by insurance companies?
A. Yes.
Q. It appears that it's a term used by medical providers?
A. I would say more often insurance companies.
Q. Okay. But if you were to give an opinion that a procedure is medically necessary for a patient, what do you mean?
A. To me it would mean that -- medical necessity would mean that the patient would benefit from the procedure -- or treatment. I should say treatment.
Q. When you say benefit, do you mean -- well, what do you mean by benefit?
A. That there would be positive impact of the treatment or the goal would be a positive impact of the treatment.
Q. You perform cosmetic surgery, correct?
A. I do.
Q. Would any cosmetic surgery be medically necessary, in your opinion?
A. So I think it would depend upon the given

procedure and typically cosmetic procedures would be self pay, not paid for by a third party. Insurance company, for example.
Q. We will get to those a little later.
Before we get any further, I want to just ask you some basic questions about your past, your experience and schooling.
You obtained a bachelor of science degree from University of Michigan, correct?
A. I did.
Q. And you obtained a medical degree from the University of Chicago Pritzker School of Medicine, correct?
A. Yes.
Q. After that, could you describe your postgraduate training including residency and fellowships chronologically from medical school graduation.
A. Yes. So following graduation from medical school, I spent three years in general surgery training, and all of these were also at the University of Chicago hospitals. So three years in general surgery, two years in plastic surgery residency, and then another year as a fellow in reconstructive microsurgery.

Q. During that time, did you perform any gender-confirming surgeries on transgender persons suffering from gender dysphoria?

A. I would say I was involved in the care as I was still in training, but yes, was involved in surgical procedures for gender-related surgeries.

Q. You are a board-certified plastic surgeon, correct?

A. Yes.

Q. Are you a psychiatrist?

A. No.

Q. Psychologist?

A. No.

Q. A counselor of any sort?

A. No.

Q. You are a founding member and president-elect of the American Society of Gender Surgeons, correct?

A. Yes.

Q. Could you please briefly describe this organization.

A. Sure. It's an organization that was founded within probably the last two years or so that is a multidisciplinary organization involving primarily surgeons, primarily American surgeons, although we also

have international members, whose interests are related to gender-related surgical procedures and care of transgender individuals.

Q. Is this organization related at all to I believe it's called the American Society of Plastic Surgeons?

A. No relationship to that, although some members -- may be joint members of each of the groups.

Q. Would that be you?

A. Myself and others.

Q. Okay. And it's correct that you are a founding member?

A. Yes.

Q. So just tell me why did you found it.

A. The increasing need to have collaboration between surgeons of varying disciplines. Most of the U.S. surgical societies that we have are based upon individual specialties, so one of the goals of this is to allow collaboration between various surgical specialties.

Q. Is there any requirement to become a member?

A. There are.

Q. What are those?

A. I don't remember off the top of my head.

Q. For example, do you have to be a surgeon?

A. Most likely to be a full member, there may be categories, different categories that allow nonsurgeons to be members in some fashion.

Q. Do you know if you need to be board-certified?

A. Most likely either board-certified or board-eligible.

Q. And could you just explain what the words in the title mean, and I will quote, gender surgeons?

A. Yes. So it is -- ASGS, as it's known, although the title says American, there are international members. It is a group of surgeons with mutual interests in gender-related surgeries and care of transgender individuals.

Q. So when you say gender-related surgery, does that mean that surgery is performed on transgender persons?

A. Yes, is one aspect of it. But that may also include individuals who are gender diverse. It may also include nontransgender individuals upon whom some form of either genitourinary surgery might be performed, so for example, congenital issues, oncological issues, traumatic issues and that would also extend beyond genitourinary to breast surgery, chest surgery, facial

surgery, body contouring.

Q. You are also on the board of directors of WPATH, correct?

A. Correct.

Q. And WPATH issues standards of care, correct?

A. I would say it helps develop standards of care. A document referred to as the standards of care.

Q. Those are guidelines for health care professionals, correct?

A. Yes.

Q. And did you author any sections of the document?

A. Yes.

Q. Which one?

A. I believe it was the relationship of the surgeon with the mental health professional and the physician prescribing hormones. And when I say author, probably better to refer to as contributor as it was a collaborative document.

Q. Did you issue any journal articles on a similar topic?

A. I believe so.

Q. Okay. It says here in your CV that you authored, and I will quote, "The Surgeon's Relationship

With the Physician Prescribing Hormones and the Mental Health Professional Review for Version 7 of the World Professional Association of Transgender Health Standards of Care."

MR. KNIGHT: If you are going to ask him about the CV, if you could just show him a copy of it so he could take a look.

MR. KILPATRICK: Sure. I will do that.

BY MR. KILPATRICK:

Q. First, just quickly, I need to understand, this was referred to as published in the International Journal of Transgenderism. Is that different than WPATH standards of care?

A. Yes.

Q. Okay.

MR. KILPATRICK: I don't have -- I didn't plan on entering exhibit --

MR. KNIGHT: If you are not going to ask any more questions about it -- I thought you were going to ask some specifics about the journal, just be able to see it. If you are not, that's fine.

MR. KILPATRICK: Okay.

BY MR. KILPATRICK:

Q. I just wanted to make sure that there was a

journal article separate from the WPATH standards of care document?

A. That's correct.

Q. Okay. Great.

I have another question about one of the organizations that you are a member of. You are chair of the board of governors of PlastyPAC; is that correct?

A. Yes.

Q. What is PlastyPAC?

A. PlastyPAC is the political action committee that advocates on behalf of plastic surgeons who are members of the American Society of Plastic Surgeons. And I'm outgoing chair; I think I will be done after our annual meeting, I believe, in October.

Q. Do you make any contributions to PlastyPAC?

A. I do.

Q. Do you solicit contributions?

A. I do.

Q. From whom?

A. Members of the American Society of Plastic Surgeons.

Q. I'm going to give you your expert witness report that you filed in the Boyden litigation without the exhibits.

A. Okay.

Q. Just for you to review.

A. Okay.

Q. Would you agree that that is a correct copy of the expert witness report that you submitted?

A. Appears to be.

MR. KILPATRICK: Can we have it marked as an exhibit, please.

(Sechechter Deposition Exhibit No. 1 marked as requested.)

BY MR. KILPATRICK:

Q. Dr. Schechter, if you could take a look on page 1, footnote 1, you state that you perform gender-confirmation or gender-affirming surgeries, correct?

A. Yes.

Q. Could you tell me why you decided to use those terms as opposed to other terms such as sex reassignment surgery?

A. Sure. There has been an evolution in terminology. Early terms were -- included were things like sex change or sex reassignment surgery. And I don't believe that that really encompasses the essence of the procedure. Either gender-confirming or

gender-affirming I believe is more appropriate in that it brings someone's body into alignment with their identity.

Q. You perform gender-confirmation surgeries on transgender persons who suffer from gender dysphoria, correct?

A. I perform surgery on transgender individuals. I perform on gender nonconforming individuals, gender fluid individuals, many of whom may have gender dysphoria.

Q. I'd like to ask you, so we are on the same page, how do you define someone who is transgender?

A. Transgender individual is someone whose gender identity is not consistent with their anatomy.

Q. You said you also perform surgeries on nonconforming individuals?

A. Yes.

Q. How do you define that?

A. Those are individuals who may or may not identify in the binary as either male or female.

Q. Is that usually a congenital issue?

A. Well, if congenital do you mean is it innate, I would say that yes, one's gender identity is innate.

Q. So do you believe that there is a difference

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between sex and gender?
A. I believe that sex typically refers to one's -- is typically assigned at birth and is often based upon one's anatomy. However, I also consider identity, gender identity to be a component of the determination of sex.
Q. And has that view that gender identity is a component of the determination of sex always been your view or has it evolved over the years?
A. I would say my views have probably evolved based on ongoing education and experience in the field.
Q. You perform gender-confirming surgeries that follow the WPATH standards of care; is that correct?
A. I would say that I practice consistent with the WPATH standards of care which allow for the flexible application of those guidelines.
Q. So there are standards of care within WPATH that specifically concern transgender patients suffering from gender dysphoria, correct?
A. Can you repeat that.
Q. Are there standards of care within WPATH that focus on transgender persons suffering from gender dysphoria?
A. So there are guidelines within the standards

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of care that refer to treatment options including surgery for transgender individuals.
Q. So have you performed gender-confirming surgeries on transgender patients who do not suffer from gender dysphoria?
A. I have most certainly performed surgeries on transgender individuals who do not have gender dysphoria.
Q. Before I get to more questions about that, how do you define gender dysphoria or what definition do you use?
A. It is the discomfort and/or distress arising from the discordance between one's identity and one's anatomy such that there is an impairment in functioning in significant areas of the individual's life.
Q. What type of functioning would that be?
A. It could be social, medical, mental health, interpersonal, professional. There may be some others that I'm not thinking of.
Q. Do you ever as a doctor ever make a diagnosis of gender dysphoria?
A. I do not typically make that diagnosis.
Q. Is that a mental health diagnosis?
A. So I believe gender dysphoria is a medical

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condition and there are also mental health components.
Q. Would the mental health components be depression and anxiety as a few examples?
A. Depression and anxiety -- individual with gender dysphoria may or may not have depression and/or anxiety.
Q. Okay. So it's possible for someone suffering from gender dysphoria not to have depression, correct?
A. I believe so.
Q. It's also possible for someone suffering from gender dysphoria to have -- to suffer from depression that is not related to gender dysphoria; an independent diagnosis, so to speak?
A. I would think that that's a possibility.
Q. Have you heard of the term severe gender dysphoria?
A. I'm not sure severe in the sense of a medical diagnosis being severe being different than gender dysphoria. I have heard the term referenced in relation to the clinical care of people.
Q. So when that term is used in that way, what are the components, the mental health conditions that may be severe?
A. Well, I'm not sure that severe represents a

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distinct diagnosis from gender dysphoria.
Q. If you could turn to page 7 of your report. In the third sentence from the top, it starts out, From the latter group, relief from gender dysphoria cannot be achieved. I just have a question about relief. Does that phrase mean that gender dysphoria can be less severe or that gender dysphoria can disappear all together?
A. I think it's consistent with the first sentence in that evidence shows that while some transgender individuals do not require surgery, so I believe that there is a heterogenous group of individuals, not all of whom require surgery or request surgery.
Q. Not all transgender individuals suffer from gender dysphoria, correct?
A. Correct.
Q. So in the previous sentence that you're referencing, are those transgender individuals that you are referring to that do not require surgery not suffering from gender dysphoria?
A. So individuals vary and individuals may find relief of their dysphoria with various modalities. Hormones may be one method of treatment. Surgery may be

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another. As for any individual patient, it would depend upon the individual circumstances.

Q. So do the WPATH standards of care guidelines permit, for lack of a better word, surgical treatment of gender-confirming surgeries on transgender individuals who do not suffer from gender dysphoria?

A. I'm sorry. Could you break that down.

Q. Sure. There are standards of care guidelines within WPATH applied to surgical treatments for transgender individuals. Correct?

A. Yes.

Q. Do the WPATH guidelines permit surgical treatments like gender-confirming surgery on transgender individuals not suffering from gender dysphoria?

A. So I think one of the important principles about the standards of care is that they are guidelines and that they are flexible guidelines and that care must be individualized, so it would depend upon the individual request for surgery.

Q. So have you performed gender-confirming surgeries on transgender persons who do not come to you with a diagnosis of gender dysphoria? Actually, I'm going to withdraw the question. I will ask it later because I think what we need to do is define what

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gender-confirming surgery is. That was one of my questions. Just give me a minute here.

So the easier question is, how do you define gender-confirming surgeries?

A. So gender-confirming surgeries represent a group of various surgical procedures, and I will -- because you asked about surgery, I will leave aside procedures that may not be surgical in nature. But they represent a compilation of procedures that are designed to align one's body and anatomy with an individual's gender identity. They may encompass facial surgeries, breast or chest surgery, body contouring procedures, surgery on the genitalia.

Q. Do you perform those surgeries you just listed?

A. I do.

Q. Are there any other types of gender-confirming surgeries that you can think of right now that you didn't just tell me about?

A. It's possible. There are things I might call procedures that may not qualify as surgery, things such as injectable fillers, and there may be other procedures that I'm not thinking -- surgical treatments that I'm not thinking of. Hair transplantation, hair removal.

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Q. So then back to the question that I withdrew. Have you ever performed a gender-confirming surgery on a transgender person who is not suffering from gender dysphoria?

A. I have probably performed gender-confirming procedures on individuals without a diagnosis of gender dysphoria.

Q. Do you recall whether those procedures were covered by third-party payers?

A. Probably not.

Q. Why do you say that?

A. Because I believe they were facial-related procedures most likely performed some time ago when majority of gender-confirming procedures were not covered by insurance or other third-party coverage.

Q. So in your view, there has been an increase in third-party payer coverage of gender-confirming surgeries?

A. Yes.

Q. And can you give an estimate in the past, let's say, five years has there been a significant increase, in your view?

A. Yes.

Q. Would you say those are mostly private health

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plans?

A. No. Medicare being one. Some state coverage.

Q. Do any of your patients have Medicare as a third-party payer?

A. I would say yes, they have Medicare. I can't necessarily define technically if it's a third party, but surgery paid for by Medicare.

Q. Getting back to patients suffering from gender dysphoria, if you have a patient who suffers from gender dysphoria, how would you know that?

A. Most patients, most individuals are referred to me for surgical treatment. Probably the most common. In addition to that, it's discussions with the patients as to their concerns as to the goal -- their goals of surgical treatment.

Q. So let's focus on the referrals. When you receive a referral from a patient's treating physician, does the person's medical file come along with that referral pursuant to the patient's consent?

A. So the referral may come from a physician. It may also come from a nonphysician health care professional. And it would vary on a case-by-case basis as to what information may be forwarded. That may also involve personal communication between a treating

professional and myself.

Q. Do you always meet with your patients prior to surgery?

A. I meet with everyone, all patients prior to surgery.

Q. That's a good segue into your own practice. When did you begin your own practice?

A. Well, I entered practice in 2000.

Q. Okay. What do you mean by that?

A. It wasn't my own practice. I was employed by a senior physician who retired after three years.

Q. Now do you practice on your own?

A. I'm now employed by Tenet, T-E-N-E-T.

Q. What is Tenet?

A. Health care company.

Q. And your patients come from all over the world?

A. Yes.

Q. Your website says -- Actually, no. I'm sorry. It was your expert report that said on page 2, 85 to 90 percent of the patients in your clinical practice are transgender individuals. Is that still correct?

A. I would say 85 to 90 percent are having either gender-related surgeries or perhaps

genitourinary-related surgeries.

Q. So just to be clear, when you say genitourinary-related surgeries, are those type of surgeries performed on transgender and cisgender persons?

A. Genitourinary, G-E-N-I-T-O urinary.

Q. Sorry. So is that -- the answer -- performed on cisgender and transgender?

A. Yes.

Q. If you could give me an estimate, let's say 5 years ago, what was the approximate percentage of patients in your practice who were transgender?

A. I would estimate probably 20 to 25 percent perhaps.

Q. So in your view, has the increase in the number of third-party private payers covering gender-confirming surgeries correlate with the increase in number of transgender patients in your practice?

A. I think there are several reasons why the volume has increased. One of them is -- the primary reason is access to care, and some of that is a result of not only private insurers but government, public insurers covering the procedures. I think there has also been generally more accepting societal -- social

attitudes toward this as well as recognition as to the fact that there are medical and surgical treatments available to people. So access to care and coverage is one issue. I think societal changes, recognition by the medical community through ongoing education are other reasons as well.

Q. On page 3 of your report, it says you're the medical director of the Center for Gender Confirmation Surgery at Weiss Memorial Hospital. Is that still true?

A. Yes.

Q. The next sentence, are you still the site director for Fellowship in Reconstructive Urology and Gender Surgery at the same hospital?

A. Yes.

Q. While we are here, ask a few questions about the courses that you have taught through WPATH's Global Education Initiative. Could you tell me what that Global Education Initiative is.

A. Yes. That's an initiative -- education initiative under the auspices of the World Professional Association for Transgender Health, and it involves multidisciplinary education pertaining to health care for transgender or gender nonconforming individuals.

Q. And how long have you taught courses?

A. I think the first course was here in Chicago, I'd have to look specifically at my CV, but I believe it was two to three years ago, if I'm not mistaken. Probably three -- two to three years ago, in that time frame.

Q. Speaking of WPATH, you are on the board of directors, correct? I think I asked you that.

A. Yes.

Q. How did you become a member of the board of directors?

A. Through a vote of the membership.

Q. Were you nominated by someone?

A. I believe I ran as part of a slate.

Q. Did someone request you to run or was that your own volition?

A. If I recollect, I believe someone asked me if I wanted to run. I don't recall asking someone if I should run.

Q. You don't remember who that was?

A. I do not. It may have been at the time a current board member, but -- or there may have been a nominating committee. I'm not entirely sure.

Q. This is one question maybe I should know the answer to, but is there an American PATH?

A. There is a USPATH.
Q. Okay. That's it.
What is -- is that related at all to -- associated with WPATH or is it a separate entity?
A. It is related to, I believe, it would be considered an affiliate organization.
Q. Does that organization publish any standards of care guidelines separate from WPATH?
A. No.
Q. Do you know of any other standard of care guidelines for the treatment of transgender persons other than WPATH?
A. There are endocrinology guidelines. And there are different models of care.
Q. What entities would create the models of care?
A. So there is also what's considered to be an informed consent model of care. Many community health centers practice in an informed consent model.
Q. Are you familiar with this informed consent model?
A. I'm familiar with the philosophy behind it.
Q. What is that philosophy?
A. That individuals through shared decisionmaking with the health care professional may achieve -- or may

access various treatment modalities.
Q. So would you say this informed consent model of care differs from WPATH standards of care guidelines?
A. No. The standards of care reference informed consent models as well.
Q. Are you familiar with the endocrinology guidelines?
A. Familiar in the sense that I have looked at them, but not in the sense that I by any means memorized them.
Q. Do you know what entity issued those guidelines?
A. I don't know the specific entity. I believe it's -- there is a relationship to organized endocrinologic societies and professionals.
Q. You are not a member of any of those?
A. Correct.
THE WITNESS: Can I use the washroom?
MR. KILPATRICK: We will take a break. Off the record.
(Discussion off the record.)
BY MR. KILPATRICK:
Q. So I'm going to ask just a few questions again about the WPATH standards of care. So when you say on

page 19 of your expert report, Consistent with the prevailing standards of care that gender-confirming -- I'm sorry. It's on page 19 under conclusions. You say, It is my professional opinion consistent with the prevailing standards of care that gender-confirming surgery is safe, effective, and medically necessary for mean individuals with gender dysphoria.
When you refer to standards of care, do you refer solely to the WPATH standards of care?
A. No.
Q. Okay. What else would you be referring to?
A. My personal experience based on treating and caring for individuals, my experience in speaking with and attending other educational seminars through other professional societies, my communications with other health care professionals.
Q. So because the WPATH standards of care are guidelines, is it safe to say that you have performed gender-confirming surgeries that may not follow the WPATH standards of care?
A. I believe that the WPATH standards of care are flexible guidelines so I practice consistent with that.
Q. So would you say then because the WPATH standards of care are flexible guidelines that you

believe you always follow the WPATH standards of care guidelines?
A. I believe I practice consistent with the standards of care.
Q. And in your view do the WPATH standards of care only apply to your transgender patients?
A. I believe that the standards of care apply to transgender, gender diverse, gender nonconforming individuals.
Q. So I asked you before if you had ever diagnosed gender dysphoria. I can't remember exactly what you said, but I don't think it was an unequivocal no. Do you believe you ever made a diagnosis of gender dysphoria on a patient?
A. I don't believe so.
Q. Would you be qualified to do so?
A. In the sense that I have an unrestricted medical license, I am able to do so. In the sense of my clinical practice, I would typically work in collaboration with mental health professionals.
Q. You had said that a mental health professional's diagnosis of gender dysphoria that comes to you upon a referral may not always be from a medical doctor, correct?

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A. I may see referrals from nonmedical doctors who have been diagnosed with gender dysphoria by a non-M.D.

Q. Right. So give me some examples of non-M.D.s who would diagnose?

A. Clinical psychologist.

Q. Psychiatrists too?

A. That would be M.D.

Q. Okay. So would you say that a transgender person suffering from gender dysphoria who receives a gender-confirming surgery has a reduction in that gender dysphoria?

A. Are we talking about a particular patient or --

Q. Just in general, question may be, do you believe that the gender-confirming surgeries you perform reduce the level of gender dysphoria in your patients?

A. So I believe that many of the gender-confirming surgeries that I perform help alleviate gender dysphoria.

Q. Do you believe that the alleviation of gender dysphoria after a patient receives a gender-confirming surgery can increase again, the level?

MR. KNIGHT: Calls for speculation.

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BY THE WITNESS:

A. I'm sorry. Can you repeat. The alleviation --

Q. So you had said that you believe that the gender-confirming surgeries help alleviate gender dysphoria. My question is, after a period of time, does -- can gender dysphoria increase again?

A. I would answer that question yes. By example, somebody may undergo, for example, mastectomy and then choose at a later date to have genital surgery.

Q. Because, for instance, facial feminization surgery is a type of gender-confirming surgery, there could be a return of a higher level of gender dysphoria after receiving that type of surgery too, correct?

A. I think that question assumes someone having facial surgery is necessarily having it for gender dysphoria.

Q. Right. So assume that.

A. I would say that individuals may undergo various treatments for gender dysphoria and facial surgery may be one. Genital surgery may be another. And as to how any individual patient would respond would depend upon the individual circumstances.

Q. So would you believe that gender-confirming surgery is medically necessary if the patient's treating M.D. or mental health provider says it is?

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A. Would I believe that gender-confirming surgery is medically necessary if the treating physician -- well, if I'm the treating physician, yes, if that is the question.

Q. A better question would be, upon a referral that you receive of a transgender patient from a medical provider, let's say an M.D. who diagnoses a person with gender dysphoria and refers that patient to you, are you or the referring physician making a determination that surgery is medically necessary?

A. So I require evaluation of all patients prior to surgery. As far as what goes into my decisionmaking is to proceed with surgery involves not only my meeting with that patient and performing a history and physical exam but also the referral information from the health care professional. The decision, of course, then to proceed with surgery is a decision -- mutual decision between myself and the patient after discussion of risks and benefits and so on.

Q. So if you were to decide that a gender-confirming surgery was not medically necessary, would you consider that surgery to be purely cosmetic?

Page 37

A. I would have to see an example --

Q. Okay.

A. -- of what you're talking about.

Q. First let's get some definitions. What do you believe is cosmetic surgery?

A. So cosmetic surgery is generally surgery performed upon normal body structures with the intention of improving appearance.

Q. A patient may arrive at your practice seeking cosmetic surgery without a referral from his or her treating physician, correct?

A. Correct.

Q. What do you consider to be reconstructive surgery?

A. Typically surgery performed upon body parts affected by congenital, tumor, trauma, infection, birth related, cancer, I may be leaving out some conditions, but generally designed to improve function, perhaps appearance, often both.

Q. So do you believe that all gender-confirming surgeries are reconstructive surgeries?

A. I believe many are but not all.

Q. If you could just give an example of a gender-confirming surgery performed on a transgender

person that would not be considered reconstructive.
A. A gender-confirming procedure performed on a transgender individual not considered reconstructive?
Q. Right.
A. So I don't necessarily consider any procedure inherently cosmetic or reconstructive. It's generally the diagnosis upon which the procedure is performed.
Q. So would a transgender person suffering from gender dysphoria, for example, needing a gender-confirming surgery be considered reconstructive surgery by you?
A. It's possible. It would depend upon the individual person and the procedure.
MR. KILPATRICK: Why don't we take a break.
(A short break was had.)
BY MR. KILPATRICK:
Q. I'm going to direct you to page 7 of your expert report. You listed some surgical treatment options for transgender women and for transgender men. Do you see that?
A. Yes.
Q. Let's first focus on the ones for transgender women. The surgical treatments that you reference, are all of those, in your consideration, gender-confirming

surgeries or gender-confirming treatments?
A. They can be.
Q. When you say "they can be," that depends on the patient's diagnosis?
A. It would depend upon the individual circumstances at hand.
Q. So let's kind of expand on that. When you say "the individual circumstances," so is there a possibility that some of these surgical treatment options would not be considered gender-confirming surgeries for a transgender woman?
A. I think if we are looking at the -- specific to a transgender woman, these would be considered gender-confirming surgeries.
Q. These also are surgical treatments that can be performed on nontransgender persons?
A. Cisgender individuals.
Q. Correct.
Okay. Let's look at the bullet points for transgender men. Same question, are these, in your consideration, gender-confirming surgeries or surgical treatments for transgender men?
A. Yes, I would consider these gender-confirming surgeries for transgender men.

Q. But there are also -- they are also surgical treatments and surgeries for cisgender persons as well, at least some of them?
A. Yes.
Q. If you could turn the page and look at page 8 at the WPATH standard of care criteria for initiation of surgical treatment. This is for adults seeking chest and/or genital reconstruction procedures. Do you make sure that these WPATH standards of care guidelines are followed by you and your transgender patients?
A. So again I think it's important to recognize that they are guidelines and they are flexible guidelines and individual treatment may vary.
Q. Not every single transgender patient that you have, for example, necessarily needs to have undergone 12 continuous months of hormone therapy prior to surgery, or is that one that is required?
A. That would be procedure-specific.
Q. Okay.
A. Most often.
Q. Okay. It could be a less amount of continuous months of hormone therapy depending on the treatment you provide?
A. There could be any reason a patient is not on

hormones. For example, there could be medical contraindications as one of the examples. So I would say it's fair to say that not every patient that I would have cared for would have received 12 continuous months of hormone therapy.
Q. Let's get on to another topic, the safety and efficacy of gender-confirming surgery. That's pages 9 and 10 of your report. First question is about these studies that you cite in the footnotes. Did you read every one of these studies?
MR. KNIGHT: Sorry. Where are you talking about?
MR. KILPATRICK: Page 9 and 10. I was asking about the studies referenced in the footnotes.
BY THE WITNESS:
A. I did.
Q. Okay. So footnote 8 makes reference to a BREAST-Q and body uneasiness test. Are you familiar with those terms?
A. I'm familiar with the BREAST-Q and I'm familiar with the body uneasiness test from the article.
Q. Okay. Would it be fair to say that those are patient-reported outcome measures?
A. The BREAST-Q is the patient-reported outcome measure. I'm not sure about the body uneasiness test.

Q. Okay. So in the Agarwal study that's referenced in footnote 8, it references the BREAST-Q. Does that mean in your view that the results of the study were based on patient-reported outcomes as opposed to provider-reported outcomes?

A. I have to look at the study specifically, but the BREAST-Q is a patient-reported outcome measure.

Q. You have stated that you reviewed peer-reviewed literature in the studies that are referenced in your report. Have you ever designed a study?

A. Yes.

Q. Okay. Which study would that be?

A. So I have two RIB studies that are ongoing now. One involves patient surveys preoperatively and then postoperatively. The second is a retrospective review of our experience relating to venous thromboembolism in postoperative vaginoplasty patients. I can then go back through my CV starting with medical school if you want, but as far back as I can remember, probably my early research interest in the burn unit at the University of Chicago related to energy expenditure in burn patients.

Q. Let's focus on the two RIB studies you first

discussed. The first you talked about was a pre-op and post-op comparison. What was the subject of that?

A. So I'm not sure I'd call it a comparison. It's a survey. It's an ongoing study looking at preoperative goals, expectations, self-identification, sexual orientation, various other parameters, and then patients are surveyed following surgery to basically see whether we have achieved our goals.

Q. What type of surgery?

A. It's open to all gender -- well, primarily genital-related gender-confirming surgeries. I believe chest surgery as well. I think we have excluded facial surgeries.

Q. You say that's an ongoing study. When did that begin?

A. I think we began enrollment maybe nine months ago following RIB approval.

Q. The second study that you referenced, is that ongoing too?

A. It is also ongoing and that study looks at the prevalence of venous thrombolic events in postoperative vaginoplasty patients.

Q. So with regard to those two studies, is anything published yet?

A. The first, the venous thrombosis preliminary data was presented at the European Federation of the Society of Microsurgery. I think that was Belgrade, may have been about March or April of this year. I believe the second referencing the survey study is accepted for presentation at the WPATH meeting in November of this year. Aside from perhaps an abstract book at the European meeting, neither have been published.

Q. Is there an intent to publish?

A. Yes.

Q. So let's go through some of the studies that are referenced starting on page 9. We will make reference to the first footnoted study, footnote 7, if you could pronounce the name for me.

A. I believe Leriche.

Q. We will call it the Leriche study. This study you say found of transgender men, 91 percent of the sample who received phalloplasty reported that the surgery was effective in aligning their physical appearance with their male gender identity. Correct?

A. Yes. That's what it says.

Q. So when you talk about effectiveness here, it is based on the patient's self-reporting?

A. I'd have to see the particular study. I don't

have that off the hand memorized.

Q. Okay. I guess, do you recall from the Leriche study whether there was a comparison of this sample group to any other group?

A. I don't believe so.

Q. So let's then turn to the next footnoted study, the Agarwal study.

A. Agarwal, yes.

Q. Agarwal. Excuse me.

We have talked a little bit about that. But just for the record, that's a peer-reviewed study of transgender men who received chest construction. You say the study found that the procedure improved psychosocial well-being and physical well-being among participants. Is it your belief that the results were based on patient outcome survey?

A. The BREAST-Q is a patient-reported outcome measure. There may have been other measures in that particular study as well. I just don't remember off the top of my head.

Q. Again, do you know whether in this study there was any comparison to another group such as a control group?

A. I don't specifically recall that.

Q. Turn the page, look at 10. Again, the top of the page references a Weigert study in footnote 9. That was a peer-reviewed study of transgender women. The study found that those who underwent breast augmentation surgeries experienced statistically significant improvement in their psychosocial wellbeing.

Do you know how the results were -- how these results came to be? Was it like the previously referred studies that they were patient-outcome-driven?

A. I don't specifically remember the metrics.

Q. So again, you don't recall, you don't know whether there was a control group comparison?

A. I do not believe there was a control group in that study.

Q. Same goes for the next referenced study, footnote 10, we will call it the Horbach study, this was a peer-reviewed study of transgender women who had vaginoplasty. The study found that the participants' mean improvement in qualify of life after surgery was 7.9 on a scale from negative 10 to 10. That's correct?

A. Yes. The particular study is a review article, so that's referencing back to another study.

Q. So is that study different than the first three we talked about?

A. In what --

Q. In the sense that it's just a referral to a study?

A. The article reference is a literature review.

Q. Okay.

A. The others were --

Q. The results of studies?

A. -- the results of studies.

Q. Okay. And then let's go to footnote 11, we will call that the Hess study, was a study of transgender women that found that surgical interventions were highly correlated with alleviating gender dysphoria. Do you know the basis of those outcomes?

A. I believe those were patient-reported outcomes. There may have also been psychological testing involved, but I don't specifically recall.

Q. Do you know whether there was a control group in that study?

A. That, I don't recall.

Q. Just wondering, have you ever authored an article in a peer-reviewed journal that is a literature review?

A. I believe some of my publications may have included a literature review. I'd have to look specifically, though, at my list.

Q. If they had, would they have been articles that were co-authored or solely authored by you?

A. Probably co-authored.

Q. Would the other authors have done the literature review?

A. That would be hard to know.

Q. Just getting back to some of the surgeries that you perform on your patients. Do you perform gender-confirming surgeries on anyone under 18 years of age?

A. Yes.

Q. What kind of surgeries?

A. Mastectomy is most common. I believe that I have performed vaginoplasty twice on 17-year-old individuals.

Q. Were those transgender persons?

A. Yes. Yes. If your question was other genital procedures, yes.

Q. Actually, if we are going to use the term gender-confirming surgeries, does that necessarily mean that the person is not cisgender?

A. Yes. I think we can agree with that.

Q. With regard to the patient who was under 18, I don't want you to disclose any protected health information, but was there any consent by the parent?

A. Yes.

Q. Okay. Is that the youngest age that you can think of that -- of a patient on whom you have performed gender-confirming surgical procedure?

A. Vaginoplasty, yes. For chest surgery, no.

Q. Okay. How young was that?

A. I believe the youngest on two occasions were the age of 14.

Q. You say those were mastectomy and any other chest surgery?

A. When I'm using the term -- for me, chest surgery is referring to mastectomy.

Q. Okay.

A. For some, chest surgery might mean breast augmentation as well, but I'm using it in the context of mastectomy.

Q. Let's turn to page 12 of your expert report. This is a section concerning complication rates and risks of the surgical procedures. Have you look to the second full paragraph, the sentence starting, Looking specifically.

A. Okay.

Q. It says, Looking specifically at the complication rates for chest surgery, two recent studies reveal a complication rate among transgender men between 11 percent and 12 percent in comparison to the complication rate of 43 percent for cisgender women undergoing breast reduction shown in a 2005 study.

My question is, are these procedures even the same? The second study you cite refers to breast reduction. In the first clause you refer to two studies regarding chest surgery. In parentheses, it's subcutaneous mastectomy and chest wall contouring. My question is, aren't those different procedures?

A. They can be different procedures or they can be similar. So for example, a breast reduction in a cisgender woman would entail removing skin, fatty tissue, breast tissue, repositioning the nipple and areola, may or may not incorporate liposuction, et cetera. The technique of chest surgery may vary between surgeons. So some surgeons may perform the chest surgery in a manner somewhat analogous, meaning removing skin, breast tissue, fatty tissue, repositioning -- resizing, repositioning the nipple and areola on a pedicle. Either breast reduction or chest surgery can be performed with the use of free nipple

areola graphs. So there are similarities and differences between the procedures.

Q. So then you would agree that when you compared the first study to the second study, we will call them footnote 15 and footnote 16, the procedures are not necessarily identical?

A. I would agree they are performed for different indications. I would agree that there may be variability in some of the procedures, on individual patients, but there may also be similarities on others.

Q. Do you know why there would be such a disparity between the complication rates between the two studies?

A. I think that it's really a reflection that complications occur in surgery and that similar procedures, whether used for gender confirmation or otherwise in cisgender individuals both carry risk and the gender-confirming procedures are not inconsistent with risks in other plastic surgery procedures.

Q. Do you know of any other studies of cisgender women undergoing breast reduction showing a complication rate that high?

A. There are many studies of cisgender women undergoing breast reduction. I'd have to look at the

various studies, but breast reduction, as we see here, does carry risk.

Q. Would you call any of the surgical procedures you performed on a transgender person a breast reduction surgery?

A. I do not, but there are other surgeons who do.

Q. Okay. What would -- Would you simply refer to a chest surgery as a mastectomy on your transgender patients?

A. I would -- my typical practice would be to refer to it as a subcutaneous mastectomy. However, there are surgeons who do call it and refer to it as a breast reduction. So there is not necessarily complete agreement on that.

Q. I think I misspoke. Those procedures would be on transgender men, correct?

A. Correct. So I'm saying -- Right. Some surgeons would call it a breast reduction when performed on a trans man.

Q. I want to have you turn to another page. I believe it's 14 of your report. I want to talk about the study cited in footnote 24. You can take some time to read that.

A. Okay. You're referring to the first citation in that?

Q. All of them, actually.

A. Okay.

Q. Okay. So you cite those studies after saying there are a substantial amount -- I'm sorry. A substantial additional body of evidence showing that the standard medical and surgical treatments for gender dysphoria are both safe and effective.

These studies cited in footnote 24, are those studies, like the previous studies we cited, patient-outcome-driven?

A. I believe the first citation is a literature review.

Q. I'm sorry. I meant patient-reported outcome-driven.

A. Yes. So there may be various variables on which they are reported, so it may include both patient-reported outcomes as well as psychological testing. I have to look -- the Patholopagous (phonetic) study, I'd have to see the specific study, that may include psychological tests as well as patient-reported outcome measures.

Q. If you could turn to page 16, footnote 31,

take some time to read that.

A. Sure.

Okay.

Q. Help me with the pronunciation of that study.

A. I can't give you much help. I say Dhejne.

Q. D-H-E-J-N-E. We will call it the Dhejne study.

You criticize the Dhejne study; would you agree?

A. Yes.

Q. Okay. You say, The study, however, does not compare transgender individuals who had gender-confirmation surgeries with transgender individuals who did not have and wanted or did not have and did not want gender-confirmation surgeries. You wrote that in the footnote, right?

A. Yes and -- yes.

Q. Can you cite a study that does that, has a compare group like you have referenced?

A. There are studies that have comparison groups, but I don't think they would fit what I would consider to be my point in this footnote.

Q. You wrote this in response to Dr. Lawrence Mayer and his article entitled, "Sexuality in Gender:

Findings from the Biological, Psychological, and Social Sciences" that was published in the New Atlantis; is that correct?

A. Well, I reference the article. I'm not -- and I think, as the footnote reads, says, As both Mayer's study and the authors concede, "the study cannot address, quote, "the effectiveness of sex reassignment surgery," et cetera, et cetera, that that may be taken from the New Atlantis article.

Q. Okay. Dr. Mayer's article that he co-authored that I just referenced, did you read that entire article?

A. I would say I read portions of it.

Q. I'm sorry to get off track here, but I have got some questions that I skipped over. Happens in depositions.

Getting off topic a bit, going back to the WPATH standards of care, have you ever declined to perform a gender-confirming surgery if you believed that the WPATH standards of care guidelines had not been met?

A. I have declined surgeries before. It may or may not be based upon the guidelines.

Q. What would be some examples for declining

gender-confirming surgery?

A. Significant comorbidities. Probably the most common reasons now are obesity, smoking, other medical comorbidities. Various things that might make the risks of surgery such that risks outweigh the benefits. Other requests for surgeries that I don't perform.

Q. Have you ever declined to perform a gender-confirming surgery because of any disagreement with a patient's treating physician upon a referral?

A. I would say the more common scenario would be a referral requesting an opinion whether surgery would be indicated or warranted. So the mental health professional may call me and say, I'm going to send this individual and I'd like to know your thoughts on that.

Q. It's not necessarily a disagreement because there wasn't a position taken by the treating physician, or is it a request for -- I don't want to say a second opinion, but would there be a disagreement between doctors?

A. It could occur.

Q. Okay. So I'm going to give you -- if I can find it -- I don't have it.

MR. KILPATRICK: Go off the record.

(Discussion off the record.)

(Schechter Deposition Exhibit No. 2 marked as requested.)

BY MR. KILPATRICK:

Q. Dr. Schechter, I provided you with a document entitled, Supplemental expert report of Loren S. Schechter, M.D. Do you see that in front of you?

A. I do.

Q. That was signed and dated by you 25th of June of this year, correct?

A. That's correct.

Q. This was submitted in the Boyden litigation, correct?

A. Yes.

Q. If you want to turn to page 4, last page.

A. Okay.

Q. So you say in paragraph 4, Not all individuals with gender dysphoria have depression. In addition, when performed on individuals with gender dysphoria, gender-confirming procedures are considered reconstructive in nature rather than cosmetic. Do you see that?

A. Yes.

Q. Is that statement -- Let me ask you this: Do you stand by that statement or are there exceptions? In

other words, it seems to say that gender-confirming surgeries on people -- transgender persons with gender dysphoria are always considered reconstructive. Am I reading that wrong?

A. What I might say is surgeries, I might not use the word procedure, I would say generally I agree with that. There may be an exception that could be thought of, but I'd say that would generally hold true.

Q. In paragraph 3 you say, These breast reconstructive procedures for cisgender women are not intended to treat the medical reason for the mastectomy such as breast cancer.

I'm wondering what you mean, "these breast reconstructive procedures"; do you mean those -- well, I guess my question is, what do you mean when you say, "these breast reconstructive procedures"?

A. So when referring to breast reconstruction following mastectomy, that would generally refer to various reconstructive techniques, either implant-based techniques, autologous techniques, used to reconstruct the breast.

Q. Are those procedures performed on transgender persons?

A. It would depend upon the procedure. So for

example, a woman may undergo a mastectomy for cancer on her left breast, may undergo reconstruction on the left breast by whatever technique, and then undergo a form of symmetry procedure on the contralateral right breast, perhaps breast augmentation. So that would be similar in nature to a transgender woman undergoing breast augmentation.

Q. So if a transgender woman underwent breast augmentation, would you consider that a gender-confirming surgery?

A. I would say if it was used in relation to gender dysphoria, I would consider that to be reconstructive in nature.

Q. Let's go down that road a bit. We talked about gender dysphoria being a psychological condition, diagnosis, correct?

A. It's a medical condition.

Q. Medical condition, okay.

A. It may have psychological manifestations.

Q. Okay. And depression is a medical condition, correct?

A. Depression is a medical condition.

Q. Okay.

A. And by medical, I also incorporate mental --

some forms of mental health.

Q. Okay. I think you know where I'm getting at. You have stated that you would not -- Let me put it this way. Let's give you another report.

(Schechter Deposition Exhibit No. 3 marked as requested.)

BY MR. KILPATRICK:

Q. Okay. I have put before you another document called Exhibit 3, Second supplemental expert witness report, Loren S. Schechter, M.D. Is that before you?

A. Yes.

Q. It's a two-page document signed and dated on July 9 of this year. Correct?

A. Yes.

Q. Okay. And this also was filed in the Boyden litigation, correct?

A. That's correct.

Q. Okay. So you can turn back to the Exhibit No. 2, which is your supplemental expert witness report, and we will go to paragraph -- well, paragraph 1 on page 2. The second paragraph, you say, Some individuals who undergo cosmetic surgery may have coexisting medical and/or psychiatric/psychological conditions. These conditions may include depression. However, depression

is not an indication for cosmetic surgery. Conversely, cosmetic surgery is not a treatment for depression.

So you have stated that there can be gender-confirming surgeries for persons suffering from gender dysphoria. Can there ever be surgeries that you would consider gender-confirming but can also be performed on cisgender persons to treat any other psychological condition?

A. Can you break that down?

Q. Sure.

A. Yeah.

Q. Person suffering from gender dysphoria is treated with surgery. Is it your testimony that a person suffering from depression is never treated with surgery?

A. So I would say depression is not an indication for plastic surgery.

Q. What do you mean by that, in layman's terms?

A. If a patient comes and their diagnosis is depression and they say, I'm depressed and I want a particular procedure, that would not be a common indication for plastic surgery nor can I say that I have ever performed a procedure for that particular reason.

Q. Okay. Is it possible that you have performed a surgery on a cisgender person with depression?
A. Yes. I would say I have performed surgery on a cisgender person who as one of their medical conditions has depression.
Q. Would that depression stem from any concern about outward appearance?
A. It would depend on the circumstance.
Q. Did you say previously -- forgive me; I can't remember -- that generally third-party payers decline to pay for cosmetic surgeries?
A. I would say cosmetic surgery is generally not covered by a third party -- if you're referring to third party as an insurer.
Q. Yes. Okay.
You need to get that?
A. No, I'm just going to send a message.
Q. Okay.
A. Thank you.
Q. Sure.
Getting back to the studies that you had referenced earlier in the deposition, and I hate to say the first or second because I think we switched that term, but the study that you do not intend to present in

Belgrade, what should we call that one?
A. Both, actually -- well, so the venous thromboembolism was presented earlier this year in Belgrade. Yeah. I believe both are going to be presented in Buenos Aires. I may have misspoke and said only the survey study, but now that I think about it, both I think are being presented.
Q. Okay. So the survey -- we will reference it as the survey study?
A. Sure.
Q. Okay. Is the survey study only surveying transgender individuals with gender dysphoria?
A. It is surveying all individuals undergoing surgery.
Q. Not just gender-confirming surgery?
A. No. It is limited to -- I believe we exclude face and I believe we exclude -- or not including body contouring procedures and that it's focusing on chest surgeries and/or genital surgeries.
Q. You don't need to have a diagnosis of gender dysphoria to be surveyed, to participate in the survey as a patient?
A. Correct. Although probably would ultimately fall out because you wouldn't be surveyed

postoperatively if you didn't have surgery and someone might not have surgery for any number of reasons.
Q. So in conducting this survey, is this the first time in your practice that you have followed up with transgender persons about outcomes post surgery?
A. I believe it's the first study, but not follow-up in terms of outcomes. We follow all patients for outcome.
Q. How do you do that?
A. So people return to the office in the postoperative period.
Q. Does the postoperative period depend on the type of procedure?
A. Yes.
Q. What do you do to determine effectiveness of the procedure?
A. So interview patients, speak with them, examine them.
Q. So you say you have done that in your practice from the beginning?
A. Yes, routinely.
Q. But there was never any statistics generated until the study began?
A. I believe -- No, I take that back. Depends

what you mean by statistics per se. I have reported on other outcome variables, for example, appearance of forearm donor site after phalloplasty as well as other case reports or case series from a practice.
MR. KILPATRICK: Off the record.
(Discussion off the record.)
BY MR. KILPATRICK:
Q. Okay. I'm going to ask you a few questions and show you some printouts from your website. I will just represent to you that I visited your website yesterday. It is drlschechter.com?
A. I believe so.
Q. I will show you some printouts from that. So on your website you have a section for gender-confirming surgical procedures, correct?
A. Probably. I haven't visited the site for awhile.
(Schechter Deposition Exhibit No. 4 marked as requested.)
BY MR. KILPATRICK:
Q. Have you had a chance to look at what we call Exhibit 4?
A. Yes.
Q. This is a printout from your website in a

section entitled, Gender confirmation. Would you agree with that?

A. It could be. I know we ported some old sites to a new site. So it looks familiar. But I can't say for sure that it's the most up-to-date, but the information looks familiar.

Q. Okay. Just to confirm, this section discusses transfeminine procedures and transmasculine procedures, correct?

A. Yes.

Q. Apart from this website, do you generally classify procedures that way?

A. I think that's a general classification, yes. Although I know the site's out of date because we don't use the particular hotel. I think the cab information is off. So I think we have some work to do.

Q. Okay.

A. You're welcome.

Q. Thank you.

Okay. You can set that aside. Here's No. 5.

(Schechter Deposition Exhibit No. 5 marked as requested.)

BY MR. KILPATRICK:

Q. Just to make things easier, all of these

printouts that I'm going to provide to you I will represent to you that I printed out yesterday from the website that I referenced earlier.

Exhibit 5 is a two-page printout of one type of transfeminine procedure that you call body contouring. Could you describe body contouring.

A. Sure. It may encompass various different procedures. Things such as abdominoplasty, liposuction, lipofilling, fat transfers, thigh lift. I'm probably missing a few, but those are reasonable representative procedures.

Q. Are those procedures also performed on cisgender women?

A. Yes.

Q. These procedures you described are designed to make the person look more feminine?

A. Depending upon the indication. So when performed on a transgender woman for that indication, yes. Abdominoplasty, for example, may have any number of reasons to be performed; removing extra skin and fat, for example, might be one.

Q. Okay. You can set that aside. I'm going to give you another one.

(Schechter Deposition Exhibit No. 6 marked as requested.)

BY MR. KILPATRICK:

Q. You have now before you Exhibit 6. This is a printout entitled, Transfeminine procedures, breast augmentation. Do you see that, Doctor?

A. I do.

Q. This was a page, again, under the menu tab of transfeminine procedures, but breast augmentation can also be performed on cisgender women, correct?

A. Yes.

Q. Would you agree then that this procedure is designed to make the person look more feminine?

A. I think it's one, one aspect of the procedure if performed on a transgender woman.

Q. Okay. You can set that aside.

MR. KILPATRICK: Here's another one.

(Schechter Deposition Exhibit No. 7 marked as requested.)

BY MR. KILPATRICK:

Q. Doctor, I put before you another document that is Exhibit 7. It's another printout from the web page entitled, Transfeminine procedures, facial feminization surgery, FFS; do you see that before you?

A. Yes.

Q. Okay. Now, could you just describe what facial feminization surgery is.

A. Sure. It can represent a constellation of different procedures that may include anything from altering the hairline, replacing the hairline, altering the forehead, altering the nose, the cheeks, the lips, the lower jaw, chin, Adam's apple. May involve, as we said, nonsurgical components, things like injectable fillers. May incorporate other procedures, face lift --

Q. Okay.

A. -- brow lift, eyelid surgery.

Q. So you refer to these procedures as facial feminization surgeries only as to transgender persons?

A. Yes. When referred to for facial feminization, that's in reference to transgender individuals.

Q. Some of these procedures, maybe all of these procedures can also be performed on cisgender women, correct?

A. I would say more like some. I suppose yes, you could, but I'm not sure that I have encountered a cisgender woman who has asked to adjust her -- break her brow bone or things of that nature.

Q. On page 2, some of the facial feminization surgical procedures bullet pointed here would be performed on cisgender women?
A. Yes.
Q. You performed those on cisgender women?
A. Yes.
Q. Okay.
(Schechter Deposition Exhibit No. 8 marked as requested.)
BY MR. KILPATRICK:
Q. Before you I have placed another printout from the web page. This was under the menu section entitled, Transmasculine procedures. Does this look familiar to you?
A. Yes.
Q. Okay. And this particular transmasculine procedure is a type of plasty, can you pronounce that for me?
A. Metoidioplasty, that's spelled M-E-T-O-I-D-I-O-plasty.
Q. Could you describe that.
A. So that refers to lengthening the existing anatomy of the clitoris, which the procedure can be done with -- also with or without lengthening the urethra and

typically refers to -- in addition to that scrotoplasty, meaning construction of the scrotum, generally from the labia majora.
Q. So scrotoplasty is a part of metiodioplasty?
A. Yes. In my practice, I generally perform that in a staged fashion. So it's -- the metiodioplasty is more than one procedure.
Q. Is there ever a situation where this procedure would be performed on a cisgender person?
A. Not that I can think of. Well, let me say, I have not had that request.
Q. Okay. You personally have not had that request. Do you know of any other surgeons who have performed this procedure on a cisgender man?
A. Not -- I'm not aware of that.
Q. Could you explain -- Well, let's get to it.
MR. KILPATRICK: No. 9.
(Schechter Deposition Exhibit No. 9 marked as requested.)
BY MR. KILPATRICK:
Q. Exhibit 9. I have placed before you another printout from the website under the menu heading transmasculine procedures. This one is called FTM phalloplasty surgery. Do you see that before you?

A. Yes.
Q. And could you describe this type of surgery.
A. Sure. So the phalloplasty is a more generic term for construction of a penis. There are different techniques used to do that and may be performed a number of different methodologies. For example, may be performed with reconstruction of lengthening of the urethra; may be performed without lengthening of the urethra; various donor tissues; other body parts may be used to construct the penis; may be used to -- or subsequent procedures may involve placing penile prosthesis for erectile function as well.
Q. So is phalloplasty different than metiodioplasty?
A. Yes.
Q. Again, in layman's terms, how is it different?
A. So metiodioplasty may be performed as a first stage procedure in anticipation of a subsequent phalloplasty by some surgeons. So there are different ways to do it. But if we are talking as standalone procedure, the metiodioplasty lengthens the existing anatomy. And as we said, can be performed with lengthening the urethra as well to allow urination while standing. It typically does not construct a penis or

phallus of sufficient dimension to allow implantation of a penile prosthesis; meaning, the ability to engage in penetrative intercourse is limited.
The phalloplasty entails construction of penis; also typically implies scrotum in these circumstances as well. Again, can be done with or without urethral lengthening and often will involve placement of penile prostheses performed as secondary procedures.
Q. So can a phalloplasty surgery be performed on a cisgender man?
A. Yes.
Q. Have you done so?
A. Yes.
MR. KILPATRICK: This is 10.
(Sechechter Deposition Exhibit No. 10 marked as requested.)
BY MR. KILPATRICK:
Q. Okay. I have placed before you Exhibit 10. This is also a printout from your website. This was under the menu tab called body contouring. It is called pectoral implants for men. Could you describe this procedure that concerns pectoral implants?
A. Yes. So that refers to placing typically

silicone implant either beneath the skin or beneath the muscle of the chest to fill out the chest.

Q. And this is for cisgender men, correct?

A. It can be either cisgender or transgender men.

Q. Okay. That's what I wanted to know. Because it wasn't under the menu, I don't believe, for a transmasculine procedure. But just to confirm, this is a -- would you consider this pectoral implants for men a type of transmasculine procedure?

A. It can be either for transgender men or for cisgender men.

Q. So would you agree that this procedure is intended to masculinize the body?

A. I would say it can -- that can be one indication. There can be others. It can also be performed on individuals with congenital-related issues where there is, for example, absence of pectoralis muscle so could be used for symmetry procedures.

Q. I'm sorry. Go ahead.

A. Go ahead.

Q. When it's performed on a transgender person, is it intended to masculinize the body?

A. I would say most often intended to masculinize in a trans man.

Q. Right.

Getting back to Exhibit 9, that was the phalloplasty surgery. When performed on a trans man, is it intended to masculinize the body?

A. Yes.

Q. The same goes for Exhibit 8, the metoidioplasty, is that intended to masculinize the body of a trans man?

A. Yes. I would say both metoidioplasty and phalloplasty are intended to create either a penis or phallus with the goal of aligning the body with the identity. So, yes, I think masculinizing the body.

Q. We will go to Exhibit 7, the facial feminization page. This is a procedure when performed on a trans woman to feminize the body?

A. The face.

Q. The face. I'm sorry.

What about Exhibit 6, the breast augmentation; would you agree that when performed on a trans woman, its intention is to feminize the body?

A. I would say as well as the intention is to, with all these procedures, make the body align with one's identity. So the augmentation in a trans woman is designed to provide -- to feminize her breasts.

Q. So considering all of these procedures, the goal at least in part being to masculinize and feminize the body, would you agree that these lead to masculine and feminine stereotypes?

A. So again I think the goal is to bring the body in alignment with one's identity. Part of that may entail feminizing or masculinizing these various structures.

Q. For example, Exhibit 6, the breast augmentation, if one of the goals is to feminize the body, would you agree that there is a stereotype that a woman, cisgender woman has breasts?

A. Well, so couple parts to the question. First, I would say the goal again is to bring the body in alignment with one's identity. And to answer the second part, cisgender women have breasts. I suppose unless there is a congenital condition in which case they may not.

MR. KILPATRICK: We can go off record.

(Discussion off the record.)

BY MR. KILPATRICK:

Q. Getting back to your practice, do you ever see repeat patients; for instance, have you performed different gender-confirming surgeries on the same

patient?

A. Yes.

Q. For the second gender-confirming surgery that you have performed, do you know whether the person's -- Let me start over.

Have you performed gender-confirming surgeries on transgender persons with gender dysphoria multiple times? So the question is, have you performed more than one gender-confirming surgery on the same patient who is a transgender person with gender dysphoria?

A. Yes.

Q. Okay.

A. That may be part of an overall treatment plan. So in other words, someone may say, frequently, I'm going to begin with mastectomy prior to bottom surgery. Someone may say, I'm going to start with facial feminization before vaginoplasty. We may choose to group various procedures, breast augmentation and body contouring and then perform vaginoplasty.

Q. So you have said that gender-confirming surgeries can alleviate gender dysphoria, correct?

A. Yes.

Q. In the examples we just discussed, if a person comes back for a second gender-confirming surgery, have

you had any examples of that patient having a level of gender dysphoria that is not reduced by the first surgery?

A. I would say the most common scenario, as we have discussed, again, recognizing that the treatment is individualized, that part of the preoperative discussion may be charting out the course for the individual person. Someone may have undergone, for example, initial facial surgery by one surgeon with the goal of having a genital procedure performed by me. Someone may have an orchiectomy, for example, without necessarily the vaginoplasty. Or they may say, I'm going to begin with orchiectomy and contemplate vaginoplasty at a later date. I think it would be uncommon where someone would say, I had a rhinoplasty thinking that would treat my dysphoria but now all of a sudden I have decided I want everything done.

Q. You're saying it's uncommon but it is possible?

A. I can't say that I have encountered that situation in my practice. Having said that, I wouldn't say it's impossible.

Q. Do you know of any such situations outside of your practice?

MR. KNIGHT: Objection. It's unclear what you're talking about, "any such situations." What are you getting at?

BY MR. KILPATRICK:

Q. Getting back to the original question, outside of your practice, are you aware of transgender patients who have one type of gender-confirming surgery performed which dissipates or reduces a level of gender dysphoria only to come back to a surgeon at a later time seeking another type of gender-confirming surgery in which their level of gender dysphoria has returned?

A. I would say probably the more common scenario which I'm aware is that a patient may choose a particular surgeon for a particular procedure. Common examples, of course, because a specialty would be to have a gynecologist perform a hysterectomy, then obviously have a plastic surgeon for mastectomy. And for various reasons those are procedures that could be combined. And then that person could choose a third surgeon for bottom surgery. So I would say it's more common it's part of an overall treatment plan or patient selection as to the particular choice of surgeon.

Q. Would you agree that gender-confirming surgeries do not serve purely a functional purpose; that is, they also serve in part a cosmetic purpose?

A. I would most, if not all, plastic surgery procedures have -- certainly many have both a functional -- or may have a functional as well as aesthetic purpose.

Q. Are you aware of the study showing that a child's gender identity may change over time?

A. I'd have to see the particular study.

Q. Do you believe that gender is an immutable characteristic?

A. I believe that gender is innate.

Q. Do you believe it may change over time?

A. I believe people can be gender fluid.

Q. Would you consider the gender-confirming surgeries that you perform to be irreversible?

A. Components of it are irreversible. For example, following removal of testicles, one would not be able to produce sperm.

MR. KILPATRICK: That's all I have for now.

MR. KNIGHT: Okay. I just have a few follow-up questions.

EXAMINATION

BY MR. KNIGHT:

Q. On the questions about whether someone would come back who -- seeking more surgery, would those be circumstances in which the gender dysphoria -- you mentioned it's commonly part of the treatment plan. So would those be situations in which the next surgery that someone is coming back to you, already had surgery, one point of surgery would be surgery -- the treatment plan would be focused on the dysphoria relating to that particular body part, that particular part of the anatomy that the surgery is focused on?

A. That's possible as well.

Q. And have you had instances in which -- I mean, is it your experience that the surgery does reduce the dysphoria, that it is successful in terms of treating the condition?

A. Yes.

Q. You were asked some questions about studies with control groups?

A. Yes.

Q. Are you aware of studies with control groups?

A. I'm aware of studies with control groups.

Q. You can't remember any today, I take it?

A. Right.

Q. That's fine. I'm not going to -- so are there reasons why -- are there challenges with creating

control groups when we are talking about surgery?

A. Yes. Let me back up. I suppose it depends what we mean by control group. There may be studies that consider themselves to be control groups. Whether they are actually good control groups may be a critique or limitation of a particular study. Some of the challenges in certainly surgical studies, plastic surgery studies, clinical studies would be basically denying an individual necessary care with for the sole purpose of serving as a control group. In other words, I don't think it would necessarily be an ethical study to deny a group of people access to medical care simply to look at the natural progression of the condition.

Q. And is there -- there is a review process to determine whether or not you can do a study; isn't there?

A. So clinical studies should be reviewed, submitted to an institutional review board to look at and examine the methods involved in the study to help ensure patient safety and harm reduction.

Q. Okay. So the kind of study you are talking about which is denying necessary care to someone so they can serve as a control group would not get through their review board?

A. I don't see -- in other words, if you're going to say we are going to select a group of transgender individuals, whether randomly or selected, and allow one group to have necessary medical care and we are going to exclude this group from obtaining that care, I don't think that would be ethical. I'd have a hard time seeing how that would get through an institutional review board.

Q. You were asked about surgery on -- I think the question was about facial feminization. You were asked about surgeries on a person who did not have a gender dysphoria diagnosis. I believe that you mentioned that you could think of at least one surgery for someone with facial feminization surgery did not have a gender dysphoria diagnosis. Do you remember talking about that?

A. Yes.

Q. And is it possible that that person had gender dysphoria?

A. It's possible.

Q. But -- Okay.

Ultimately the natural follow-up is that diagnosis was not necessary to your being able to conduct the surgery at that time?

A. Correct.

Q. Part of the reason why it wasn't necessary is because there was no coverage to provide for the surgery?

MR. KILPATRICK: Objection, leading.

BY THE WITNESS:

A. There could be many reasons. Number one, it -- coverage may or may not have played a role. But other reasons would be, for example, consistent with the standards of care, it is not necessarily mental health assessment required for facial surgery.

Q. You were asked some questions about patient-reported outcomes in terms of the studies, in terms of evaluating the surgeries to treat gender dysphoria?

A. Yes.

Q. Is that -- Does that mean those -- Does that make those studies any different from studies for other kinds of surgical procedures or surgical procedures for nontransgender people?

A. So many certainly plastic surgery studies look at things like quality of life as well as patient-reported outcome. BREAST-Q was designed specifically to look at patient-reported outcome,

recognized the importance of that.

Q. Okay. So I guess the key question is, are -- does that differentiate studies of effectiveness of treatment for -- effectiveness of surgery to treat gender dysphoria from the studies -- other kinds of studies of surgical treatment?

A. No, I would say the -- many of the studies relating to gender-related surgeries and other studies of nongender-related surgeries in the plastic surgery literature.

Q. Okay.

MR. KNIGHT: That's all I have got.

MR. KILPATRICK: I have just a couple quick follow-ups.

FURTHER EXAMINATION

BY MR. KILPATRICK:

Q. Doctor, would you consider a study to be more reliable if there were a control group?

A. The study may have a higher level of evidence if there was a control group.

Q. Okay. And then with regard to the question your attorney asked you about a study that would deny treatment to a patient likely would not go forward because it was unethical, you yourself said that it is

possible to have a control group in which a transgender individual wanted or did not have and did not want gender-confirming surgery, correct?

A. I'm sorry. I have to --

Q. Okay. You can go to page 16 of your expert witness report. I believe that was Exhibit 1.

A. Okay.

Q. Footnote 31. Six lines down starting with, The study however.

A. Okay. Yes.

Q. So don't you admit there that there could be a control group of transgender individuals who were not denied gender-confirmation surgery?

A. No. I'm just saying it is a limitation of the study.

Q. So are you saying that there cannot be a control group in determining effectiveness of surgeries on transgender persons suffering from gender dysphoria without denying a patient surgery?

A. No. I think that's what we referenced -- well, let me say, I think that was referenced in the earlier study, would depend what one meant by control group. In other words, there might be individuals who had surgery before a certain date or after a certain

date. Those might be considered control groups. But whether they met criteria to serve as an acceptable comparison could be debatable.

Q. So is it possible to have a control group in which those patients in the control group were not necessarily denied surgery because you say they may not have wanted surgery?

A. I would have to say it would depend on how we define or use the term control group to make -- to see whether it's an adequate control group. I can see how, as we said, there may be individuals who had surgery or did not have surgery, which would be different than, for example, selecting through a randomized process one group of individuals -- assuming all wanted surgery, one group of individuals who were allowed to have surgery and another who were not.

Q. It's certainly possible that a person -- transgender person suffering from gender dysphoria may not always want surgery?

A. I would say that not all transgender individuals seek surgery and some may not want surgery.

MR. KILPATRICK: That's all I have unless you want to follow up.

MR. KNIGHT: I have no follow-up.

MR. KILPATRICK: I think we're done.

THE REPORTER: Did you want to order this?

MR. KILPATRICK: Yes. We definitely need -- what do they call it when there's four on a page?

THE REPORTER: Oh, yes, a mini.

MR. KILPATRICK: Mini. Yes. Condensed. That's the way the Court requires it. And electronic copy too.

THE REPORTER: Mr. Knight, did you want a copy?

MR. KNIGHT: Yes.

(Witness excused.)

STATE OF ILLINOIS)
) SS.
COUNTY OF COOK)

I, Nina Dudziak, Certified Shorthand Reporter, do hereby certify that on the 23rd day of August, A.D., 2018, the deposition of the witness, LOREN SCHECHTER, M.D., called by the Defendants, was taken before me, reported stenographically, and was thereafter reduced to typewriting under my direction.

The said deposition was taken at 6201 North Broadway, Chicago, Illinois; and there were present counsel as previously set forth.

The said witness, LOREN SCHECHTER, M.D., was first duly sworn to tell the truth, the whole truth, and nothing but the truth, and was then examined upon oral interrogatories.

I further certify that the foregoing is a true, accurate, and complete record of the questions asked of and answers made by the said witness, LOREN SCHECHTER, M.D., at the time and place hereinabove referred to.

The undersigned is not interested in the within case, nor of kin or counsel to any of the parties.

Witness my official signature on this 2nd day of September, A.D., 2018.

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