

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.

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1 APPEARANCES:

2 ROGER BALDWIN FOUNDATION OF AMERICAN CIVIL  
LIBERTIES UNION OF ILLINOIS

3 MR. JOHN KNIGHT  
MS. CAROLYN WALD  
4 180 North Michigan Avenue  
Suite 2300  
5 Chicago, Illinois 60601  
Phone: (312) 201-9740  
6 E-mail: jknight@aclu-il.org  
cwald@aclu-il.org

7 On behalf of the Plaintiffs;

8 STATE OF WISCONSIN  
9 DEPARTMENT OF JUSTICE  
MR. STEVEN C. KILPATRICK  
10 17 West Main Street  
P.O. Box 7857  
11 Madison, Wisconsin 53707-7857  
Phone: (608) 266-1792  
12 E-mail: kilpatricksc@doj.state.wi.us  
13 On behalf of the Defendants.

14  
15 \* \* \* \* \*

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1 (Witness sworn.)

2 WHEREUPON:

3 LOREN SCHECHTER, M.D.,  
4 called as a witness herein, having been first duly  
5 sworn, was examined and testified as follows:

6 EXAMINATION

7 BY MR. KILPATRICK:

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

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

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

17 Have you ever been deposed before?

18 A. I have.

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

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

4 A. Yes. Thanks.

5 Q. Great.

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

8 A. Not to my knowledge.

9 Q. Great.

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

13 A. Yes.

14 Q. Great.

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

17 A. I have.

18 Q. What cases?

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

21 Q. What case is that?

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

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

Page 6

1 state court case?  
 2 A. Federal.  
 3 Q. Federal case.  
 4 And what was the case about?  
 5 A. Case regarding coverage for gender-related  
 6 surgeries.  
 7 I was also retained in another case involving  
 8 Wisconsin, also a federal case, involving coverage  
 9 related to gender-related surgeries.  
 10 Q. Is that the Flack case?  
 11 A. The attorney I had worked with is Wordenski.  
 12 Q. I'm the attorney on that as well. Sorry.  
 13 A. I have -- There may be other treating  
 14 physician cases where I have been deposed or involved as  
 15 well.  
 16 Q. But I'm more concerned about being an expert  
 17 witness. Those cases in South Dakota and the other in  
 18 Wisconsin are the only expert witness cases -- cases in  
 19 which you have been an expert witness that you have been  
 20 involved in other than medical malpractice?  
 21 A. No. There was -- There have been other  
 22 medical-related cases not involving medical malpractice  
 23 where I have been involved in. I was also deposed in  
 24 2006 in the Kosilek, K-O-S-I-L-E-K, case. Again,

Page 7

1 involving coverage related to -- I think 2006. May have  
 2 been 2007. I don't remember.  
 3 Q. What court was that in, if you recall?  
 4 A. I believe the case was out of Massachusetts.  
 5 I was deposed by phone locally.  
 6 Q. In the Kosilek case, excuse me, were you  
 7 retained by the plaintiffs?  
 8 A. I was retained presumably by the law firm  
 9 representing the plaintiff, yes.  
 10 Q. And the same goes for the suit brought by the  
 11 ACLU in South Dakota?  
 12 A. Yes.  
 13 Q. The suit in South Dakota, are you aware  
 14 whether the issue regarding gender-confirmation surgery  
 15 deals with an employee state coverage exclusion?  
 16 A. I'm aware that it deals with an exclusion. I  
 17 don't know specifically the nature of employment.  
 18 Q. And if you recall, what was the issue in the  
 19 Kosilek case in Massachusetts?  
 20 A. It was pertaining to coverage for, I believe,  
 21 vaginoplasty for the plaintiff who was incarcerated.  
 22 Q. If you recall, in the Kosilek case, what was  
 23 your opinion?  
 24 A. I believe that the procedure, if I'm

Page 8

1 remembering correctly, was medically necessary.  
 2 Q. That brings up a great topic. Medical  
 3 necessity, you're aware that medical necessity is a term  
 4 that is used by insurance companies?  
 5 A. Yes.  
 6 Q. It appears that it's a term used by medical  
 7 providers?  
 8 A. I would say more often insurance companies.  
 9 Q. Okay. But if you were to give an opinion that  
 10 a procedure is medically necessary for a patient, what  
 11 do you mean?  
 12 A. To me it would mean that -- medical necessity  
 13 would mean that the patient would benefit from the  
 14 procedure -- or treatment. I should say treatment.  
 15 Q. When you say benefit, do you mean -- well,  
 16 what do you mean by benefit?  
 17 A. That there would be positive impact of the  
 18 treatment or the goal would be a positive impact of the  
 19 treatment.  
 20 Q. You perform cosmetic surgery, correct?  
 21 A. I do.  
 22 Q. Would any cosmetic surgery be medically  
 23 necessary, in your opinion?  
 24 A. So I think it would depend upon the given

Page 9

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

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1 Q. During that time, did you perform any  
2 gender-confirming surgeries on transgender persons  
3 suffering from gender dysphoria?  
4 A. I would say I was involved in the care as I  
5 was still in training, but yes, was involved in surgical  
6 procedures for gender-related surgeries.  
7 Q. You are a board-certified plastic surgeon,  
8 correct?  
9 A. Yes.  
10 Q. Are you a psychiatrist?  
11 A. No.  
12 Q. Psychologist?  
13 A. No.  
14 Q. A counselor of any sort?  
15 A. No.  
16 Q. You are a founding member and president-elect  
17 of the American Society of Gender Surgeons, correct?  
18 A. Yes.  
19 Q. Could you please briefly describe this  
20 organization.  
21 A. Sure. It's an organization that was founded  
22 within probably the last two years or so that is a  
23 multidisciplinary organization involving primarily  
24 surgeons, primarily American surgeons, although we also

Page 11

1 have international members, whose interests are related  
2 to gender-related surgical procedures and care of  
3 transgender individuals.  
4 Q. Is this organization related at all to I  
5 believe it's called the American Society of Plastic  
6 Surgeons?  
7 A. No relationship to that, although some  
8 members -- may be joint members of each of the groups.  
9 Q. Would that be you?  
10 A. Myself and others.  
11 Q. Okay. And it's correct that you are a  
12 founding member?  
13 A. Yes.  
14 Q. So just tell me why did you found it.  
15 A. The increasing need to have collaboration  
16 between surgeons of varying disciplines. Most of the  
17 U.S. surgical societies that we have are based upon  
18 individual specialties, so one of the goals of this is  
19 to allow collaboration between various surgical  
20 specialties.  
21 Q. Is there any requirement to become a member?  
22 A. There are.  
23 Q. What are those?  
24 A. I don't remember off the top of my head.

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1 Q. For example, do you have to be a surgeon?  
2 A. Most likely to be a full member, there may be  
3 categories, different categories that allow nonsurgeons  
4 to be members in some fashion.  
5 Q. Do you know if you need to be board-certified?  
6 A. Most likely either board-certified or  
7 board-eligible.  
8 Q. And could you just explain what the words in  
9 the title mean, and I will quote, gender surgeons?  
10 A. Yes. So it is -- ASGS, as it's known,  
11 although the title says American, there are  
12 international members. It is a group of surgeons with  
13 mutual interests in gender-related surgeries and care of  
14 transgender individuals.  
15 Q. So when you say gender-related surgery, does  
16 that mean that surgery is performed on transgender  
17 persons?  
18 A. Yes, is one aspect of it. But that may also  
19 include individuals who are gender diverse. It may also  
20 include nontransgender individuals upon whom some form  
21 of either genitourinary surgery might be performed, so  
22 for example, congenital issues, oncological issues,  
23 traumatic issues and that would also extend beyond  
24 genitourinary to breast surgery, chest surgery, facial

Page 13

1 surgery, body contouring.  
2 Q. You are also on the board of directors of  
3 WPATH, correct?  
4 A. Correct.  
5 Q. And WPATH issues standards of care, correct?  
6 A. I would say it helps develop standards of  
7 care. A document referred to as the standards of care.  
8 Q. Those are guidelines for health care  
9 professionals, correct?  
10 A. Yes.  
11 Q. And did you author any sections of the  
12 document?  
13 A. Yes.  
14 Q. Which one?  
15 A. I believe it was the relationship of the  
16 surgeon with the mental health professional and the  
17 physician prescribing hormones. And when I say author,  
18 probably better to refer to as contributor as it was a  
19 collaborative document.  
20 Q. Did you issue any journal articles on a  
21 similar topic?  
22 A. I believe so.  
23 Q. Okay. It says here in your CV that you  
24 authored, and I will quote, "The Surgeon's Relationship

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1 With the Physician Prescribing Hormones and the Mental  
2 Health Professional Review for Version 7 of the World  
3 Professional Association of Transgender Health Standards  
4 of Care."  
5 MR. KNIGHT: If you are going to ask him about the  
6 CV, if you could just show him a copy of it so he could  
7 take a look.  
8 MR. KILPATRICK: Sure. I will do that.  
9 BY MR. KILPATRICK:  
10 Q. First, just quickly, I need to understand,  
11 this was referred to as published in the International  
12 Journal of Transgenderism. Is that different than WPATH  
13 standards of care?  
14 A. Yes.  
15 Q. Okay.  
16 MR. KILPATRICK: I don't have -- I didn't plan on  
17 entering exhibit --  
18 MR. KNIGHT: If you are not going to ask any more  
19 questions about it -- I thought you were going to ask  
20 some specifics about the journal, just be able to see  
21 it. If you are not, that's fine.  
22 MR. KILPATRICK: Okay.  
23 BY MR. KILPATRICK:  
24 Q. I just wanted to make sure that there was a

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1 journal article separate from the WPATH standards of  
2 care document?  
3 A. That's correct.  
4 Q. Okay. Great.  
5 I have another question about one of the  
6 organizations that you are a member of. You are chair  
7 of the board of governors of PlastyPAC; is that correct?  
8 A. Yes.  
9 Q. What is PlastyPAC?  
10 A. PlastyPAC is the political action committee  
11 that advocates on behalf of plastic surgeons who are  
12 members of the American Society of Plastic Surgeons.  
13 And I'm outgoing chair; I think I will be done after our  
14 annual meeting, I believe, in October.  
15 Q. Do you make any contributions to PlastyPAC?  
16 A. I do.  
17 Q. Do you solicit contributions?  
18 A. I do.  
19 Q. From whom?  
20 A. Members of the American Society of Plastic  
21 Surgeons.  
22 Q. I'm going to give you your expert witness  
23 report that you filed in the Boyden litigation without  
24 the exhibits.

Page 16

1 A. Okay.  
2 Q. Just for you to review.  
3 A. Okay.  
4 Q. Would you agree that that is a correct copy of  
5 the expert witness report that you submitted?  
6 A. Appears to be.  
7 MR. KILPATRICK: Can we have it marked as an  
8 exhibit, please.  
9 (Sechechter Deposition Exhibit No. 1  
10 marked as requested.)  
11 BY MR. KILPATRICK:  
12 Q. Dr. Schechter, if you could take a look on  
13 page 1, footnote 1, you state that you perform  
14 gender-confirmation or gender-affirming surgeries,  
15 correct?  
16 A. Yes.  
17 Q. Could you tell me why you decided to use those  
18 terms as opposed to other terms such as sex reassignment  
19 surgery?  
20 A. Sure. There has been an evolution in  
21 terminology. Early terms were -- included were things  
22 like sex change or sex reassignment surgery. And I  
23 don't believe that that really encompasses the essence  
24 of the procedure. Either gender-confirming or

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1 gender-affirming I believe is more appropriate in that  
2 it brings someone's body into alignment with their  
3 identity.  
4 Q. You perform gender-confirmation surgeries on  
5 transgender persons who suffer from gender dysphoria,  
6 correct?  
7 A. I perform surgery on transgender individuals.  
8 I perform on gender nonconforming individuals, gender  
9 fluid individuals, many of whom may have gender  
10 dysphoria.  
11 Q. I'd like to ask you, so we are on the same  
12 page, how do you define someone who is transgender?  
13 A. Transgender individual is someone whose gender  
14 identity is not consistent with their anatomy.  
15 Q. You said you also perform surgeries on  
16 nonconforming individuals?  
17 A. Yes.  
18 Q. How do you define that?  
19 A. Those are individuals who may or may not  
20 identify in the binary as either male or female.  
21 Q. Is that usually a congenital issue?  
22 A. Well, if congenital do you mean is it innate,  
23 I would say that yes, one's gender identity is innate.  
24 Q. So do you believe that there is a difference

Page 18

1 **between sex and gender?**  
 2 A. I believe that sex typically refers to  
 3 one's -- is typically assigned at birth and is often  
 4 based upon one's anatomy. However, I also consider  
 5 identity, gender identity to be a component of the  
 6 determination of sex.  
 7 **Q. And has that view that gender identity is a**  
 8 **component of the determination of sex always been your**  
 9 **view or has it evolved over the years?**  
 10 A. I would say my views have probably evolved  
 11 based on ongoing education and experience in the field.  
 12 **Q. You perform gender-confirming surgeries that**  
 13 **follow the WPATH standards of care; is that correct?**  
 14 A. I would say that I practice consistent with  
 15 the WPATH standards of care which allow for the flexible  
 16 application of those guidelines.  
 17 **Q. So there are standards of care within WPATH**  
 18 **that specifically concern transgender patients suffering**  
 19 **from gender dysphoria, correct?**  
 20 A. Can you repeat that.  
 21 **Q. Are there standards of care within WPATH that**  
 22 **focus on transgender persons suffering from gender**  
 23 **dysphoria?**  
 24 A. So there are guidelines within the standards

Page 19

1 of care that refer to treatment options including  
 2 surgery for transgender individuals.  
 3 **Q. So have you performed gender-confirming**  
 4 **surgeries on transgender patients who do not suffer from**  
 5 **gender dysphoria?**  
 6 A. I have most certainly performed surgeries on  
 7 transgender individuals who do not have gender  
 8 dysphoria.  
 9 **Q. Before I get to more questions about that, how**  
 10 **do you define gender dysphoria or what definition do you**  
 11 **use?**  
 12 A. It is the discomfort and/or distress arising  
 13 from the discordance between one's identity and one's  
 14 anatomy such that there is an impairment in functioning  
 15 in significant areas of the individual's life.  
 16 **Q. What type of functioning would that be?**  
 17 A. It could be social, medical, mental health,  
 18 interpersonal, professional. There may be some others  
 19 that I'm not thinking of.  
 20 **Q. Do you ever as a doctor ever make a diagnosis**  
 21 **of gender dysphoria?**  
 22 A. I do not typically make that diagnosis.  
 23 **Q. Is that a mental health diagnosis?**  
 24 A. So I believe gender dysphoria is a medical

Page 20

1 condition and there are also mental health components.  
 2 **Q. Would the mental health components be**  
 3 **depression and anxiety as a few examples?**  
 4 A. Depression and anxiety -- individual with  
 5 gender dysphoria may or may not have depression and/or  
 6 anxiety.  
 7 **Q. Okay. So it's possible for someone suffering**  
 8 **from gender dysphoria not to have depression, correct?**  
 9 A. I believe so.  
 10 **Q. It's also possible for someone suffering from**  
 11 **gender dysphoria to have -- to suffer from depression**  
 12 **that is not related to gender dysphoria; an independent**  
 13 **diagnosis, so to speak?**  
 14 A. I would think that that's a possibility.  
 15 **Q. Have you heard of the term severe gender**  
 16 **dysphoria?**  
 17 A. I'm not sure severe in the sense of a medical  
 18 diagnosis being severe being different than gender  
 19 dysphoria. I have heard the term referenced in relation  
 20 to the clinical care of people.  
 21 **Q. So when that term is used in that way, what**  
 22 **are the components, the mental health conditions that**  
 23 **may be severe?**  
 24 A. Well, I'm not sure that severe represents a

Page 21

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

Page 22

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

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

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

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

11 A. Yes.

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

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

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

Page 23

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

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

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

14 Q. Do you perform those surgeries you just  
15 listed?

16 A. I do.

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

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

Page 24

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

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

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

10 A. Probably not.

11 Q. Why do you say that?

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

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

19 A. Yes.

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

23 A. Yes.

24 Q. Would you say those are mostly private health

Page 25

1 plans?

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

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

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

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

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

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

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



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1 professional and myself.

2 Q. Do you always meet with your patients prior to

3 surgery?

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

5 surgery.

6 Q. That's a good segue into your own practice.

7 When did you begin your own practice?

8 A. Well, I entered practice in 2000.

9 Q. Okay. What do you mean by that?

10 A. It wasn't my own practice. I was employed by

11 a senior physician who retired after three years.

12 Q. Now do you practice on your own?

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

14 Q. What is Tenet?

15 A. Health care company.

16 Q. And your patients come from all over the

17 world?

18 A. Yes.

19 Q. Your website says -- Actually, no. I'm sorry.

20 It was your expert report that said on page 2, 85 to

21 90 percent of the patients in your clinical practice are

22 transgender individuals. Is that still correct?

23 A. I would say 85 to 90 percent are having either

24 gender-related surgeries or perhaps

Page 27

1 genitourinary-related surgeries.

2 Q. So just to be clear, when you say

3 genitourinary-related surgeries, are those type of

4 surgeries performed on transgender and cisgender

5 persons?

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

7 Q. Sorry. So is that -- the answer -- performed

8 on cisgender and transgender?

9 A. Yes.

10 Q. If you could give me an estimate, let's say

11 5 years ago, what was the approximate percentage of

12 patients in your practice who were transgender?

13 A. I would estimate probably 20 to 25 percent

14 perhaps.

15 Q. So in your view, has the increase in the

16 number of third-party private payers covering

17 gender-confirming surgeries correlate with the increase

18 in number of transgender patients in your practice?

19 A. I think there are several reasons why the

20 volume has increased. One of them is -- the primary

21 reason is access to care, and some of that is a result

22 of not only private insurers but government, public

23 insurers covering the procedures. I think there has

24 also been generally more accepting societal -- social

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1 attitudes toward this as well as recognition as to the

2 fact that there are medical and surgical treatments

3 available to people. So access to care and coverage is

4 one issue. I think societal changes, recognition by the

5 medical community through ongoing education are other

6 reasons as well.

7 Q. On page 3 of your report, it says you're the

8 medical director of the Center for Gender Confirmation

9 Surgery at Weiss Memorial Hospital. Is that still true?

10 A. Yes.

11 Q. The next sentence, are you still the site

12 director for Fellowship in Reconstructive Urology and

13 Gender Surgery at the same hospital?

14 A. Yes.

15 Q. While we are here, ask a few questions about

16 the courses that you have taught through WPATH's Global

17 Education Initiative. Could you tell me what that

18 Global Education Initiative is.

19 A. Yes. That's an initiative -- education

20 initiative under the auspices of the World Professional

21 Association for Transgender Health, and it involves

22 multidisciplinary education pertaining to health care

23 for transgender or gender nonconforming individuals.

24 Q. And how long have you taught courses?

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1 A. I think the first course was here in Chicago,

2 I'd have to look specifically at my CV, but I believe it

3 was two to three years ago, if I'm not mistaken.

4 Probably three -- two to three years ago, in that time

5 frame.

6 Q. Speaking of WPATH, you are on the board of

7 directors, correct? I think I asked you that.

8 A. Yes.

9 Q. How did you become a member of the board of

10 directors?

11 A. Through a vote of the membership.

12 Q. Were you nominated by someone?

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

14 Q. Did someone request you to run or was that

15 your own volition?

16 A. If I recollect, I believe someone asked me if

17 I wanted to run. I don't recall asking someone if I

18 should run.

19 Q. You don't remember who that was?

20 A. I do not. It may have been at the time a

21 current board member, but -- or there may have been a

22 nominating committee. I'm not entirely sure.

23 Q. This is one question maybe I should know the

24 answer to, but is there an American PATH?

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1 A. There is a USPATH.  
 2 Q. Okay. That's it.  
 3 What is -- is that related at all to --  
 4 associated with WPATH or is it a separate entity?  
 5 A. It is related to, I believe, it would be  
 6 considered an affiliate organization.  
 7 Q. Does that organization publish any standards  
 8 of care guidelines separate from WPATH?  
 9 A. No.  
 10 Q. Do you know of any other standard of care  
 11 guidelines for the treatment of transgender persons  
 12 other than WPATH?  
 13 A. There are endocrinology guidelines. And there  
 14 are different models of care.  
 15 Q. What entities would create the models of care?  
 16 A. So there is also what's considered to be an  
 17 informed consent model of care. Many community health  
 18 centers practice in an informed consent model.  
 19 Q. Are you familiar with this informed consent  
 20 model?  
 21 A. I'm familiar with the philosophy behind it.  
 22 Q. What is that philosophy?  
 23 A. That individuals through shared decisionmaking  
 24 with the health care professional may achieve -- or may

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

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

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1 believe you always follow the WPATH standards of care  
 2 guidelines?  
 3 A. I believe I practice consistent with the  
 4 standards of care.  
 5 Q. And in your view do the WPATH standards of  
 6 care only apply to your transgender patients?  
 7 A. I believe that the standards of care apply to  
 8 transgender, gender diverse, gender nonconforming  
 9 individuals.  
 10 Q. So I asked you before if you had ever  
 11 diagnosed gender dysphoria. I can't remember exactly  
 12 what you said, but I don't think it was an unequivocal  
 13 no. Do you believe you ever made a diagnosis of gender  
 14 dysphoria on a patient?  
 15 A. I don't believe so.  
 16 Q. Would you be qualified to do so?  
 17 A. In the sense that I have an unrestricted  
 18 medical license, I am able to do so. In the sense of my  
 19 clinical practice, I would typically work in  
 20 collaboration with mental health professionals.  
 21 Q. You had said that a mental health  
 22 professional's diagnosis of gender dysphoria that comes  
 23 to you upon a referral may not always be from a medical  
 24 doctor, correct?

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1 A. I may see referrals from nonmedical doctors  
2 who have been diagnosed with gender dysphoria by a  
3 non-M.D.  
4 **Q. Right. So give me some examples of non-M.D.s**  
5 **who would diagnose?**  
6 A. Clinical psychologist.  
7 **Q. Psychiatrists too?**  
8 A. That would be M.D.  
9 **Q. Okay. So would you say that a transgender**  
10 **person suffering from gender dysphoria who receives a**  
11 **gender-confirming surgery has a reduction in that gender**  
12 **dysphoria?**  
13 A. Are we talking about a particular patient  
14 or --  
15 **Q. Just in general, question may be, do you**  
16 **believe that the gender-confirming surgeries you perform**  
17 **reduce the level of gender dysphoria in your patients?**  
18 A. So I believe that many of the  
19 gender-confirming surgeries that I perform help  
20 alleviate gender dysphoria.  
21 **Q. Do you believe that the alleviation of gender**  
22 **dysphoria after a patient receives a gender-confirming**  
23 **surgery can increase again, the level?**  
24 MR. KNIGHT: Calls for speculation.

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1 BY THE WITNESS:  
2 A. I'm sorry. Can you repeat. The  
3 alleviation --  
4 **Q. So you had said that you believe that the**  
5 **gender-confirming surgeries help alleviate gender**  
6 **dysphoria. My question is, after a period of time,**  
7 **does -- can gender dysphoria increase again?**  
8 A. I would answer that question yes. By example,  
9 somebody may undergo, for example, mastectomy and then  
10 choose at a later date to have genital surgery.  
11 **Q. Because, for instance, facial feminization**  
12 **surgery is a type of gender-confirming surgery, there**  
13 **could be a return of a higher level of gender dysphoria**  
14 **after receiving that type of surgery too, correct?**  
15 A. I think that question assumes someone having  
16 facial surgery is necessarily having it for gender  
17 dysphoria.  
18 **Q. Right. So assume that.**  
19 A. I would say that individuals may undergo  
20 various treatments for gender dysphoria and facial  
21 surgery may be one. Genital surgery may be another.  
22 And as to how any individual patient would respond would  
23 depend upon the individual circumstances.  
24 **Q. So would you believe that gender-confirming**

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1 **surgery is medically necessary if the patient's treating**  
2 **M.D. or mental health provider says it is?**  
3 A. Would I believe that gender-confirming surgery  
4 is medically necessary if the treating physician --  
5 well, if I'm the treating physician, yes, if that is the  
6 question.  
7 **Q. A better question would be, upon a referral**  
8 **that you receive of a transgender patient from a medical**  
9 **provider, let's say an M.D. who diagnoses a person with**  
10 **gender dysphoria and refers that patient to you, are you**  
11 **or the referring physician making a determination that**  
12 **surgery is medically necessary?**  
13 A. So I require evaluation of all patients prior  
14 to surgery. As far as what goes into my decisionmaking  
15 is to proceed with surgery involves not only my meeting  
16 with that patient and performing a history and physical  
17 exam but also the referral information from the health  
18 care professional. The decision, of course, then to  
19 proceed with surgery is a decision -- mutual decision  
20 between myself and the patient after discussion of risks  
21 and benefits and so on.  
22 **Q. So if you were to decide that a**  
23 **gender-confirming surgery was not medically necessary,**  
24 **would you consider that surgery to be purely cosmetic?**

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1 A. I would have to see an example --  
2 **Q. Okay.**  
3 A. -- of what you're talking about.  
4 **Q. First let's get some definitions. What do you**  
5 **believe is cosmetic surgery?**  
6 A. So cosmetic surgery is generally surgery  
7 performed upon normal body structures with the intention  
8 of improving appearance.  
9 **Q. A patient may arrive at your practice seeking**  
10 **cosmetic surgery without a referral from his or her**  
11 **treating physician, correct?**  
12 A. Correct.  
13 **Q. What do you consider to be reconstructive**  
14 **surgery?**  
15 A. Typically surgery performed upon body parts  
16 affected by congenital, tumor, trauma, infection, birth  
17 related, cancer, I may be leaving out some conditions,  
18 but generally designed to improve function, perhaps  
19 appearance, often both.  
20 **Q. So do you believe that all gender-confirming**  
21 **surgeries are reconstructive surgeries?**  
22 A. I believe many are but not all.  
23 **Q. If you could just give an example of a**  
24 **gender-confirming surgery performed on a transgender**

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

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1 surgeries or gender-confirming treatments?  
 2 A. They can be.  
 3 Q. When you say "they can be," that depends on  
 4 the patient's diagnosis?  
 5 A. It would depend upon the individual  
 6 circumstances at hand.  
 7 Q. So let's kind of expand on that. When you say  
 8 "the individual circumstances," so is there a  
 9 possibility that some of these surgical treatment  
 10 options would not be considered gender-confirming  
 11 surgeries for a transgender woman?  
 12 A. I think if we are looking at the -- specific  
 13 to a transgender woman, these would be considered  
 14 gender-confirming surgeries.  
 15 Q. These also are surgical treatments that can be  
 16 performed on nontransgender persons?  
 17 A. Cisgender individuals.  
 18 Q. Correct.  
 19 Okay. Let's look at the bullet points for  
 20 transgender men. Same question, are these, in your  
 21 consideration, gender-confirming surgeries or surgical  
 22 treatments for transgender men?  
 23 A. Yes, I would consider these gender-confirming  
 24 surgeries for transgender men.

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1 Q. But there are also -- they are also surgical  
 2 treatments and surgeries for cisgender persons as well,  
 3 at least some of them?  
 4 A. Yes.  
 5 Q. If you could turn the page and look at page 8  
 6 at the WPATH standard of care criteria for initiation of  
 7 surgical treatment. This is for adults seeking chest  
 8 and/or genital reconstruction procedures. Do you make  
 9 sure that these WPATH standards of care guidelines are  
 10 followed by you and your transgender patients?  
 11 A. So again I think it's important to recognize  
 12 that they are guidelines and they are flexible  
 13 guidelines and individual treatment may vary.  
 14 Q. Not every single transgender patient that you  
 15 have, for example, necessarily needs to have undergone  
 16 12 continuous months of hormone therapy prior to  
 17 surgery, or is that one that is required?  
 18 A. That would be procedure-specific.  
 19 Q. Okay.  
 20 A. Most often.  
 21 Q. Okay. It could be a less amount of continuous  
 22 months of hormone therapy depending on the treatment you  
 23 provide?  
 24 A. There could be any reason a patient is not on

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

<p style="text-align: right;">Page 42</p> <p>1 Q. Okay. So in the Agarwal study that's 2 referenced in footnote 8, it references the BREAST-Q. 3 Does that mean in your view that the results of the 4 study were based on patient-reported outcomes as opposed 5 to provider-reported outcomes? 6 A. I have to look at the study specifically, but 7 the BREAST-Q is a patient-reported outcome measure. 8 Q. You have stated that you reviewed 9 peer-reviewed literature in the studies that are 10 referenced in your report. Have you ever designed a 11 study? 12 A. Yes. 13 Q. Okay. Which study would that be? 14 A. So I have two RIB studies that are ongoing 15 now. One involves patient surveys preoperatively and 16 then postoperatively. The second is a retrospective 17 review of our experience relating to venous 18 thromboembolism in postoperative vaginoplasty patients. 19 I can then go back through my CV starting with medical 20 school if you want, but as far back as I can remember, 21 probably my early research interest in the burn unit at 22 the University of Chicago related to energy expenditure 23 in burn patients. 24 Q. Let's focus on the two RIB studies you first</p>	<p style="text-align: right;">Page 44</p> <p>1 A. The first, the venous thrombosis preliminary 2 data was presented at the European Federation of the 3 Society of Microsurgery. I think that was Belgrade, may 4 have been about March or April of this year. I believe 5 the second referencing the survey study is accepted for 6 presentation at the WPATH meeting in November of this 7 year. Aside from perhaps an abstract book at the 8 European meeting, neither have been published. 9 Q. Is there an intent to publish? 10 A. Yes. 11 Q. So let's go through some of the studies that 12 are referenced starting on page 9. We will make 13 reference to the first footnoted study, footnote 7, if 14 you could pronounce the name for me. 15 A. I believe Leriche. 16 Q. We will call it the Leriche study. This study 17 you say found of transgender men, 91 percent of the 18 sample who received phalloplasty reported that the 19 surgery was effective in aligning their physical 20 appearance with their male gender identity. Correct? 21 A. Yes. That's what it says. 22 Q. So when you talk about effectiveness here, it 23 is based on the patient's self-reporting? 24 A. I'd have to see the particular study. I don't</p>
<p style="text-align: right;">Page 43</p> <p>1 discussed. The first you talked about was a pre-op and 2 post-op comparison. What was the subject of that? 3 A. So I'm not sure I'd call it a comparison. 4 It's a survey. It's an ongoing study looking at 5 preoperative goals, expectations, self-identification, 6 sexual orientation, various other parameters, and then 7 patients are surveyed following surgery to basically see 8 whether we have achieved our goals. 9 Q. What type of surgery? 10 A. It's open to all gender -- well, primarily 11 genital-related gender-confirming surgeries. I believe 12 chest surgery as well. I think we have excluded facial 13 surgeries. 14 Q. You say that's an ongoing study. When did 15 that begin? 16 A. I think we began enrollment maybe nine months 17 ago following RIB approval. 18 Q. The second study that you referenced, is that 19 ongoing too? 20 A. It is also ongoing and that study looks at the 21 prevalence of venous thrombotic events in postoperative 22 vaginoplasty patients. 23 Q. So with regard to those two studies, is 24 anything published yet?</p>	<p style="text-align: right;">Page 45</p> <p>1 have that off the hand memorized. 2 Q. Okay. I guess, do you recall from the Leriche 3 study whether there was a comparison of this sample 4 group to any other group? 5 A. I don't believe so. 6 Q. So let's then turn to the next footnoted 7 study, the Agarwal study. 8 A. Agarwal, yes. 9 Q. Agarwal. Excuse me. 10 We have talked a little bit about that. But 11 just for the record, that's a peer-reviewed study of 12 transgender men who received chest construction. You 13 say the study found that the procedure improved 14 psychosocial well-being and physical well-being among 15 participants. Is it your belief that the results were 16 based on patient outcome survey? 17 A. The BREAST-Q is a patient-reported outcome 18 measure. There may have been other measures in that 19 particular study as well. I just don't remember off the 20 top of my head. 21 Q. Again, do you know whether in this study there 22 was any comparison to another group such as a control 23 group? 24 A. I don't specifically recall that.</p>

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1 Q. Turn the page, look at 10. Again, the top of  
2 the page references a Weigert study in footnote 9. That  
3 was a peer-reviewed study of transgender women. The  
4 study found that those who underwent breast augmentation  
5 surgeries experienced statistically significant  
6 improvement in their psychosocial wellbeing.  
7 Do you know how the results were -- how these  
8 results came to be? Was it like the previously referred  
9 studies that they were patient-outcome-driven?  
10 A. I don't specifically remember the metrics.  
11 Q. So again, you don't recall, you don't know  
12 whether there was a control group comparison?  
13 A. I do not believe there was a control group in  
14 that study.  
15 Q. Same goes for the next referenced study,  
16 footnote 10, we will call it the Horbach study, this was  
17 a peer-reviewed study of transgender women who had  
18 vaginoplasty. The study found that the participants'  
19 mean improvement in quality of life after surgery was  
20 7.9 on a scale from negative 10 to 10. That's correct?  
21 A. Yes. The particular study is a review  
22 article, so that's referencing back to another study.  
23 Q. So is that study different than the first  
24 three we talked about?

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1 A. In what --  
2 Q. In the sense that it's just a referral to a  
3 study?  
4 A. The article reference is a literature review.  
5 Q. Okay.  
6 A. The others were --  
7 Q. The results of studies?  
8 A. -- the results of studies.  
9 Q. Okay. And then let's go to footnote 11, we  
10 will call that the Hess study, was a study of  
11 transgender women that found that surgical interventions  
12 were highly correlated with alleviating gender  
13 dysphoria. Do you know the basis of those outcomes?  
14 A. I believe those were patient-reported  
15 outcomes. There may have also been psychological  
16 testing involved, but I don't specifically recall.  
17 Q. Do you know whether there was a control group  
18 in that study?  
19 A. That, I don't recall.  
20 Q. Just wondering, have you ever authored an  
21 article in a peer-reviewed journal that is a literature  
22 review?  
23 A. I believe some of my publications may have  
24 included a literature review. I'd have to look

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1 specifically, though, at my list.  
2 Q. If they had, would they have been articles  
3 that were co-authored or solely authored by you?  
4 A. Probably co-authored.  
5 Q. Would the other authors have done the  
6 literature review?  
7 A. That would be hard to know.  
8 Q. Just getting back to some of the surgeries  
9 that you perform on your patients. Do you perform  
10 gender-confirming surgeries on anyone under 18 years of  
11 age?  
12 A. Yes.  
13 Q. What kind of surgeries?  
14 A. Mastectomy is most common. I believe that I  
15 have performed vaginoplasty twice on 17-year-old  
16 individuals.  
17 Q. Were those transgender persons?  
18 A. Yes. Yes. If your question was other genital  
19 procedures, yes.  
20 Q. Actually, if we are going to use the term  
21 gender-confirming surgeries, does that necessarily mean  
22 that the person is not cisgender?  
23 A. Yes. I think we can agree with that.  
24 Q. With regard to the patient who was under 18, I

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1 don't want you to disclose any protected health  
2 information, but was there any consent by the parent?  
3 A. Yes.  
4 Q. Okay. Is that the youngest age that you can  
5 think of that -- of a patient on whom you have performed  
6 gender-confirming surgical procedure?  
7 A. Vaginoplasty, yes. For chest surgery, no.  
8 Q. Okay. How young was that?  
9 A. I believe the youngest on two occasions were  
10 the age of 14.  
11 Q. You say those were mastectomy and any other  
12 chest surgery?  
13 A. When I'm using the term -- for me, chest  
14 surgery is referring to mastectomy.  
15 Q. Okay.  
16 A. For some, chest surgery might mean breast  
17 augmentation as well, but I'm using it in the context of  
18 mastectomy.  
19 Q. Let's turn to page 12 of your expert report.  
20 This is a section concerning complication rates and  
21 risks of the surgical procedures. Have you look to the  
22 second full paragraph, the sentence starting, Looking  
23 specifically.  
24 A. Okay.

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1 Q. It says, Looking specifically at the  
2 complication rates for chest surgery, two recent studies  
3 reveal a complication rate among transgender men between  
4 11 percent and 12 percent in comparison to the  
5 complication rate of 43 percent for cisgender women  
6 undergoing breast reduction shown in a 2005 study.  
7 My question is, are these procedures even the  
8 same? The second study you cite refers to breast  
9 reduction. In the first clause you refer to two studies  
10 regarding chest surgery. In parentheses, it's  
11 subcutaneous mastectomy and chest wall contouring. My  
12 question is, aren't those different procedures?  
13 A. They can be different procedures or they can  
14 be similar. So for example, a breast reduction in a  
15 cisgender woman would entail removing skin, fatty  
16 tissue, breast tissue, repositioning the nipple and  
17 areola, may or may not incorporate liposuction,  
18 et cetera. The technique of chest surgery may vary  
19 between surgeons. So some surgeons may perform the  
20 chest surgery in a manner somewhat analogous, meaning  
21 removing skin, breast tissue, fatty tissue,  
22 repositioning -- resizing, repositioning the nipple and  
23 areola on a pedicle. Either breast reduction or chest  
24 surgery can be performed with the use of free nipple

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1 areola graphs. So there are similarities and  
2 differences between the procedures.  
3 Q. So then you would agree that when you compared  
4 the first study to the second study, we will call them  
5 footnote 15 and footnote 16, the procedures are not  
6 necessarily identical?  
7 A. I would agree they are performed for different  
8 indications. I would agree that there may be  
9 variability in some of the procedures, on individual  
10 patients, but there may also be similarities on others.  
11 Q. Do you know why there would be such a  
12 disparity between the complication rates between the two  
13 studies?  
14 A. I think that it's really a reflection that  
15 complications occur in surgery and that similar  
16 procedures, whether used for gender confirmation or  
17 otherwise in cisgender individuals both carry risk and  
18 the gender-confirming procedures are not inconsistent  
19 with risks in other plastic surgery procedures.  
20 Q. Do you know of any other studies of cisgender  
21 women undergoing breast reduction showing a complication  
22 rate that high?  
23 A. There are many studies of cisgender women  
24 undergoing breast reduction. I'd have to look at the

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1 various studies, but breast reduction, as we see here,  
2 does carry risk.  
3 Q. Would you call any of the surgical procedures  
4 you performed on a transgender person a breast reduction  
5 surgery?  
6 A. I do not, but there are other surgeons who  
7 do.  
8 Q. Okay. What would -- Would you simply refer to  
9 a chest surgery as a mastectomy on your transgender  
10 patients?  
11 A. I would -- my typical practice would be to  
12 refer to it as a subcutaneous mastectomy. However,  
13 there are surgeons who do call it and refer to it as a  
14 breast reduction. So there is not necessarily complete  
15 agreement on that.  
16 Q. I think I misspoke. Those procedures would be  
17 on transgender men, correct?  
18 A. Correct. So I'm saying -- Right. Some  
19 surgeons would call it a breast reduction when performed  
20 on a trans man.  
21 Q. I want to have you turn to another page. I  
22 believe it's 14 of your report. I want to talk about  
23 the study cited in footnote 24. You can take some time  
24 to read that.

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1 A. Okay. You're referring to the first citation  
2 in that?  
3 Q. All of them, actually.  
4 A. Okay.  
5 Q. Okay. So you cite those studies after saying  
6 there are a substantial amount -- I'm sorry. A  
7 substantial additional body of evidence showing that the  
8 standard medical and surgical treatments for gender  
9 dysphoria are both safe and effective.  
10 These studies cited in footnote 24, are those  
11 studies, like the previous studies we cited,  
12 patient-outcome-driven?  
13 A. I believe the first citation is a literature  
14 review.  
15 Q. I'm sorry. I meant patient-reported  
16 outcome-driven.  
17 A. Yes. So there may be various variables on  
18 which they are reported, so it may include both  
19 patient-reported outcomes as well as psychological  
20 testing. I have to look -- the Patholopagous (phonetic)  
21 study, I'd have to see the specific study, that may  
22 include psychological tests as well as patient-reported  
23 outcome measures.  
24 Q. If you could turn to page 16, footnote 31,

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1 take some time to read that.

2 A. Sure.

3 Okay.

4 Q. Help me with the pronunciation of that study.

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

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

7 study.

8 You criticize the Dhejne study; would you

9 agree?

10 A. Yes.

11 Q. Okay. You say, The study, however, does not

12 compare transgender individuals who had

13 gender-confirmation surgeries with transgender

14 individuals who did not have and wanted or did not have

15 and did not want gender-confirmation surgeries. You

16 wrote that in the footnote, right?

17 A. Yes and -- yes.

18 Q. Can you cite a study that does that, has a

19 compare group like you have referenced?

20 A. There are studies that have comparison groups,

21 but I don't think they would fit what I would consider

22 to be my point in this footnote.

23 Q. You wrote this in response to Dr. Lawrence

24 Mayer and his article entitled, "Sexuality in Gender:

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1 Findings from the Biological, Psychological, and Social

2 Sciences" that was published in the New Atlantis; is

3 that correct?

4 A. Well, I reference the article. I'm not -- and

5 I think, as the footnote reads, says, As both Mayer's

6 study and the authors concede, "the study cannot

7 address, quote, "the effectiveness of sex reassignment

8 surgery," et cetera, et cetera, that that may be taken

9 from the New Atlantis article.

10 Q. Okay. Dr. Mayer's article that he co-authored

11 that I just referenced, did you read that entire

12 article?

13 A. I would say I read portions of it.

14 Q. I'm sorry to get off track here, but I have

15 got some questions that I skipped over. Happens in

16 depositions.

17 Getting off topic a bit, going back to the

18 WPATH standards of care, have you ever declined to

19 perform a gender-confirming surgery if you believed

20 that the WPATH standards of care guidelines had not

21 been met?

22 A. I have declined surgeries before. It may or

23 may not be based upon the guidelines.

24 Q. What would be some examples for declining

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1 gender-confirming surgery?

2 A. Significant comorbidities. Probably the most

3 common reasons now are obesity, smoking, other medical

4 comorbidities. Various things that might make the risks

5 of surgery such that risks outweigh the benefits. Other

6 requests for surgeries that I don't perform.

7 Q. Have you ever declined to perform a

8 gender-confirming surgery because of any disagreement

9 with a patient's treating physician upon a referral?

10 A. I would say the more common scenario would be

11 a referral requesting an opinion whether surgery would

12 be indicated or warranted. So the mental health

13 professional may call me and say, I'm going to send this

14 individual and I'd like to know your thoughts on that.

15 Q. It's not necessarily a disagreement because

16 there wasn't a position taken by the treating physician,

17 or is it a request for -- I don't want to say a second

18 opinion, but would there be a disagreement between

19 doctors?

20 A. It could occur.

21 Q. Okay. So I'm going to give you -- if I can

22 find it -- I don't have it.

23 MR. KILPATRICK: Go off the record.

24 (Discussion off the record.)

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1 (Schechter Deposition Exhibit No. 2

2 marked as requested.)

3 BY MR. KILPATRICK:

4 Q. Dr. Schechter, I provided you with a document

5 entitled, Supplemental expert report of Loren S.

6 Schechter, M.D. Do you see that in front of you?

7 A. I do.

8 Q. That was signed and dated by you 25th of June

9 of this year, correct?

10 A. That's correct.

11 Q. This was submitted in the Boyden litigation,

12 correct?

13 A. Yes.

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

15 A. Okay.

16 Q. So you say in paragraph 4, Not all individuals

17 with gender dysphoria have depression. In addition,

18 when performed on individuals with gender dysphoria,

19 gender-confirming procedures are considered

20 reconstructive in nature rather than cosmetic. Do you

21 see that?

22 A. Yes.

23 Q. Is that statement -- Let me ask you this: Do

24 you stand by that statement or are there exceptions? In



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

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

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

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

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

22 Q. Are those procedures performed on transgender  
23 persons?

24 A. It would depend upon the procedure. So for

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

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

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

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

17 A. It's a medical condition.

18 Q. Medical condition, okay.

19 A. It may have psychological manifestations.

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

22 A. Depression is a medical condition.

23 Q. Okay.

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

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1 some forms of mental health.

2 Q. Okay. I think you know where I'm getting at.  
3 You have stated that you would not -- Let me put it this  
4 way. Let's give you another report.  
5 (Schechter Deposition Exhibit No. 3  
6 marked as requested.)

7 BY MR. KILPATRICK:

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

11 A. Yes.

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

14 A. Yes.

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

17 A. That's correct.

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

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

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

9 A. Can you break that down?

10 Q. Sure.

11 A. Yeah.

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

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

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

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

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

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

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1 postoperatively if you didn't have surgery and someone  
2 might not have surgery for any number of reasons.  
3 Q. So in conducting this survey, is this the  
4 first time in your practice that you have followed up  
5 with transgender persons about outcomes post surgery?  
6 A. I believe it's the first study, but not  
7 follow-up in terms of outcomes. We follow all patients  
8 for outcome.  
9 Q. How do you do that?  
10 A. So people return to the office in the  
11 postoperative period.  
12 Q. Does the postoperative period depend on the  
13 type of procedure?  
14 A. Yes.  
15 Q. What do you do to determine effectiveness of  
16 the procedure?  
17 A. So interview patients, speak with them,  
18 examine them.  
19 Q. So you say you have done that in your practice  
20 from the beginning?  
21 A. Yes, routinely.  
22 Q. But there was never any statistics generated  
23 until the study began?  
24 A. I believe -- No, I take that back. Depends

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

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

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

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

10 A. Yes.

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

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

17 Q. Okay.

18 A. You're welcome.

19 Q. Thank you.

20 Okay. You can set that aside. Here's No. 5.  
21 (Schechter Deposition Exhibit No. 5  
22 marked as requested.)

23 BY MR. KILPATRICK:

24 Q. Just to make things easier, all of these

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

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

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

12 Q. Are those procedures also performed on  
13 cisgender women?

14 A. Yes.

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

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

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

24

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

3 BY MR. KILPATRICK:

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

7 A. I do.

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

11 A. Yes.

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

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

16 Q. Okay. You can set that aside.

17 MR. KILPATRICK: Here's another one.  
18 (Schechter Deposition Exhibit No. 7  
19 marked as requested.)

20 BY MR. KILPATRICK:

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

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1 A. Yes.

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

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

11 Q. Okay.

12 A. -- brow lift, eyelid surgery.

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

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

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

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

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

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

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

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

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

3 Q. And this is for cisgender men, correct?

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

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

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

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

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

19 Q. I'm sorry. Go ahead.

20 A. Go ahead.

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

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

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

5 A. Yes.

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

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

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

16 A. The face.

17 Q. The face. I'm sorry.  
18 What about Exhibit 6, the breast augmentation;  
19 would you agree that when performed on a trans woman,  
20 its intention is to feminize the body?

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

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

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

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

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

19 MR. KILPATRICK: We can go off record.  
20 (Discussion off the record.)  
21 BY MR. KILPATRICK:  
22 Q. Getting back to your practice, do you ever see  
23 repeat patients; for instance, have you performed  
24 different gender-confirming surgeries on the same

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1 patient?

2 A. Yes.

3 Q. For the second gender-confirming surgery that  
4 you have performed, do you know whether the person's --  
5 Let me start over.  
6 Have you performed gender-confirming surgeries  
7 on transgender persons with gender dysphoria multiple  
8 times? So the question is, have you performed more than  
9 one gender-confirming surgery on the same patient who is  
10 a transgender person with gender dysphoria?

11 A. Yes.

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

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

22 A. Yes.

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

Page 78

1 you had any examples of that patient having a level of  
2 gender dysphoria that is not reduced by the first  
3 surgery?  
4 A. I would say the most common scenario, as we  
5 have discussed, again, recognizing that the treatment is  
6 individualized, that part of the preoperative discussion  
7 may be charting out the course for the individual  
8 person. Someone may have undergone, for example,  
9 initial facial surgery by one surgeon with the goal of  
10 having a genital procedure performed by me. Someone may  
11 have an orchiectomy, for example, without necessarily  
12 the vaginoplasty. Or they may say, I'm going to begin  
13 with orchiectomy and contemplate vaginoplasty at a later  
14 date. I think it would be uncommon where someone would  
15 say, I had a rhinoplasty thinking that would treat my  
16 dysphoria but now all of a sudden I have decided I want  
17 everything done.  
18 Q. You're saying it's uncommon but it is  
19 possible?  
20 A. I can't say that I have encountered that  
21 situation in my practice. Having said that, I wouldn't  
22 say it's impossible.  
23 Q. Do you know of any such situations outside of  
24 your practice?

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1 MR. KNIGHT: Objection. It's unclear what you're  
2 talking about, "any such situations." What are you  
3 getting at?  
4 BY MR. KILPATRICK:  
5 Q. Getting back to the original question, outside  
6 of your practice, are you aware of transgender patients  
7 who have one type of gender-confirming surgery performed  
8 which dissipates or reduces a level of gender dysphoria  
9 only to come back to a surgeon at a later time seeking  
10 another type of gender-confirming surgery in which their  
11 level of gender dysphoria has returned?  
12 A. I would say probably the more common scenario  
13 which I'm aware is that a patient may choose a  
14 particular surgeon for a particular procedure. Common  
15 examples, of course, because a specialty would be to  
16 have a gynecologist perform a hysterectomy, then  
17 obviously have a plastic surgeon for mastectomy. And  
18 for various reasons those are procedures that could be  
19 combined. And then that person could choose a third  
20 surgeon for bottom surgery. So I would say it's more  
21 common it's part of an overall treatment plan or patient  
22 selection as to the particular choice of surgeon.  
23 Q. Would you agree that gender-confirming  
24 surgeries do not serve purely a functional purpose; that

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1 is, they also serve in part a cosmetic purpose?  
2 A. I would most, if not all, plastic surgery  
3 procedures have -- certainly many have both a  
4 functional -- or may have a functional as well as  
5 aesthetic purpose.  
6 Q. Are you aware of the study showing that a  
7 child's gender identity may change over time?  
8 A. I'd have to see the particular study.  
9 Q. Do you believe that gender is an immutable  
10 characteristic?  
11 A. I believe that gender is innate.  
12 Q. Do you believe it may change over time?  
13 A. I believe people can be gender fluid.  
14 Q. Would you consider the gender-confirming  
15 surgeries that you perform to be irreversible?  
16 A. Components of it are irreversible. For  
17 example, following removal of testicles, one would not  
18 be able to produce sperm.  
19 MR. KILPATRICK: That's all I have for now.  
20 MR. KNIGHT: Okay. I just have a few follow-up  
21 questions.  
22 EXAMINATION  
23 BY MR. KNIGHT:  
24 Q. On the questions about whether someone would

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1 come back who -- seeking more surgery, would those be  
2 circumstances in which the gender dysphoria -- you  
3 mentioned it's commonly part of the treatment plan. So  
4 would those be situations in which the next surgery that  
5 someone is coming back to you, already had surgery, one  
6 point of surgery would be surgery -- the treatment plan  
7 would be focused on the dysphoria relating to that  
8 particular body part, that particular part of the  
9 anatomy that the surgery is focused on?  
10 A. That's possible as well.  
11 Q. And have you had instances in which -- I mean,  
12 is it your experience that the surgery does reduce the  
13 dysphoria, that it is successful in terms of treating  
14 the condition?  
15 A. Yes.  
16 Q. You were asked some questions about studies  
17 with control groups?  
18 A. Yes.  
19 Q. Are you aware of studies with control groups?  
20 A. I'm aware of studies with control groups.  
21 Q. You can't remember any today, I take it?  
22 A. Right.  
23 Q. That's fine. I'm not going to -- so are there  
24 reasons why -- are there challenges with creating

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1 control groups when we are talking about surgery?  
 2 A. Yes. Let me back up. I suppose it depends  
 3 what we mean by control group. There may be studies  
 4 that consider themselves to be control groups. Whether  
 5 they are actually good control groups may be a critique  
 6 or limitation of a particular study. Some of the  
 7 challenges in certainly surgical studies, plastic  
 8 surgery studies, clinical studies would be basically  
 9 denying an individual necessary care with for the sole  
 10 purpose of serving as a control group. In other words,  
 11 I don't think it would necessarily be an ethical study  
 12 to deny a group of people access to medical care simply  
 13 to look at the natural progression of the condition.  
 14 Q. And is there -- there is a review process to  
 15 determine whether or not you can do a study; isn't  
 16 there?  
 17 A. So clinical studies should be reviewed,  
 18 submitted to an institutional review board to look at  
 19 and examine the methods involved in the study to help  
 20 ensure patient safety and harm reduction.  
 21 Q. Okay. So the kind of study you are talking  
 22 about which is denying necessary care to someone so they  
 23 can serve as a control group would not get through their  
 24 review board?

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1 A. I don't see -- in other words, if you're going  
 2 to say we are going to select a group of transgender  
 3 individuals, whether randomly or selected, and allow one  
 4 group to have necessary medical care and we are going to  
 5 exclude this group from obtaining that care, I don't  
 6 think that would be ethical. I'd have a hard time  
 7 seeing how that would get through an institutional  
 8 review board.  
 9 Q. You were asked about surgery on -- I think the  
 10 question was about facial feminization. You were asked  
 11 about surgeries on a person who did not have a gender  
 12 dysphoria diagnosis. I believe that you mentioned that  
 13 you could think of at least one surgery for someone with  
 14 facial feminization surgery did not have a gender  
 15 dysphoria diagnosis. Do you remember talking about  
 16 that?  
 17 A. Yes.  
 18 Q. And is it possible that that person had gender  
 19 dysphoria?  
 20 A. It's possible.  
 21 Q. But -- Okay.  
 22 Ultimately the natural follow-up is that  
 23 diagnosis was not necessary to your being able to  
 24 conduct the surgery at that time?

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1 A. Correct.  
 2 Q. Part of the reason why it wasn't necessary is  
 3 because there was no coverage to provide for the  
 4 surgery?  
 5 MR. KILPATRICK: Objection, leading.  
 6 BY THE WITNESS:  
 7 A. There could be many reasons. Number one,  
 8 it -- coverage may or may not have played a role. But  
 9 other reasons would be, for example, consistent with the  
 10 standards of care, it is not necessarily mental health  
 11 assessment required for facial surgery.  
 12 Q. You were asked some questions about  
 13 patient-reported outcomes in terms of the studies, in  
 14 terms of evaluating the surgeries to treat gender  
 15 dysphoria?  
 16 A. Yes.  
 17 Q. Is that -- Does that mean those -- Does that  
 18 make those studies any different from studies for other  
 19 kinds of surgical procedures or surgical procedures for  
 20 nontransgender people?  
 21 A. So many certainly plastic surgery studies look  
 22 at things like quality of life as well as  
 23 patient-reported outcome. BREAST-Q was designed  
 24 specifically to look at patient-reported outcome,

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1 recognized the importance of that.  
 2 Q. Okay. So I guess the key question is, are --  
 3 does that differentiate studies of effectiveness of  
 4 treatment for -- effectiveness of surgery to treat  
 5 gender dysphoria from the studies -- other kinds of  
 6 studies of surgical treatment?  
 7 A. No, I would say the -- many of the studies  
 8 relating to gender-related surgeries and other studies  
 9 of nongender-related surgeries in the plastic surgery  
 10 literature.  
 11 Q. Okay.  
 12 MR. KNIGHT: That's all I have got.  
 13 MR. KILPATRICK: I have just a couple quick  
 14 follow-ups.  
 15 FURTHER EXAMINATION  
 16 BY MR. KILPATRICK:  
 17 Q. Doctor, would you consider a study to be more  
 18 reliable if there were a control group?  
 19 A. The study may have a higher level of evidence  
 20 if there was a control group.  
 21 Q. Okay. And then with regard to the question  
 22 your attorney asked you about a study that would deny  
 23 treatment to a patient likely would not go forward  
 24 because it was unethical, you yourself said that it is

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1 possible to have a control group in which a transgender  
2 individual wanted or did not have and did not want  
3 gender-confirming surgery, correct?  
4 A. I'm sorry. I have to --  
5 Q. Okay. You can go to page 16 of your expert  
6 witness report. I believe that was Exhibit 1.  
7 A. Okay.  
8 Q. Footnote 31. Six lines down starting with,  
9 The study however.  
10 A. Okay. Yes.  
11 Q. So don't you admit there that there could be a  
12 control group of transgender individuals who were not  
13 denied gender-confirmation surgery?  
14 A. No. I'm just saying it is a limitation of the  
15 study.  
16 Q. So are you saying that there cannot be a  
17 control group in determining effectiveness of surgeries  
18 on transgender persons suffering from gender dysphoria  
19 without denying a patient surgery?  
20 A. No. I think that's what we referenced --  
21 well, let me say, I think that was referenced in the  
22 earlier study, would depend what one meant by control  
23 group. In other words, there might be individuals who  
24 had surgery before a certain date or after a certain

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1 date. Those might be considered control groups. But  
2 whether they met criteria to serve as an acceptable  
3 comparison could be debatable.  
4 Q. So is it possible to have a control group in  
5 which those patients in the control group were not  
6 necessarily denied surgery because you say they may not  
7 have wanted surgery?  
8 A. I would have to say it would depend on how we  
9 define or use the term control group to make -- to see  
10 whether it's an adequate control group. I can see how,  
11 as we said, there may be individuals who had surgery or  
12 did not have surgery, which would be different than, for  
13 example, selecting through a randomized process one  
14 group of individuals -- assuming all wanted surgery, one  
15 group of individuals who were allowed to have surgery  
16 and another who were not.  
17 Q. It's certainly possible that a person --  
18 transgender person suffering from gender dysphoria may  
19 not always want surgery?  
20 A. I would say that not all transgender  
21 individuals seek surgery and some may not want surgery.  
22 MR. KILPATRICK: That's all I have unless you want  
23 to follow up.  
24 MR. KNIGHT: I have no follow-up.

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1 MR. KILPATRICK: I think we're done.  
2 THE REPORTER: Did you want to order this?  
3 MR. KILPATRICK: Yes. We definitely need -- what  
4 do they call it when there's four on a page?  
5 THE REPORTER: Oh, yes, a mini.  
6 MR. KILPATRICK: Mini. Yes. Condensed. That's  
7 the way the Court requires it. And electronic copy too.  
8 THE REPORTER: Mr. Knight, did you want a copy?  
9 MR. KNIGHT: Yes.  
10 (Witness excused.)  
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1 STATE OF ILLINOIS )  
2 ) SS.  
3 COUNTY OF COOK )  
4  
5 I, Nina Dudziak, Certified Shorthand Reporter,  
6 do hereby certify that on the 23rd day of August, A.D.,  
7 2018, the deposition of the witness, LOREN SCHECHTER,  
8 M.D., called by the Defendants, was taken before me,  
9 reported stenographically, and was thereafter reduced to  
10 typewriting under my direction.  
11 The said deposition was taken at 6201 North  
12 Broadway, Chicago, Illinois; and there were present  
13 counsel as previously set forth.  
14 The said witness, LOREN SCHECHTER, M.D., was  
15 first duly sworn to tell the truth, the whole truth, and  
16 nothing but the truth, and was then examined upon oral  
17 interrogatories.  
18 I further certify that the foregoing is a  
19 true, accurate, and complete record of the questions  
20 asked of and answers made by the said witness, LOREN  
21 SCHECHTER, M.D., at the time and place hereinabove  
22 referred to.  
23  
24

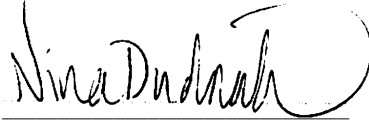


Boyden vs State of Wisconsin Dept of Employee Trust Fund  
Loren Schechter, M.D. - 08/23/2018

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

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

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NINA DUDZIAK, CSR  
180 North LaSalle Street  
Suite 2800  
Chicago, Illinois 60601  
Phone: (312) 236-6936

CSR No. 084-00382

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